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dissertation entitled

THE MEANING OF MOTHERHOOD, SELF PERCEIVED MATERNAL ADEQUACY AND TREATMENT RETENTION

presented by

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has been accepted towards fulfillment
of the requirements for

Ph.D. degree in Psychology

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Date October 19, 1998

THE MEANING OF MOTHERHOOD, SELF-PERCEIVED MATERNAL ADEQUACY AND TREATMENT RETENTION

BY

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A DISSERTATION

Submitted to
Michigan State University
in partial fulfillment of the requirements for the degree of

Doctorate of Philosophy

Department of Psychology

1998

ABSTRACT

THE MEANING OF MOTHERHOOD, SELF-PERCEIVED MATERNAL ADEQUACY, AND TREATMENT RETENTION

By

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In recent years, there has been a dramatic rise in the number of substance addicted mothers who are mandated to treatment in order to regain custody of children remanded to foster care. Regardless of strong feelings for their children, and the desire for reunification, however, many women fail to comply with treatment mandates, losing their children in the process. Despite the fact that there exists a general lack of consensus around factors which motivate and maintain individuals in treatment, and that our understanding of substance impaired mothers is limited, social service and legal entities continue to base their interventions with substance abusing mothers on factors related to mothering. This study was a step towards understanding substance addicted women as mothers, while at the same time contributing to the retention literature by exploring the relationship between various mother-related constructs and retention in treatment. While participating in one of five substance abuse treatment programs, seventy-two mothers were interviewed regarding their attitudes, feelings, and beliefs about children and motherhood. Retention was defined by the percentage of treatment completed at two time points: 8 weeks and discharge. Results indicate a relationship between self-perceived maternal adequacy and retention in treatment. Recommendations are made for integrating these results into child placement decisions, as well as treatment program

protocol and curriculum. Further exploration of the constructs examined in this study, and their relationship to retention, is warranted.

DEDICATION

For my father.

We must have one love, one great love, since it gives us an alibi for all the moments when we are filled with motiveless despair.

- Albert Camus

ACKNOWLEDGEMENTS

It is difficult to find the words to acknowledge all those who helped bring this project to fruition. At the end of this endeavor, I find myself overwhelmed, thinking of everyone who has touched and enriched my life. For their sake, as well as mine, I wish to thank them.

First, I would like to thank my committee, Cliff Broman, Hi Fitzgerald and Bertram Stoffelmayr, for their support and encouragement. A special thanks must be extended to Bob Caldwell, my chair. Through the good, the bad and the indifferent, Bob gave me the insight, the strength and the fortitude to persevere. In times of strife, I grew accustomed to the comfort of his mild manner, sense of humor, and supportive ways. Without his unconditional commitment to my success, it simply might not be.

My brother John. My love and appreciation for him is something difficult to articulate with mere words. As with my Master's thesis, he was with me every step of the way. The incessant questions. The incessant problems. All handled with the tact of a seasoned professional, and the compassion of a big brother. It is with my whole heart and soul that I thank him.

And, there is my mother. Plain and simple: She has supported me in everything I have ever done. I thank her for always letting me be whoever and whatever I wanted to be.

And finally, there is Paul and Lucy. It is with a profound sense of love and friendship that I thank them for being a part of my life.

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Chapter 1

Review of the Literature[1]

Society has expectations of women based on their role as mothers. In our society, parenting is a major social role, a normative sign of adulthood and an important developmental task (Mowbray, Oyserman, & Ross, 1995). Women gain social influence through their roles as mothers (Hill-Collins, 1987). In fact, for some women, motherhood is the only legitimate social role (Kearney, Murphy, & Rosenbaum, 1994). As such, women are often under intense pressure to become mothers, so much so that women without children are often labeled defective (Trebilcot, 1983). It is easy to understand, therefore, why, in our society, the role of mother has become essential to a woman's sense of self, and how success in this area may lead to a sense of competence and worth, while setbacks provide the basis for a negative self-image (Mowbray et al., 1995). "Feeling a sense of failure about being a mother could be the greatest source of shame for women" (Jessup, 1983, p. 375).

Historically, the phenomenon of motherhood has been studied within the context of the relationship between child-rearing practices and the developing abilities, or lack

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[1] Throughout this document, women with substance abuse problems are referred to using multiple terms, interchangeably: Substance abusing, mother with substance abuse problems, substance impaired mothers, and substance addicted, among others, are terms used to refer to mothers with chronic and usually severe drug or alcohol problems. "Substance" is a catch-all for alcohol or drugs. The term "addicted mother" was not frequently used as the literature suggests, and the author concurs, that women can have substance use problems, but not necessarily be addicted. Contrary to much of the addiction literature, the author does not see all use, even problem use, as addiction. This document tries to capture the continuum of substance use.

thereof, of children. Specifically, past bodies of literature have tended toward two related issues: One, the mother's ability to produce an "adjusted and promising offspring" (Gerson, Alpert, & Richardson, 1984), and two, the negative outcomes of either excessive or deficient mothering; in other words, blaming women for their children's problems, from homosexuality to drug addiction (Eliason & Skinstad, 1995). Unfortunately, "mother-blaming" has created a context in which existing social assumptions about "good" and "bad" mothers have been validated. That is, "good" mothers are totally self sacrificing, always physically present, and emotionally ready to serve their child's every need (Williams, 1983), while "bad" mothers are those not engaged in the care of their children at all times, whether that is because they are working, studying, or using substances (Eliason & Skinstad, 1995; Finkelstein, 1993).

Not only does society expect women to become mothers, but they are also required to be good mothers. Good mothers are those who define themselves in relation to their children (and often their spouses) and their needs, putting the needs of the family before her own: in essence, sacrificing other, less "acceptable" but self-defining roles - career woman, for example - to that of mother (and wife) (Gilligan, 1982). Regardless of its validity, this socially constructed and historically valued viewpoint of women creates a standard by which we have come to judge all mothers. As a result, mothers who are considered deviant - those who have violated social norms by using drugs or having a career - are automatically assumed to lack positive mothering skills (Eliason & Skinstad, 1995). In general, we know little about the fabric of addicted mothers lives, however,

including the relationship they have with their children (Colten, 1982). Lacking from the literature is any substantive information about the strengths and capabilities of addicted women as mothers, the importance they place on their role as a parent, or the role parenting plays in how they define themselves socially, behaviorally, and emotionally. "Beyond the need for child care, issues of motherhood are rarely addressed in the substance abuse literature" (Eliason & Skinstad, 1995, p. 84). Instead, the focus of the literature has been the negative consequences associated with drug and alcohol use, and parenting; consequences which have come to define, almost solely, our assumptions and attitudes regarding mothers with substance abuse problems.

The Negative Consequences

Understanding the serious ramifications of drug addiction among women of childbearing years is important (Luthar & Walsh, 1995). Of the few studies which have explored issues specific to addiction and mothering, however, most have concentrated on the short term, negative effects of addiction during pregnancy and on the developing child (Eliason & Skinstad, 1995; Kaplan-Sanoff & Leib, 1995; Kearney et al., 1994).

Children of substance impaired mothers may be at risk for physical as well as social problems, including developmental, cognitive, and behavioral deficits (Baumann & Doughtery, 1983). In addition, while negotiating the transition to parenthood, substance using mothers may become socially isolated which, in turn, tends to isolate their children as well. Unfortunately, this isolation often manifests in inadequate medical care for women and their children, in addition to a lack of access to social and community

supports and resources (Luthar & Walsh, 1995).

Substance impaired mothers may also experience vulnerability to psychiatric disorders, disturbed interpersonal relationships, and problems with child rearing (Luthar & Walsh, 1995). Emotionally and psychologically comprised by these and other problems, including the financial and emotional stress associated with single parenting, and the physical and psychological strain of drug addiction, substance addicted mothers may resort to severe discipline practices when resolving parent-child conflicts (Eliason & Skinstad, 1995; Luthar & Walsh, 1995). Unfortunately, this situation often culminates in CPS involvement, and ultimately, out-of-home placement for the child(ren).

Most assume that the problems associated with substance impaired parenting are indicative of inadequacy and incompetence on the mother's part, accompanied by her inability to put her children's needs before her own. The problems substance abusing mothers may experience with child rearing, however, may result more from their own experiences of inadequate parenting, than from incompetence or a lack of concern regarding their children (Levy & Rutter, 1992). Lacking the influence of positive parental role models, substance addicted mothers may behave with their children in inappropriate ways; sometimes expecting the child to provide them with the emotional gratification they fail to get from the other adults and roles in their lives (Levy & Rutter, 1992). "In discussing why they [young, addicted moms who were raised in addicted families or with addicted partners] treated their babies in particular ways, they usually said that these were the ways they themselves had been treated or had observed adults

treating infants" (Singer, 1974, p. 80).

In light of this information, many question the ability of substance impaired mothers to parent effectively without harm to the physical, emotional, and social development of their child(ren). This type of conclusion, however, is based more on social expectations of what it means to be a "good parent" than on empirical documentation. Controversy still abounds over the effects of a mother's addiction on her children. Much of the debate stems from the limitations of the existing research which, in the past, has been limited not only in quantity, but more importantly, in scope. As a consequence, although we have become knowledgeable regarding the physical and developmental problems related to substance impaired parenting, we have done so to the exclusion of exploring what motherhood means for this population (Colten, 1982; Eliason & Skinstad, 1995). We have not looked past the tangible effects of addicted parenting and explored the relationships between a substance addicted mother's attitudes and beliefs about parenting, and the influence of these perceptions on decisions which impact her life and her children: a more intrinsic understanding of substance impaired mothers (Colten, 1982). "Although the majority of [drug addicted] women are mothers, scant attention has been paid to the meaning of that role for them, and even less attention has been given to the significance of the mothering role in the treatment process" (Colten, 1982, p. 78).

Mothers with Substance Abuse Problems

Considering the empirical limitations in this area of study, much of what we know about the lives of substance addicted mothers is based on assumptions. For many generations we have saddled chemically dependent women with the stigma of being poor mothers and immoral human beings, unable to care for their children or put the needs of their children before their own (Eliason & Skinstad, 1995; Finkelstein, 1993; Kane-Caviola & Rullo-Cooney, 1991). Existing stereotypes portray the substance using mother as uncaring and cold, inadequate and abusive (Eliason & Skinstad, 1995; Finkelstein, 1993). Contrary to popular opinion, however, many substance addicted mothers highly value motherhood and often hold firm standards for child rearing (Colten, 1983; Davis, 1994; Kearney et al., 1994; Rosenbaum, 1979.)

It is interesting to note that the few parenting studies which have compared addicted and non-addicted women have found parenting attitudes which were more similar than different (Bauman & Doughtery, 1983; Colten, 1983; Rosenbaum, 1979); intimating that substance using mothers may be less different from non-using mothers than has been thought previously. In fact, when comparing the mothering attitudes, experiences and self-perceptions of heroin addicts and non-addicts, Colten (1983) found very little difference in women's perceptions of how having children had changed their life, the best and worst things about having children, and good and bad reasons for having children. Both groups also had similar feelings and perceptions regarding their children, and engaged in similar parent-child activities. In addition, differences between addicted

and non-addicted mothers' realistic understanding of the impact of having children, and in reporting that their children were not only fun, but an actual joy to have around, have not been validated (Colten, 1983; Davis, 1994; Rosenbaum, 1979). In fact, researchers have suggested that, overall, substance addicted mothers are not necessarily worse parents than non-addicted mothers, and that they often have similar opportunities to positively influence their children's outcomes as do non-using mothers (Colten, 1983; Kearney et al., 1994).

Despite the similarities, some speculate that substance impaired and non-using mothers may have different attributional styles which can result in more negative behavior patterns for addicted mothers (Dix, 1994). Attributions that promote negative affect often depend on mother's ideologies about children and child rearing (Dix, 1994). Mothers who lack information, knowledge, or confidence regarding effective parenting, therefore, may place a negative attributional style on their child's behavior, becoming more upset if they think their children understand, intend, and have control over their negative behaviors (Dix, 1994). Some suggest this attributional style may translate into inappropriate and negative parent-child interactions (Bauman & Doughtery, 1983; Dix, 1994). Substance addicted mothers are not the only group of women who lack information, knowledge, or confidence regarding parenting. It is naive to think, therefore, that substance impaired mothers are the only parents who believe that children intend to misbehave, or experience occasional, inappropriate parent-child interactions.

In fact, there is evidence which is quite to the contrary. Substance impaired

mothers perceive motherhood as a priority, often reporting that their children are the most important part of their lives, and that they feel dedicated to, proud of, and responsible for them (Davis, 1994; Kane-Caviola & Rullo-Cooney, 1991; Kearney et al., 1994; Luthar & Walsh, 1995; Woodhouse, 1992). In addition, substance addicted mothers often demonstrate appropriate mothering goals and behaviors, including nurturing and role modeling (Kearney et al., 1994). Substance addicted mothers, like mothers without substance abuse problems, often require that children are clean and well-dressed, spend quality time giving children attention, affection, and helping them with their homework, are available to them for support and reassurance, and attempt to redirect children away from trouble and into productive activities (Kearney et al., 1994). In addition, substance addicted mothers have been found to spend a great deal of time negotiating ways to maintain their parenting standards even while they continue to use drugs. These patterns of negotiation, or "defensive compensation" (Kearney et al., 1994), stem not from an addict's selfish desire to meet their own needs but from the important and central role motherhood plays in their lives (Colten, 1983; Davis, 1994; Kearney et al., 1994).

Interestingly, though not surprisingly, evidence has suggested that women who view motherhood as central and self-relevant, important and satisfying, and describe themselves in positive terms are more likely to perceive themselves as competent parents, and to exhibit more positive parenting behaviors, than those who view motherhood from an alternative perspective (Mowbray et al., 1995). In addition, these women tend to have children with fewer behavior problems and in general, function better as both parents and

community members (Mowbray et al., 1995).

Despite the positive influence of the mothering role on behavior, however, the centrality of motherhood may also create stress for a mother with substance abuse problems. Substance impaired mothers often express "great pain" over the effect their continued drug use may be having on their children (Davis, 1994; Woodhouse, 1992). Many have reported "fear of effecting their children's lives" as the most feared consequence of their continued drug use (Davis, 1994). And, although substance impaired mothers report additional fears associated with continued drug use including medical problems, financial problems, going to jail, and overdosing, the most frequently and consistently stated "identified threat" associated with continued use has been losing their parental rights (Davis, 1994).

Parenting Standards Breakdown.

Unfortunately, as with any situation where resources are limited, skills are lacking, and challenges are interminable, coping mechanisms often break down. Compromised by chronic and severe substance abuse problems, many mothers, regardless of effort, can not maintain their mothering standards. Once parenting standards break down, children may be removed from the home (Kearney et al., 1994). Mothers who are able to recognize the impending demise of their parenting strategies often voluntarily place their children with family members or friends while they focus on quitting drugs or intensifying their efforts to manage their drug use and their parenting responsibilities (Kearney et al., 1994). In the absence of social and family support, however, some

women can only keep their children safe by disclosing their drug habit to someone who may separate them from their children (Kearney et al. 1994). For mothers who are unable to acknowledge the decline of their parenting responsibilities, the shock of outside intervention, specifically, involuntary removal of children from the home, often forces them to come to terms with their failings (Kearney et al., 1994). However it happens, a majority of the children of substance impaired mothers will spend some of their childhood in foster care.

Out-of-Home Placement.

For at least the last decade, child welfare agencies, particularly those in urban areas, have reported significant increases in children being placed out of the home (Gustavsson & Rycraft, 1994). In one year, 675,000 of the 900,000 substantiated referrals to child welfare agencies involved a chemically dependent caretaker (Daro & Mitchell, 1990). In one study of chemically dependent women, 49% of their children were living in out of home placements (Eliason, Skinstad, & Gerken, 1995).

Much of the increase in out of home placement has been linked to laws written and enacted in the 1980's; a time when social welfare and legal systems noted a marked increase in licit and illicit drug use among women of childbearing years (Gustavsson & Rycraft, 1994). Many of these laws, however, were specifically instituted to legally punish substance use in pregnant and parenting women (Gustavsson & Rycraft, 1994; Horowitz, 1990), not necessarily to protect children from abusive and neglectful parents.

In fact, some states have even instituted laws which require a child abuse

screening if the mother is know to use substances, intimating that all substance addicted women abuse their children (Bauman & Doughtery, 1983; Eliason & Skinstad, 1995; Horowitz, 1990). This, however, is not always the case. Substance addicted mothers are no more likely to abuse their children than are non-addicted moms (Colten, 1983; Davis, 1994). Nevertheless, studies have shown that despite a lack of evidence substantiating abuse or neglect, children may still be removed from the home of a substance using mother (Eliason, Skinstad & Gerken, 1995).[2] It seems then that substance impaired women may lose custody of their children simply because they have departed from the idealized stereotype of motherhood (Chesler, 1991).

There are certainly times when removing a child from the home is warranted. There are mothers, some who are substance addicted, who pose a danger to their children and as such, should relinquish their care. Nonetheless, controversy exists over the utility of this as the primary means of intervention with mothers who have substance abuse problems (Lindsey, 1992; Tracy, 1994). Part of the debate arises from the fact that services are often not made available to mothers prior to the removal of the child from the home. In fact, there are times when a parent's first interaction with a social service agency is during a home investigation, often prior to removal of the child (Tracy, 1994). In addition, prior to placing a child out of the home, efforts to motivate a parent to enter

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[2] Interestingly, the contribution of drug using men to the physical, behavioral, and emotional problems in their offspring has not been examined and remains poorly understood (Gustavsson & Rycraft, 1994). "...Focusing exclusively on women, sexist assumptions about the roles of women as mothers has been perpetuated" (Gustavsson & Rycraft, 1994, pg 58).

treatment are generally non-existent or seriously lacking. As a result, the possibility for change *within* the family often remains untapped (Tracy, 1994).

Another important component of this debate centers around the limitations of the child welfare system. Typically, child welfare workers have limited training and knowledge about issues related to substance abuse (Kearney et al., 1994; Lindsey, 1992; Tracy, 1994). At an individual level, therefore, workers are forced to make decisions without understanding important client and systems level issues (Kearney et al., 1994). Unfortunately, this often sets the precedent for decision making; a precedent whereby the objectivity and professional judgment of decision makers becomes clouded by personal issues, individual beliefs and negative attitudes (Atkinson & Butler, 1996).

Social service workers, and others involved with child welfare systems, have been known to approach substance using mothers with "scorn and stigma" (Kearney et al., 1994, p. 359). This kind of perspective minimizes the possibility that substance addicted mother's behaviors and attitudes will be interpreted in a professional and unbiased manner, subsequently increasing the likelihood of inappropriate and misinformed child placement decisions.

At an organizational level, deficient training and knowledge often result in a great deal of all-or-none thinking about maternal substance abuse (Tracy, 1994). This often discourages individual child welfare workers from child placement decisions which are inconsistent with the political and social climate of the agency in which they are employed (Lindsey, 1992). Often, there is no real consensus about when to remove a

child except that which is supported by the overall ideology of the decision making agency or entity. As a result, under the current decision-making conditions in the foster care system, nearly one half of all children in need of placement are returned home, while one half of the number of children removed from their homes and placed in foster care do not need it (Lindsey, 1992). "It is my belief that if only those children were placed in foster care who would actually need it, we would have very few children in foster care" (Pelton, 1989, p 72).

In spite of the limitations of the current foster care and child welfare systems, "child protective services today [i.e. out-of-home placement] constitute the core public child and family service, the fulcrum, and sometimes, in some places, the totality of the system" (Kamerman & Kahn, 1990, p. 8). As a result, the child welfare system has become quite powerful, often holding a woman's child(ren) as collateral until she meets (or fails to meet) the standards by which we judge the adequacy of her personal and parenting skills. For substance impaired women, this standard is often defined by her ability to successfully engage in and complete substance abuse treatment. Specifically, as the current system is set up, substance abuse treatment becomes a contingency for either dismissal of a child dependency case or return of the children from foster care (Gustavsson & Rycraft, 1994).

One of the problems with this contingency based system, however, is that it often fails to work: it does not always result in the intended outcome. Specifically, substance addicted mothers do not always successfully complete mandated treatment and as a

result, may not regain custody of their children. In fact, in one study of parental compliance to court mandates in cases of child custody, 97% of the parents who did not fully comply with court recommendations, including substance abuse treatment, lost custody of their children (Murphy, Jellinek, Poitrast, Quinn, Bishop, & Goshko, 1992). Unfortunately, many interpret this failing as indicative of a substance addicted mother's inability and/or lack of desire to care for her children. But, we have already determined that substance addicted mothers love their children, and care about their well-being. So then, what is it that keeps them from completing treatment and regaining that which often characterizes the most important part of their lives?

Treatment Retention.

What is it that keeps drug addicts in treatment? Interestingly, despite a great deal of empirical work conducted in the substance abuse field aimed at answering this very question, there is no consensus regarding what motivates and maintains chemically dependent individuals in treatment, let alone what factors influence the decisions of those forced into treatment (Davis, 1994; DeLeon & Jainchill, 1986; Hoffman, Caudill, Koman, Luckey, Flynn, & Hubbard, 1994; Siddal & Conway, 1988; Williams & Roberts, 1991). And, although it is clear that retention in treatment is predictive of positive client outcomes, retention itself is difficult to predict (Condelli & Duntemann, 1993). There is one area of agreement, however: retention rates in substance abuse treatment programs are problematic.

The literature suggests that client dropout occurs in the greatest numbers within

the first three months of treatment (Condelli & DeLeon, 1993; Simpson & Joe, 1993) although *significant* drop out rates, defined as at least 30% of the treatment population, have been noted within the first twenty-three days (Siddal & Conway, 1988) and even earlier within the first seven (Hoffman et al., 1994) to fourteen days (DeLeon & Schwartz, 1984). Interestingly, approximately 15% of clients will fail to keep their first appointment, and 95% of those admitted to a treatment program will drop out within the first year (Stark, 1992).

Another area of some consensus is that drop out rates tend to be higher for women than for men (Burman, 1992; Kingree, 1995). But, studies which focus exclusively on the retention patterns of women have been limited. Because treatment is most often provided in a setting in which both men and women reside, it is difficult to focus on the special needs of women in recovery (Kane-Caviola & Rullo-Cooney, 1991; Wallen, 1992). Instead, many have simply attempted to document factors related to retention without express attention to gender differences.

Some speculate that individual motivation is the key to retention and a lack of motivation, therefore, can be used to explain the failure of individuals to enter and remain in treatment (DeLeon & Jainchill, 1986; Klingemann, 1991; Miller, 1985; Simpson & Joe, 1993). The concept of motivation is often operationalized differently across studies, however, and so it can be difficult to determine what is really at work. In one context, motivation is thought a multidimensional variable that includes clients perceptions of internal and external pressure (courts, probation, social services, family and peer

influence), commitment to change, and the appropriateness of the treatment modality (DeLeon & Jainchill, 1986; Simpson & Joe, 1993). While in yet another context, motivation is discussed as a state that results from acknowledged and anticipated consequences or specific social sanctions (Klingemann, 1991). Still, many question the link between motivation and retention even as they struggle to understand the concept of motivation (DeLeon & Jainchill, 1986; Simpson & Joe, 1993). Without a consistent definition of motivation, however, it is difficult to determine the nature of its influence on retention.

Still others have explored the relationship between retention and involvement with the legal system (Condelli & DeLeon, 1993; Condelli & Dunteman, 1993; Davis, 1994; Joe, Chastain, & Simpson, 1990; Siddal & Conway, 1988; Williams & Roberts, 1991). Recently, while attempting to manage the frightening increase in drug related criminal activity, courts have adopted protocols that mandate substance abuse treatment instead of, or in addition to, jail time, depending on the chronicity and severity of the offenders activities. And, in some instances involuntary admission associated with criminal justice involvement, and the subsequent fear of being sent to jail, has motivated some individuals to remain in treatment (Joe et al., 1990; Siddal & Conway, 1988). In other cases, however, pre-treatment arrest rates and involuntary admissions were not significantly different for women who dropped out of treatment and those who graduated (Holland, 1978; Williams & Roberts, 1991). In addition, other factors including depression, family background, education and employment levels, and financial stability

have been shown to supersede the relationship between legal involvement and treatment compliance (Condelli & DeLeon, 1993; Siddal & Conway, 1988; Simpson & Joe, 1990). Again, the relationship proves equivocal.

Factors such as the presence or absence of social support and family involvement are thought to be important and positive predictors of retention (Britt, Knisely, Dawson & Schnoll, 1995; Kane-Cavaiola & Rullo-Cooney, 1991; Kelly, Kroop & Manhal-Baugus, 1995; Siddal & Conway, 1988; Simpson & Joe, 1993). Social support and family involvement can increase a woman's emotional strength, helping her cope with the problems and stresses of day-to-day living, and the unfamiliar lifestyle associated with a drug-free existence (Kelly et al., 1995). In addition, addicted women often experience resistance from spouses and children when the prospect of treatment is introduced (Kane-Cavaiola & Rullo-Cooney, 1991). Family involvement encourages family members to deal with their own issues, while helping staff identify addicted family systems, both factors which can impede a woman's progress toward recovery. Unfortunately, female addiction is often misunderstood within the context of a variety of social stigmas, and family disapproval and denial. These factors often result in isolation, and feelings of guilt and shame for many substance addicted women: factors which decrease the likelihood that a woman will enter or remain in treatment.

Race has also been explored within the context of treatment retention: specifically, minority status (Brown, Joe & Thompson, 1985; Shiffman, Read & Jarvik, 1985). Examining treatment programs in which African-Americans, Hispanics, and

Caucasians constituted the significant majority or minority group, those in the minority were significantly more likely to have lower rates of retention, and to receive unfavorable staff ratings (Brown et al., 1985). This type of information may have influenced the recent trend towards race-specific treatment programs, run by race-specific staff. The effectiveness of such programs, however, remains to be seen.

There is also speculation that the type of drug used and the subsequent severity of a woman's addiction may also influence retention (Britt et al., 1995; Condelli & DeLeon, 1993; Copeland & Hall, 1992). Women addicted to "hard drugs" (i.e. heroin, crack) may be more likely to drop out of treatment than those who abuse "soft" drugs (i.e. alcohol) (Britt et al., 1995; Condelli & DeLeon, 1993; Schilling & Sachs, 1993; Williams & Roberts, 1991). In one study, however, women cocaine addicts were *more* likely to stay in treatment than women abusing other substances (Laken & Hutchins, 1996). Regardless, drug use, specifically the use of street drugs such as crack cocaine, has been shown to negatively affect decision making due to the mood and perception altering qualities of these drugs (Davis, 1994). For many women with serious substance abuse problems, this may generalize to decisions regarding treatment compliance, resulting in the decision to terminate prematurely. The severity of a woman's addiction may also influence her ability to be an effective parent. Substance abuse can drain a mother's attentiveness, deplete familial financial resources, and intrude upon a mother's efforts to be an appropriate role model (Colten, 1982; Kearney et al., 1994). The abuse of crack cocaine has been shown to increase maternal stress and concerns while decreasing already

compromised mothering resources (Kearney et al., 1994).

Despite supporting evidence, there is also controversy regarding the relationship between the severity of addiction and retention. Davis (1994) found that an objective assessment of addiction severity was, in fact, not predictive of treatment compliance, but that self perceived severity - the woman's perception of the seriousness of her addiction - differentiated those who remained in treatment from those who did not. The more serious a woman perceived her addiction, the more serious she perceived the consequences of continued use and therefore, the more likely she was to remain in treatment (Davis, 1994).

There is also evidence which fails to support *any* relationship between the severity of an individual's addiction and their ability to comply with treatment (Longshore, Hsieh, & Anglin, 1993; Lundy, Gottheil, Serota, Weinstein, & Sterling, 1995; Wallen, 1993). Much of this research suggests that the relationship between addiction and retention is secondary to the influence of other problems including depression, self-perceived need for treatment, traumatic life events including a history of sexual abuse, and current living situations (Longshore et al., 1993; Lundy et al., 1995; Wallen, 1993). Regardless of the debate, however, it seems logical to suggest that the severity of a woman's addiction may play some role, whether directly or indirectly, in both treatment compliance and mothering experiences.

Unfortunately, most of these inquiries have been executed in order to identify factors associated with retention patterns in general. As a result, retention studies are

often implemented within the context of co-ed treatment programs or female programs built on traditional, male dominated ideology. It is not surprising then, that we are still unsure of the individual, social, and environmental characteristics associated with female clients and treatment retention (Britt et al., 1995; Condelli & DeLeon, 1993).

Retention and Treatment Program Issues

There are those who believe that retention is related more to the dynamics associated with the treatment program itself, rather than any individual characteristic of the clients. For example, despite the fact that relationships are of central importance to women's lives (Comfort, Shipley, White, Griffith & Schandler, 1990; Finkelstein, 1990), traditional models of treatment have often failed to incorporate and support the relational skills and needs of women (Finkelstein, 1993). As a result, substance addicted women are often treated outside of the context of their role as wife, mother, daughter and sibling; even many gender specific programs still ascribe to a treatment modality focused exclusively on the individual. Many residential programs prohibit women from having contact with partners or family members during treatment, and most discourage women from future contact with "using" family and friends. Unfortunately, in many cases where women are unable to maintain relationships while in treatment, especially relationships with romantic partners, they leave (Saunders, 1993). "Rather than building on traditional relational strength [of women], women can find themselves isolated and alienated in a treatment environment that disregards the context of their lives" (Wobie, Eyler, Conlon, Clarke & Behnke, 1997, pg. 587).

Furthermore, spousal and other romantic relations are often developed and maintained within the context of a woman's addiction, relations which will inevitably change if a woman stops using. Partners can be extremely resistant to their significant other's attempts at sobriety and may actually initiate activities intended to sabotage her treatment program (Kane-Cavaiola & Rullo-Cooney, 1991). As one would expect, this issue is heightened when a woman is involved with a using partner.

When relational needs are incorporated into treatment, retention is often enhanced. For example, women are more likely to remain in treatment if they are allowed to have their children with them, or if they have permission and support to maintain consistent and frequent contact with them throughout treatment (Stevens & Arbiter, 1995; Wobie et al., 1997). Women who reside in treatment with their children also have lower rates of depression, and higher self-esteem, than women without their children (Wobie et al., 1997). For many women, however, the rules and regulations that govern the treatment center, or the fact that their children have been remanded to foster care, require that their children be left behind. The depression and frustration women experience while away from their children often distracts them from engaging in treatment activities, increasing the likelihood that they will terminate prematurely (Wobie et al., 1997).

In recent years, there has been some progress in developing gender specific treatment programming. Specifically, in the early 1980's the crack epidemic legitimized the experience of thousands of female users and addicts. In response, Federal, State, and

private entities channeled millions of dollars into the development and implementation of gender specific treatment programs. The advent of gender programming brought with it opportunities for researchers to learn about substance addicted women within the context of a treatment program designed to meet their specific needs. From these endeavors, a number of gender specific, retention related factors are beginning to surface. Though promising, early indications suggest that, for a variety of reasons including differences in treatment ideology and program curriculum, staffing, and location, much of this research has been difficult to replicate across treatment setting.

The fact that retention is difficult to predict, especially from client characteristics, may have several explanations. First, the type of data collected and the methods used in retention studies conducted thus far may minimize the true meaning and/or importance of the variable(s) of interest to the individual, and to retention. For example, predicting retention from a client's score on the Beck Depression Inventory excludes from analysis the influence of the specific events which may have preceded the onset of depression, and also the client's interpretation and understanding of those life events in general, and within the context of their present situation. Methods which give an individual the opportunity to openly express thoughts, feelings and perceptions regarding their situation and related behaviors, such as interviews, may result in data that is more insightful than information extrapolated from surveys or standardized psychological measures; methods many past retention studies have utilized (Kearney et al, 1994).

Secondly, the fact that retention is difficult to predict from the characteristics of

substance users implies that the population is more similar than they are different (DeLeon & Jainchill, 1986). And in fact, measures of specific, individual characteristics of substance abusers in treatment tend to demonstrate low variability (DeLeon & Jainchill, 1986). Overall, however, the characteristics of any given population vary widely. Studies that have attempted to explain behavior by comparing substance addicted individuals on characteristics they have in common, therefore, often fail to acknowledge the potential influence of factors which may differentiate them. These differences may be reflective not of an individual's background or personality characteristics, but rather their *perceptions* of themselves, their circumstances and their life options at the time of treatment (DeLeon & Jainchill, 1986).

The third point follows from the second. That is, there may exist other, diverse characteristics of a population that account for dropout but which have not yet been explored (DeLeon & Jainchill, 1986). In other words, a mother's failure to complete mandated treatment and regain custody of her child(ren) may not be explained by her depression, her anger, her income or her drug of choice, but of certain self perceptions: self perceptions that, until now, have not been examined.

Considering the information presented thus far, it seems that if a link exists between the individual characteristics of women and treatment retention, it is, at best, ambiguous. In fact, many researchers have been unable to substantiate client characteristics as potential predictors of retention (Davis, 1994; Hoffman et al. 1994). And, although dropout seems to be the rule for many in treatment, little is known about

who drop outs let alone *why* they leave treatment (DeLeon & Jainchill, 1986). To date, no real client profile has been developed to predict retention (Davis, 1994; Hoffman et al., 1994; Siddal & Conway, 1988; Williams & Roberts, 1991) and overall, our knowledge of the kind of woman who enters, and stays in treatment, remains limited (Faupel & Hanke, 1993). It remains important, nonetheless, to continue to make strides in this area.

> The multitude of confounding situations inherent within [retention] research makes the isolation of important variables a tedious, if not impossible, task. Nevertheless, the value of attempting to identify characteristics and treatment modalities that can assist in the accurate prediction of treatment outcomes remains a worthwhile research endeavor (Kelly et al., 1995, pg. 43).

Parental Adequacy and Treatment Retention

Despite the fact that there exists a general lack of consensus around factors which motivate and maintain individuals in substance abuse treatment, and that the perceptions and attitudes of substance impaired mothers have been excluded from retention studies, social service and legal entities continue to base their intervention with substance addicted mothers (i.e, their decisions regarding child custody) on certain factors (Chesler, 1991). Specifically, factors related to mothering. A general belief exists that the threat or experience of losing custody of a child should be reason enough for a "good" mother to successfully negotiate treatment. And, when she is unable to do so, there has been limited inquiry into the reasons why. We simply return to familiar assumptions - she

doesn't care about her children, she is unable to care for them, motherhood is not central enough to her identity - instead of developing and exploring alternative explanations.

But, these assumptions are really contrary to what little information we have do have about substance using mothers (Bauman & Doughtery, 1983; Colten, 1982; Davis, 1994; Kane-Caviola & Rullo-Cooney, 1991; Kearney et al., 1994; Luther & Walsh, 1995; Woodlouse, 1992). For example, we know that mothers with serious substance abuse problems care about their children. We also know that the maternal role is generally satisfying, self-defining and meaningful, and that their children are often the most important part of their lives (Bauman & Doughtery, 1983; Colten, 1982; Davis, 1994; Kane-Caviola & Rullo-Cooney, 1991; Kearney et al., 1994; Luther & Walsh, 1995; Woodlouse, 1992). Given this, it *is* rather perplexing that many mothers will fail at completing mandated treatment, losing custody of the children by whom they define their existence. Except, that there is still so much about this population that we do not know. Despite our assumptions about mothers who are unable to comply with court mandates involving the custody of their children, we lack information regarding their perceptions of themselves as mothers, their attitudes and beliefs about their children, and their understanding and perceptions of court ordered compliance, in general (Atkinson & Butler, 1996). In addition, we sometimes fail to recognize the influence of an individual's interpretation and understanding of their problems, abilities, and life circumstances on treatment compliance (Atkinson & Butler, 1996). Furthermore, we have yet to explore if and how the mothering role influences treatment outcomes (Colten,

1982).

To date, studies that have focused on the relationship between the mothering role and treatment retention, specifically court mandated treatment, are virtually non-existent. Some insight has been gained into how the two may be related, however, through research that has explored the self-perceptions of addicted parents (Colten, 1982; Davis, 1994; Kearney et al., 1994).

In general, addicts seem to approach their role as parent with some trepidation. Understanding that they are violating the standards of good parenting - good moms don't do drugs - many substance addicted mothers experience some level of depression and guilt (Colten, 1982; Davis, 1994; Kearney et al., 1994). In addition, many have been raised in families in which poor parenting was the standard, and so bring to the mothering role preexisting feelings of inadequacy, often accompanied by doubts regarding their ability to control their own lives, as well as the lives of their children (Colten, 1983; Kearney et al., 1994; Levy & Ratter, 1992). In fact, in one study substance addicted mothers were asked about who had control over how their children turned out: most felt that the street or some other aspect of the outside world had more control over their kids than they did (Colten, 1983).

Existing feelings of inadequacy and lack of control may develop from, and are subsequently reinforced by, the responses of others to the mother with substance abuse problems (Colten, 1982). Negative attitudes towards chemically impaired mothers are so pervasive that women often find themselves withstanding frequent, negative feedback

from family, friends, and partners (Colten, 1982; Finkelstein, 1993). Even other addicts make assumptions about mothers who abuse substances. Both male and female addicts agree that addicts who are mothers are looked down on more than male or female addicts (Singer, 1974).

For many women, unfortunately, this persistent negative assessment is internalized, extending into many aspects of their lives, including the mothering role (Elias on & Skinstad, 1995). For example, in one study women were asked about their parenting practices. Twenty percent of the addicted moms, compared with none of the non-addicted moms, stated that they were performing "poorer than most mothers" (Colten, 1982). It may be the case then, that when mothers with substance abuse problems are made to feel guilty, shameful and inept as parents, they begin to believe they are, increasing the probability that they will act that way (Bandura, 1977; Colten, 1982). After all, "...what we do tends to create a solid self-concept; what we do [or think we do] poorly results in the opposite" (Valeska, 1983, p 75).

In addition to feelings of inadequacy and lack of control, substance impaired mothers may also be coping with other issues which can put additional strain on their self perceptions, their existing competencies, their behavior, and ultimately, their relationship with their child(ren). They may be trying to manage psychological risk factors such as coexisting depression and limited emotional resources, while sometimes engaged in abusive and degrading relationships with men who also abuse substances (Grossman & Schottenfeld, 1992). The combination of feelings of inadequacy around parenting and

difficult situational variables may reinforce underdeveloped feelings of competence and mastery, and encourage perceptions of helplessness, guilt and shame. This may manifest in a number of negative affective feelings through which substance addicted women relate to their role as mother, including confusion around what constitutes appropriate child rearing techniques, and mothering skills (Colten, 1982; Grossman & Schottenfeld, 1992; Luther & Walsh, 1995).

Feelings of inadequacy pervade many the self perceptions and behaviors of many individuals, not just mothers with substance abuse problems. Specifically, social learning and self-efficacy theory have found that an individual's perception of their abilities - whether that individual is a business person, an athlete, or a parent - can interfere with, or enhance, successful accomplishment of important tasks (Bandura, 1977; Maddux, Sherer, & Rogers, 1982). In effect, that behavior is influenced by an individual's self-perceptions: when a behavior is perceived as difficult to perform, those who believe in their ability to perform the behavior, and furthermore, assume their behavior will result in favorable outcomes, may be more likely to express confidence in their ability to perform, and therefore, to initiate action (Maddux et al., 1982). On the contrary, those who doubt their competence, and expect negative outcomes, may be less likely to initiate action and more likely to fail when they do. This creates a dynamic whereby an individual's sense of personal adequacy acts as an important mediator of behavior, and decisions that influence their behavior (Bandura, 1977).

If there exists a relationship between self perceptions and behavior, how does a

negative perception such as maternal inadequacy, manifest in the behavior of substance using mothers? First, within the context of child welfare, one of the most important aspects of maternal perception and behavior may involve issues of control and adequacy (Atkinson & Butler, 1996). That is, when mothers feel like they have some control over their ability to influence their own lives, and the lives of their children, their sense of competence and control is fostered, increasing the probability that they will engage in or initiate action (Atkinson & Butler, 1996). By its very nature, mandated treatment thrusts women into a situation in which they have little control, and about which they may feel ambivalent about their ability to succeed: feelings which, theoretically, decrease the probability of action.

Secondly, feelings of parental inadequacy may significantly influence the types of behavior in which substance addicted mothers may choose to participate, especially when exacerbated by past and present emotional and environmental stressors. These factors together may so impact a woman's perceived ability to be an effect parent that, when children are removed, mothers become immobilized, unable to participate in activities, like mandated treatment, that further validate feelings of incompetency and failure as a parent.

And in fact, there is some support for such a relationship. One research team, interested in the parenting strategies of crack addicts, found that custody loss threatened each woman's maternal identity to some extent. Women responded to custody loss differently, however, depending on their maternal self-perceptions (Kearney et al., 1994).

Women who perceived themselves to be "good and competent" parents - self-perceived maternal *adequacy* - were more likely than women who were less confident in their maternal abilities to fight to regain custody of their child(ren) (Kearney et al., 1994). Women who believed in their integrity and ability as mothers, were more resilient to setbacks, using the temporary loss of children not as a sign of failure, but as a sign for action: a time to recognize the potential loss they could endure with continued drug use, and to get one's act together (Davis, 1994; Kearney et al., 1994). Confident that their children belonged with them, they were often successful in pulling themselves away from drugs, negotiating court-ordered requirements, and actively engaging in the fight to regain custody of their children (Kearney et al., 1994).

On the contrary, substance addicted mothers with a vulnerable sense of parental adequacy and control often interpreted the removal of their child(ren) as further validation of their failings as a parent. Feelings of failure in turn manifested in anger, feelings of fatalism and guilt, culminating in the assumption that their children might be better off without them (Kearney et al, 1994):

> Once children were out of harm's way [removed from custody], a mother's lifestyle often became the largest obstacle to regaining custody. Drug use escalated because women had no mothering responsibilities and much pain and sadness. In their desire for their children's health and happiness, *mothers already labeled as unfit by the child welfare system had little confidence in their mothering abilities* and were reluctant to remove their children from stable

homes... The longer children were in someone else's care, the more difficult it became to rationalize taking them back (p 356-357).

For these women, the ability to deal with custody loss, and comply with court mandated requirements was not at all related to how much they cared for their children; they all did and very much. Nor was it related to a lack of importance, satisfaction or meaning related to the mothering role; the mothering role was very central to their lives (Colten, 1982; Kearney et al., 1994; Rosenbaum, 1979). What differentiated the behavior of each group was the perception they maintained of themselves as mothers, whether negative or positive, and its influence on their interpretation of the situation, and ultimately their behavior. This study was an attempt to further explore this relationship.

Conclusion

This discussion has given a context in which to place the sometimes confusing behavior of addicted mothers by addressing the individual and systems level factors which affect their experiences. And, despite significant levels of research in the area of substance abuse treatment, and child welfare policies and practice, we continue to ignore the feelings, perceptions, and experiences of addicted mothers: Some of the very things we are, at the same time, trying to change.

At this point, we know that drug addicted mothers are a vulnerable population; vulnerable in many ways. And, as parents, they often approach their role lacking both skills and knowledge, and with preexisting feelings of guilt, shame, inadequacy, and lack of control. Despite these factors, however, they value their role as mother, love and adore

their children, and spend emotional and physical time negotiating ways to maintain their parenting strategies in spite of their addiction. Unfortunately, for both parent and child, parenting strategies often break down, leaving women and children susceptible to social service intervention, namely custody loss and court mandated substance abuse treatment.

Despite the love they have for their children, however, once custody is lost and treatment becomes a part of the child reunification plan, women still fail to comply with treatment demands. Until now, however, there has been little exploration of factors which might explain this phenomenon: the existing retention literature does not explore it, nor is it dealt with in the child welfare arena. In fact, we just really don't know much about this population and subsequently, this issue.

Recently, however, an advance has been made. Through a qualitative study of the parenting strategies of drug addicts, women's self-perceptions, specifically their maternal self-perception, emerged as a link to treatment compliance (Kearney et al., 1994). Given the stakes involved in mandated drug treatment and custody loss, including the emotional and psychological consequences for both mother and child, and the financial resources required to process the case and place the child, this relationship needs further exploration. In addition, presently state and federal entities allocate millions of dollars each year for substance abuse treatment programs, and the policy and practice of child welfare agencies. It seems reasonable, therefore, to question the efficacy of such practices if only to suggest alternatives for those needing improvement.

For all of these reasons, this study was an attempt to explore the role of

motherhood to retention in treatment. Specifically, retention for those women mandated to substance abuse treatment as a method through which to regain custody of their child(ren). The study accomplished this by pursuing the following three main goals: goals aimed toward achieving a better understanding of the substance addicted mother. First, this study intended to demonstrate that self-perceived maternal adequacy, or the belief that one is a good and competent parent, may be a factor in determining treatment retention for substance addicted mothers. Secondly, this study attempted to validate women's experience of motherhood as important, meaningful, and satisfying. And finally, the experiences of substance addicted women, revealed through their own words, was used to broaden our awareness of the issues which affect their lives, their decisions and their children.

Purpose and Hypotheses

In this research study, the variables of interest, and the potential relationships between them were explored using the following hypotheses:

Purpose 1

This study explored the relationship between three concepts related to motherhood and self-perceived maternal adequacy. In this context, the three related concepts were: (a) role importance, (b) the *meaning* of motherhood, and (c) maternal *satisfaction*. These three constructs - role importance, meaning, and satisfaction - were evaluated as individual constructs.

The concept of self-perceived maternal adequacy was defined as a woman's

perception that she is a good and competent parent; in a sense, her perception of herself as a mom and how competent she sees herself as a parent. Self-perceived maternal adequacy was explored as a single construct, and in relation to role importance, the *meaning* of motherhood, and maternal *satisfaction.*

Hypothesis 1
It was expected that role importance would have a direct, positive relationship with self-perceived maternal adequacy.

Hypothesis 2
It was expected that meaning of motherhood would have a direct, positive relationship with self-perceived maternal adequacy.

Hypothesis 3
It was expected that maternal satisfaction would have a direct, positive relationship with self-perceived maternal adequacy.

Purpose 2

Importance, satisfaction, and meaning of motherhood, along with self-perceived maternal adequacy, were explored in relation to treatment retention. The exploration of this relationship was an attempt to understand the implications these constructs may have for retention in mandated substance abuse treatment. It proceeded in the following way: (a) The following three constructs - role importance, meaning and satisfaction - were evaluated in relation to their individual contribution to treatment retention, (b) the relationship between self-perceived maternal adequacy and treatment retention was also explored, and (c) the relationship between all variables and treatment retention was assessed.

Hypothesis 4
It was expected that a small, positive relationship would exist between role importance and treatment retention.

Hypothesis 5
It was expected that a small, positive relationship would exist between meaning of motherhood and treatment retention.

Hypothesis 6
It was expected that a small, positive relationship would exist between maternal satisfaction and treatment retention.

Hypothesis 7
It was expected that a positive, linear relationship would exist between self-perceived maternal adequacy and treatment retention.

Hypothesis 8
It was expected that parental adequacy would mediate the relationship between the three other individual constructs - role importance, meaning and satisfaction - and retention.

It was expected that when parental adequacy was high, a positive linear relationship between importance, satisfaction and meaning, and treatment retention would exist. Similarly, when parental adequacy was low, it was expected that no functional relationship between these three constructs and treatment retention would exist.

Hypothesis 9
It was expected that an interaction effect would exist between parental adequacy and the three other individual predictors on treatment retention.

Exploration of motherhood.

Various open ended questions were posed to women to gain information regarding their experiences, attitudes, beliefs, etc. as parents.

Chapter 2

Methods

Research Design

The investigator used a correlational, multivariate research design to elucidate the relationship(s) between the following continuous variables: (a) role importance, (b) the meaning of motherhood, (c) satisfaction with motherhood, (d) self-perceived maternal adequacy, and (e) retention in substance abuse treatment. This design was appropriate as the study intended to create a linear combination of continuous independent variables to optimally predict one continuous dependent variable (retention in treatment). The design accommodated descriptive, qualitative and statistical analyses of variables of interest. The next section presents a description of the research participants, data collection sites, and the measures and procedures used for data collection.

The Sample

The sample for this study consisted of approximately 72 women[3] with children, between the ages of 18 and 55, recruited from five local Lansing drug/alcohol treatment facilities. Three of the programs, including an intensive outpatient, a residential and a day treatment program, were associated with The National Council on Alcoholism, Lansing Regional Area, Inc (NCA-LRA), Two additional sites - Cristo Rey Living Free and Southland Counseling Program - both intensive outpatient programs, were added

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[3] Sample size was determined using power analysis techniques outlined by Tabachnick & Fidell (1996) and Green (1991). Assuming a small to moderate effect size, adequate power can be achieved for N=72.

after 6 months of data collection failed to reach the anticipated number of participants. Prior to the addition of Cristo Rey and Southland Counseling, interviews were conducted with program directors in order to ensure that clients were as closely matched to the original population as possible. Women at both Cristo Rey, and Southland Counseling appeared to match women in the original three sites demographically, and with regard to addiction severity, and associated psychological, health, and family problems.

There were two specific criteria for inclusion in this study. First, a woman had to have at least one child with whom she had primary custody and/or guardianship regardless of whether the child(ren) was residing with her at the time. Second, the woman must have initiated contact with one of the programs/facilities listed below, regardless of whether or not contact was self-initiated or mandated by external entities (court, Child Protective Services, physician, etc.). Formal admission to the program was not a stipulation for participation in this study and is discussed below.

The Sites

The mission of NCA-LRA is to identify and meet the needs of individuals and families in the Mid-Michigan area experiencing alcohol and other drug problems. The National Council on Alcoholism, Lansing Regional Area offers a wide range of programs and services for individuals and families experiencing substance abuse related problems and is currently the only substance abuse provider in Mid-Michigan with gender-specific, residential and day treatment programming for women. All three of NCA-LRA's gender-specific programs were targeted for this project and include the Women's Day Treatment

Program, Glass House, and IOP-E. Each program is briefly described below.

The Women's Day Treatment Program (WDTP), located at 321 N. Pine, was created to fill a gap in the continuum of available treatment options in the Lansing Area. The program serves chemically dependent women, specifically targeting African-American women, including pregnant, post-partum women, and women with children. Women in this program are usually in an advanced state of chemical dependence and are often addicted to multiple drugs.

More than any other NCA/LRA gender specific program, WDTP addresses the ravages of crack/cocaine. In fact, 61% of the women admitted to WDTP report crack/cocaine as their primary drug of choice. As a result of the severity of their dependence, these women often experience related legal, financial, psychological and health problems and, in many cases, are mandated to treatment by family court. Consistent with court mandated treatment, many of the women had lost temporary custody of their minor child(ren).

The Women's Day Treatment Program uses an individualized treatment plan, including substance abuse education, individual and group therapy, art and recreation therapy, and supportive services, to help women overcome their addiction and achieve abstinence. To eliminate any barriers to treatment participation, the program is offered during the day and also offers transportation, meals and child care for preschool aged children. The complete treatment program is intended to take place over a six month time period. However, for the calendar year 1995, the latest available statistics, only 25%

stayed at least six months, while 51% of women admitted to the program stayed 90 days or less. Of those who stayed less than 90 days, only 22% stayed 1 to 3 months. The remaining women dropped out sometime within the first 4 weeks of treatment.

Located in downtown Lansing is the Glass House, a fourteen bed residential facility for chemically dependent women who need intensive, residential treatment services. Many of the women at Glass House are admitted in an advanced stage of dependence, similar to those at WDTP. Glass House clients, however, were more likely to be polydrug users (54%) but share with WDTP a large number of crack addicted women (31%). Because of the severity of their dependence, Glass House clients, like the clients at WDTP, frequently experience problems in addition to their addiction, including legal, financial, psychological, and health problems. Again, many of the women were mandated to treatment by family court in an attempt to regain custody of their minor child(ren).

The Glass House program utilizes a comprehensive treatment plan which includes individual and group therapy, education, parent skills training, and daily attendance at community sponsored 12-step group meetings to meet the needs of the clients. The length of stay typically varies between three and six months, depending on the individual needs of the client and her insurance coverage. Originally, however, the program was designed to progress from admission to completion in six months. As with WDTP, retention is an issue at Glass House. For the 1995 calendar year, the latest available statistics, 20% of the women admitted to Glass House stayed 16 days or less,

71% stayed anywhere from one to three months, while only 5% stayed more than 120 days.

The Intensive Outpatient Program - Evening (IOP-E), located at 3400 S. Cedar St., Suite 200, takes place in the evenings and was designed to provide the structure and intensity needed by severely dependent clients in an outpatient format. Approximately half of IOP-E clients are employed, cannot leave their families, or face other circumstances that make residential or day treatment less feasible as a treatment option.

Intensive outpatient clients were just as likely as residential or day treatment clients to be experiencing legal, financial and psychological problems related to their substance abuse problems, but were less likely to be mandated by family court to treatment. Instead, more than Women's Day or Glass House clients, IOP-E clients were more likely to be in treatment to fulfill the requirements of their probation. Many, however, were also trying to regain custody of their children. Fifty-three percent of IOP-E clients reported alcohol as their primary drug of choice as compared to WDTP or Glass House clients who used more drugs than alcohol. The IOP-E program shares with WDTP and Glass House problems with retention. For the calendar year 1995, again, the latest year statistics are available, approximately 31% of clients enrolled in IOP-E remained in treatment 30 days or less. Sixty one percent stayed anywhere from one to three months, while only 22% stayed between 2 and 4 months. Only 3% were retained in IOP-E for more than 4 months.

The Living Free Women's Program[4] is an intensive outpatient case management and substance abuse treatment program housed in the Counseling Department at Cristo Rey Community Center, 1717 High St., Lansing, Michigan. The Living Free Program provides case management, substance abuse counseling, support and education services, home visits and personal needs care to any woman with a current or recent history of alcohol and/or other drug addiction or is at risk for a substance abuse problem and is currently pregnant and/or the mother of dependent children, whether or not they currently reside in her custody.

After contacting the treatment program, each program participant receives an initial intake assessment to determine eligibility for the program and to identify any urgent problems that require immediate intervention. At the same time, if a woman's children presently reside with her, their individual needs are assessed as well, and appropriate referrals are made. Once a client is admitted, an individualized treatment program is developed consisting of some combination of individual and group substance abuse counseling, weekly AA/NA meetings, and participation in weekly parenting and women's support group meetings. In some cases, women are assigned to attend an independent living skills group to assist the client in gaining self-sufficiency. Throughout the program, clients are closely monitored by case managers to ensure they are meeting their program goals. As with the other three programs, however, Living Free had its share of retention problems. Based on anecdotal evidence reported by the

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[4] Living Free and Cristo Rey are used interchangeably throughout this document.

program director, approximately 60% of clients drop out at some "early point in their treatment," after being admitted to the Living Free program. Although formal data were not available to confirm this information, Living Free is a very small program and the program director is intimately involved with each case. It seemed likely, therefore, that her perspective was closely aligned with actual retention rates.

Southland Counseling Center, a program of the Clinton-Eaton-Ingham Community Mental Health Association, is a large, comprehensive substance abuse treatment program located at 808 Southland, Suite C, Lansing, Michigan. Southland provides intensive outpatient treatment services for persons and their families with problems relating to chemical dependency. Treatment for alcohol and drug addiction is individualized, and consists of a wide variety of outpatient services including assessment and evaluation, individual and group therapy, psychoeducation groups, women's groups, family therapy, methadone maintenance, and dual treatment for mental illness and substance abuse. Southland also emphasizes family participation and responsible community relationships.

Different from the other program sites, Southland Counseling serves a very large population, most of whom are self-referred. In 1997, Southland admitted 350 women to the program, 115 of whom were court mandated or referred by the Department of Corrections (33%). The remaining admissions were self-referred. Southland also sees a severely addicted population - thirty percent present with a chronic opiate addiction - and "almost all" admissions to Southland are considered moderately to severely addicted.

Many of the women admitted to the program come to Southland for methadone maintenance, one of the few places in the area which offers this type of treatment.

Similar to the other program sites, however, Southland has it's share of retention problems. According to records, of those admitted to treatment, 25% stay less than one month, 40% stay one to three months, 23% stay four to six months, 9% stay seven to eight months, and only 3% stay ten to eleven months. The outpatient therapy program was designed to take between three and six months to complete. Methadone maintenance, on the other hand, requires a minimum of two years, but typically lasts for four.

Recruiting

Recruiting procedures were defined differently in each of the five sites. At both the NCA/LRA and Southland Counseling sites, approval was first granted by the respective Board of Directors. Formal proposals were submitted and reviewed prior to interviewing. Cristo Rey was a much more informal setting; after a brief presentation to the executive director regarding study objectives and methods, permission was granted for interviewing to take place.

In all cases, prior to project implementation, the investigator met with treatment staff at each of the participating programs. At this time, staff were informed of the project goals and methods, and questions and concerns were addressed. Procedures for recruiting and interviewing were presented in depth and discussion was encouraged. Recognizing the importance of investigator-staff relationships, and the desire to keep the

interview process from intruding on the treatment day, when appropriate and/or necessary staff input was solicited and integrated into the recruiting and interviewing protocol.

NCA/LRA Program Recruiting

Any pregnant or parenting woman who had physical contact[5] with and/or was admitted to any one of the programs was asked to participate in the study. Protocol for contacting women was different for each site and was carried out by the research team, which consisted of five Psychology undergraduate students and the investigator during the first 5 months of data collection, and one student and the investigator for the remaining 7 months.

Women's Day Treatment Program (WDTP).

The WDTP comes into contact with more women than either of the other two NCA-LRA sites. Consequently, 3 research team members were assigned to work with WDTP staff and clients. Women who were in treatment when the study began, as well as those women who were subsequently admitted, were asked to participate. It was initially thought that women would be recruited during a mandatory, pre-admission orientation session. And, in fact, this was often the case. As the study progressed, however, women scheduled for the mandatory orientation session frequently failed to attend and were allowed to reschedule for another day, at their own convenience. Unfortunately, this new time was often unknown to the research team. This often made it difficult to keep track of new admissions. As this situation became more common, the

[5] This eliminates those women who had only had phone contact with the program.

research team often made frequent trips to the center, on previously unscheduled days, in order to keep track of and recruit new admissions during the treatment day. This tactic also served to minimize the possibility of overlooking potential participants, and to ensure that all potential participants were given the opportunity to take part in the study.

To engage women in the study, one research team member was present at each orientation session. When women were in attendance, which was not always the case, the purpose of the study, and participants rights, including confidentiality and voluntary participation were explained, and women were allowed to ask questions. When a woman agreed to participate, an interview appointment was scheduled to take place within a day or two. The sense of urgency surrounding the scheduling process was an attempt to minimize the possibility that women would drop out of treatment prior to the interview.[6] In many cases, this procedure was successful but in others cases, women were lost; they left treatment before we could interview them. Of the 52 women admitted to the program from June, 1997 to June, 1998, 21 were interviewed. All interviews were conducted on site.

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[6] The literature suggests that client dropout occurs in the greatest numbers within the first three months of treatment (Condelli & DeLeon, 1993; Simpson & Joe, 1993). However, significant drop out rates have been noted within the first 23 days (Siddal & Conway, 1989) and, even earlier, within seven (Hoffman, Caudill, Koman, Luckey, Flynn & Hubbard, 1994) to fourteen days (DeLeon & Schwartz, 1984). In addition, the clinical supervisor at NCA-LRA has suggested that, in his experience, of those women who drop out, many leave within the first two weeks. As a result, it was imperative to try to complete interviews in the first two weeks following a woman's admission to treatment.

Glass House.

Glass House is a 14 bed, residential facility to which two research team members were assigned to work with both staff and clients. In general, women are referred to Glass House by an external source who is responsible for contacting treatment staff and making arrangements for admission. As a result, there was usually time between program contact and client admission, a few days to be exact, for program staff to be notified of an incoming client. In order to access new admissions within a one week time limit, and to establish our presence on site, each research team member was present on a specific day each week, at a regularly scheduled time, to meet and talk with the women regarding the study. At this time, women were introduced to the study and given information regarding participant rights, including confidentiality and voluntary participation. If a woman agreed to participate, she was scheduled for an interview within a few days at which time the interviewer would return. All interviews were conducted on site.

Intensive Outpatient Evening.

Two research team members were assigned to this site. Women in this program meet two to three evenings per week, depending on their treatment plan. All women, however, including new admissions and current clients (those women already in treatment when the study began), are required to attend a two hour group every Monday evening. Initially, one research team member was present every Monday evening. After a time, however, team members were present only when at least one new woman was

scheduled to attend the Monday session. During these sessions, women were introduced to the study and participant rights were explained, including confidentiality and voluntary participation. Those who agreed to participate were either interviewed that evening or were scheduled for a subsequent evening. Of the 78 women admitted between June 1, 1997 and June 1, 1998, 26 were interviewed.

Living Free Recruiting

As previously mentioned, working with the Living Free Program was very informal from the start due in part to the size of the program; at the time there were 18 women enrolled. Participants were recruited through the case manger, who is responsible for seeing each client at least once per week. During their regular meeting, the case manager would give each client a one page summary of the study, ask the woman to read it, and to think about whether or not she would like to participate. The summary had been written from the original consent form and included a brief introduction to the study, and an explanation of participants' rights including confidentiality and voluntary participation. Near the end of the session, the case manager and the client discussed the study and, upon the client's request, scheduled her for an interview during her next regular session. The case manager then contacted the investigator to provide the necessary information. During this process, the case manager and investigator worked together to ensure that interviews were scheduled at the clients' convenience. Of the 18 women enrolled in Living Free, 7 agreed to participate in the study, but only 3 were interviewed. The other 4 failed to show up for their scheduled appointments. It is likely

that more women might have been recruited from this site had the case manager not left the program for maternity leave, without a replacement. At the time of her departure in December, 1997, contact with the Living Free Program was terminated.

Southland Counseling Recruiting

A formal request for permission to interview was submitted to the Board of Directors of the Clinton-Eaton-Ingham Community Mental Health Association in October, 1997. Recruiting did not begin until January, 1998, however, as the request had to be processed through all required administrative channels. While awaiting approval, the team met with the counseling staff to determine the most efficient means of recruiting participants.

During meetings with staff, it was discovered that most clients enrolled in the Southland Counseling Program were required, each week, to attend two group and one individual counseling sessions. As such, it was decided that group time presented the best opportunity for interacting with as many potential participants as possible. When staff offered to schedule recruiting time before and after Monday morning and Friday afternoon group sessions, and time during group sessions for women to complete interviews, the recruiting/interviewing protocol was set. A member of the research team was present at both the beginning and end of group sessions at which time women were introduced to the study and participant rights were explained, including confidentiality and voluntary participation. Those who agreed to participate were either interviewed that day or were scheduled for a subsequent time.

Interviews

Interviewer Training.

The investigator and five undergraduate students were responsible for recruiting and interviewing research participants. Undergraduate students exchanged approximately 6-10 hours a week for either independent study credits (Psychology 491), or in some cases, the experience.

All students were asked to commit to two semesters (spring and summer, 1997), and were required to participate in an 8 week training session, conduct interviews, record and submit interview protocols, and have weekly contact with the primary investigator. Four of the five students remained on the project for the time requested (two semesters), while one stayed on from February, 1997 through June, 1998.

The training was a combination of readings, discussion and experiential learning exercises (role-plays and mock interviews) aimed at practical application of new skills. Topics included education about substance abuse, special issues and concerns related to drug addicted women, ethical and practical issues related to research including confidentiality and participants' rights, interviewing skills including empathy and active listening, an overview of qualitative theory and methods, and introduction to, training in, and practice using the research interview instrument.

After successfully completing training, students were assigned to one of the three NCA/LRA program sites, [7] depending on schedules and personal preferences. Before

[7] Additional sites were added after four of the five students had completed their project term.

data collection began, the investigator accompanied each student to their respective site, introducing them to program staff and administrators. After initial introductions, students established a schedule with program staff for recruiting and interviewing. In the event team members were unable to fulfill their weekly obligation, they were to find a replacement team member. If other team members were unavailable and the student had to cancel or change plans, both the investigator and program staff were notified. Interviews were rescheduled as soon as possible. Throughout the course of data collection, this occurred very infrequently.

Weekly supervision was required to provide students with progress evaluation and feedback. In most instances, supervision took place by phone at which time students could ask questions, discuss feelings or concerns, or simply talk about their experiences. When requested, supervision was conducted in person.

Interview protocol.

The following protocol was used for data collection:

Procedures for recruiting and scheduling interviews are outlined above. Once an interviewed was scheduled, each trained interviewer met the woman at the treatment program site, at the time agreed upon. Before beginning, the topic of study was again explained, as was voluntary participation and confidentiality, and women were given an opportunity to ask questions or voice concerns. Participants were asked for permission to audio-tape for research purposes, and questions or concerns related to taping were discussed. All women gave consent for audio-taping. A consent form summarized all of

the above in written form and women were asked to sign the consent form only if they understood their rights, and the subject matter of the interview (See Appendix A for consent form). After the consent form had been signed, the interview began. In most cases, interviews lasted approximately one to one and one half hours. This did vary, however, but never dramatically. At the end of the interview women were once more encouraged to ask questions, and were thanked for their time and their contribution to the process. No further efforts were made to contact women once an interview had been completed. In some cases, however, women would approach the interviewer days or weeks after their own interview with questions or concerns. These matters were handled immediately and in most cases required nothing more than further information or additional clarification. In two cases women became concerned about the content of their interview, and the possibility that it might be used against them in court. In these instances, women were assured of their confidentiality, the purpose of the audio-tape, and were encouraged to talk about the context of their concerns. Although the investigator believes that these two women felt more at ease after the discussion, they were assured that if their concerns continued they could take possession of the tape. Neither woman opted for this choice.

Measurement Issues

Much of the instrument (see Appendix B), an interview protocol which includes both closed and open ended questions, has been modeled after the data collection instrument used in The Mom's Project. The Mom's Project is a research study taking

place in the Detroit/Wayne County area, examining the relationship between the meaning of motherhood, community functioning, and social support in chronically, mentally ill mothers (Mowbray & Osyerman, 1995).

This instrument was chosen for three reasons. First, the manner in which the Mom's Project had operationalized, and subsequently measured, motherhood—in terms of Meaning, Satisfaction, Importance, and Adequacy—was similar to the author's initial conceptualization of motherhood. Secondly, the Mom's Project instrument had been developed specifically to evaluate motherhood in a comprised population. Thirdly, after several conversations with the principle investigator for the Mom's Project (conversations in which the Mom's Project instrument was reviewed), and the context and dynamics of the current study were outlined and discussed—it became clear that parts of the Mom's Project instrument were well aligned with the goals of the current study. For these reasons, various sections of the Mom's Project instrument were used for this study as well.

Analysis of the instrument for the Mom's Project indicates that four constructs - role importance, meaning of motherhood, maternal satisfaction, and self-perceived maternal adequacy - are distinct, but related concepts; related by their contribution to the concept of "meaning of motherhood." Each separate component has been has been empirically documented with a chronically mentally ill population (Mowbray, Oyserman, Zemencuk, & Ross, 1995; Osyerman, Mowbray, & Zemencuk, 1994; Zemencuk, Rogosch, & Mowbray, 1995). Given the similarities between a chronically mentally ill

population and a severely addicted one, there was no reason to believe that the interview would not be appropriate for use in this project. Minor modifications, however, were made to reflect the differences in pathology between the two groups. For example, in some cases references to mental illness were changed to reflect the substance problems of the present population.

Pilot testing

The interview protocol was pilot tested on 10 women, randomly selected from each of the three participating sites. Preliminary analysis of the pilot testing indicated that minor modifications, mostly rewording of questions or additional probing, were necessary. These changes were initiated before subsequent interviews were completed.

Measures

The purpose of the current study was to explore the relationship between role importance, the meaning of motherhood, maternal satisfaction, self perceived maternal adequacy, and treatment retention. Data were collected through face-to-face interviews using a semi-structured interview protocol. The interview includes Likert-type questions, and both open and closed ended questions and statements. In most cases, the interview was completed in approximately 1 hour, although in some cases it took longer. The interview was designed to elicit information to explore and evaluate the following constructs: role importance of motherhood, the meaning of motherhood, satisfaction with mother-child relationships and self perceived maternal adequacy. The measure includes scales developed by other researchers, some of which have been modified for the

purposes of this endeavor, as well as questions which were developed specifically for this research study. A description of each construct of interest, and the means by which it will be assessed are outlined below. The presentation divides the scale into descriptive, quantitative and qualitative sections. Psychometric properties are reported for existing quantitative measures.[8]

Descriptive Information

Demographics

Demographic variables were collected in order to describe the sample of women in the study. Women were asked to report on a number of variables including age, race, ethnicity, and marital status, along with questions about family, children, employment, and educational status.

Quantitative Measures

Severity of Drug/Alcohol Use.

The Drug Assessment Screening Test (DAST) was used to evaluate the severity of a woman's drug addiction.[9] The DAST, a 20-item screening instrument, yields a quantitative index of the degree of consequences related to drug abuse. Scoring assumes that the higher the consequences associated with use (i.e. a high DAST score), the more severe an individual's drug problem. The internal consistency of the DAST is estimated at .92 and factor analysis of item inter-correlations has suggested a unidimensional scale

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[8] Results of reliability analyses from this study are reported in the Results section.

[9] This variable was assessed at the request of management staff at the NCA/LRA. It was not intended to be a focus of the study.

(Skinner, 1983). For the purpose of this study, the DAST was modified to include alcohol consumption as well as drug use. For example, the DAST asks: Have you ever missed work due to drug use? For this study the question was reworded to ask: Have you ever missed work due to drug and/or alcohol use? This change was made to accommodate women being treated solely for alcohol addiction. Additionally, and at the request of NCA-LRA management staff the question "What is your drug of choice?" was added.

The following sections of the interview were taken from the Mom's Project. Permission to use the Mom's Project instrument was granted by the primary investigator, Carol Mowbray, Ph.D., by phone on November 1, 1996. Some of the subscales in the Mom's Study instrument were written by the Moms Project research team, while others were taken from existing measures. This information is noted below.

Role Importance

The 11 statements on the Importance scale (labeled PIMP) constitute two related factors designed to assess the importance of being a mother, and the centrality of social roles, personality characteristics and feelings in the mother's life. In this section, women rated the importance of family roles (Importance - Family, $\propto$ = .67) and personal or individual roles (Importance - Individual, $\propto$ = .60) on a 5 point Likert scale where 1 = not at all important, and 5 = extremely important. This scale was developed by the Mom's Project staff and was based on work by Herzog and Markus (1995).

Parental Satisfaction

The 11 statements which make up the Satisfaction scale (those labeled PSAT) were developed by Mom's Project staff. Two related factors measure a woman's satisfaction with her relationship with her children (Satisfaction - Relationship, $\propto$ = .84) and with herself as a caretaker or provider (Satisfaction - Caring/Providing, $\propto$ = .76). Women rated statements on a 5 point Likert scale, where 1 = very dissatisfied, and 5 = very satisfied. The statements were developed by Mom's Study project personnel.

Self perceived maternal adequacy

There are 14 statements which were designed to measure Self-Perceived Maternal Adequacy. Five items (PADEQ a, b, c, d, and o) were taken from the Parenting Domain of the Parenting Stress Index (Abidin, 1990, $\propto$ .93), while the other 9 items (items e - m) were from the Parental Locus of Control Scale (Campis, Lyman, & Prentice-Dunn, 1986; Mom's Project, $\propto$ = .74). These statements were designed to elicit a woman's sense of competence and adequacy as a mother; in a sense, how she perceives herself as a mom, how responsible she feels for her child(ren)'s behavior and how competent she sees herself as a parent. Women rated statements on a 5 point Likert scale, where 1 = strongly disagree, and 5 = strongly agree.

Meaning of motherhood

This section of the instrument uses a series of 5 open-ended questions (labeled PMEAN) to understand the centrality of the parenting role and its meaning for the mother (Mowbray, Oyserman, & Ross, 1995). Questions concern events surrounding advantages

and disadvantages of having children, examples of something that makes a woman feel good, and bad, about being a mother, and how motherhood has changed a woman's life.

This section was originally designed as a qualitative measure. In order to enter Meaning into the regression equation, however, participant responses had to be converted into a quantitative index of 'meaning.' For this purpose, careful content analysis was used to develop a 4 point rating scale whereby a score of 1 indicated that motherhood was negative or held low Meaning for a woman, and 4 indicated that motherhood was very highly Meaningful. The rating scale, content categories, and examples are presented in Appendix C, and explained below. [10] Inter-rater reliability was conducted to determine the validity of the rating scale. Of the 62 interviews from which Meaning data was available, 26 were randomly selected and coded by the author and a trained independent rater. Across all categories coded, there was 96% agreement. Disagreements were resolved by discussion.

Three open-ended questions were developed by the author to invoke information about a woman's drug history and drug of choice, and the effects of drug and alcohol abuse on a woman's family and children, focusing specifically on her children (items labeled DSOo a and b). These questions were written so that responses could be easily collapsed into quantitative indices.

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[10] The development of the rating scale is outlined in the results section.

Qualitative Measures

The following open-ended questions were designed to gather new information and/or provide a more in-depth analysis of quantitative variables. These questions were analyzed for common themes and content.

Three questions - labeled PIMPO, PIMPa, and PIMP2 - were used to further assess the importance of the mothering role. The first two questions were developed by the author, while one (PIMP2) was created by Mom's Project staff.

One open-ended question was written by the author to elicit information regarding the process by which women were admitted to treatment (REASON1). In this context, "the process" refers to the woman's legal status at the time of admission, whether or not she was court-involved or court-mandated, and whether or not her children had been removed as a result of her use. Probes were written to gain further insight into women's feelings and perceptions regarding the circumstances surrounding their entry into treatment.

One question (labeled DSOc) was written by the author to understand the means by which women negotiate their parenting while continuing to use drugs. Probes were written to explore this area as fully as possible, while helping participants feel comfortable discussing issues related to substance use which may have taken place in the presence of their family and children.

In an attempt to gather information regarding women's perceptions of themselves, outside of any specific context or role, women were asked to briefly describe themselves,

taking into consideration *their* impression of themselves, including what they are like, and what is important to them. This question (PWAY1) was developed by Mom's Project staff.

Meaning of motherhood

This section of the instrument, taken from the Mom's Project, uses a series of 5 open-ended questions (PMEAN 1-5) to understand the centrality of the parenting role and its meaning for the mother (Mowbray, Oyserman, & Ross, 1995). Questions concern events surrounding advantages and disadvantages of having children, the hardest thing about being a mom, and how motherhood has changed a woman's life.

Category Development and Coding for Open-ended Questions[11]

Qualitative analyses were used in this study to help describe the population and support empirical findings. Through content analysis, primary patterns or themes in the data were allowed to emerge. In this way, the experience of the participants was understood from their own perspective, rather than from any preconceived notions.

As an iterative process, content analysis required that, throughout the review process, existing themes be discarded as new themes were identified, and categories and codes were collapsed. The process used for this analysis proceeded as follows: First, interviews were transcribed and the contents were reviewed. At this time, as they emerged from the interview data, broad themes were identified and noted. This was the first step in the development of the coding categories. Second, interviews were

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[11] Codes, categories, and examples are presented in Appendix D.

categorized by question. That is, full responses were pulled from individual text and catalogued according to question. Using the previously identified themes as a framework, responses were reviewed by question. This step constituted the longest and most laborious stage as successively evolving themes and interpretations were organized into categories and codes. With successive readings of the data, categories and codes continued to evolve as emergent themes were integrated into the coding scheme. During this process, and prior to the third step - coding the data - the categories and codes used to analyze the Mom's Project data (the coding scheme), along with their reliability data, were acquired by the author, from the Mom's Project staff.

Careful review of the Mom's Project coding scheme revealed that categories and themes identified by the author, prior to the acquisition of the Mom's Study materials, were very similar in content to those which had been developed and implemented in the Mom's Project. In order to verify the fit, two coding sessions were conducted whereby the Mom's Project coding scheme was applied to the present data. This exercise corroborated the fit between the data and the Mom's Project coding scheme. At this point, it seemed appropriate, both theoretically and methodologically, to utilize the existing coding scheme for analysis in the present study. Permission was granted by the Mom's Project staff for use of the coding scheme, and for the right to add or delete categories as necessary. The next section outlines the method by which the Mom's Project categories and codes were developed, including their reported kappa values. Changes or modifications are noted. In the present study, inter-rater reliability was

evaluated by analyzing the percentage of coding agreement across the author and an independent rater. This information is further clarified below.

For all questions, the Mom's Project categories were developed by two of their staff members, based on content analysis of the first fifty responses. Category and code development was initiated and completed by taking into account meaningful units within each response. After categories had been developed, responses were coded by two, sometimes three, different members of the Mom's Project staff. The general protocol was as follows: Staff met and discussed the meaning and the scope of each category and coded approximately 25 responses together. Then, each person coded 25 responses separately. Coding was then compared and disagreements were discussed and resolved. The next 50 responses were coded and used to calculate inter-rater agreement using kappa analyses. Following each category outlined below kappas are reported in parentheses. Asterisks indicate categories for which kappa could not be calculated because at least one coder did not use the category. For all open ended questions, inter-rater sessions continued until kappa values were .50 or above. In all but two cases (Pimp 2 and Pway 1) this was achieved in the first session. For Pimp 2 and Pway 1, two sessions of inter-rater coding were necessary to achieve acceptable kappa levels. For these two questions, final kappas are reported. Any discrepancies in this order are noted below. Inter-rater reliability was also conducted for the present study, using the Mom's Project categories and codes. For each question, 20 responses were randomly selected and coded by the investigator and a trained independent rater. Across all categories there was 93%

agreement. Disagreements were resolved through discussion.

Pway 1

Pway 1 asks: "In thinking about who you are, what you are like, and what is important to you, how would you describe yourself?" Three Mom's Project staff worked with the first 90 responses of their data to develop the categories for this question. The first 5 categories developed focused on the following themes: children, being a mom; personality; addiction or mental illness; hobbies/activities; and social role. As many of the responses were personality related, that category was expanded to include responses focusing on drug and alcohol use, religiosity, and ethnic identity. An additional code - material self, poverty - was added as references to money or poverty did not fit any other category. As this study was focused on drug and alcohol use, not mental illness, the category which focused on negative mood or mental illness was excluded. The final categories are: hobbies, activities (.89); focus on child or being a mother (.89); social role: role in life or relationship to others (1.0); general social goal (.62); physical characteristics (1.0); personality: positive social characteristics (.72); personality: negative social characteristics (.79); personality: moral characteristics (.91); personality: positive agentic characteristics (.93); personality: negative agentic characteristics (.69); personality: happy, positive characteristics (1.0); drug and alcohol related (.65); material self, poverty related (.79); religiosity, spirituality (.87); ethnic or national identity (1.0). For this study, one code was added and three were dropped. The added category was "Don't know who I am." The following five categories were dropped for lack of

response: physical characteristics or physical health; general social role; religiosity, spirituality; material self, poverty related; and ethnic or national identity.

Pimp 2

Pimp 2 asks: "What about being a mother is most important to you?" Ten categories were developed for coding responses to this question, 8 of which were used in this study. The following categories were created: give love and emotional support (.86); teach values, educate (.83); provide structure (.78); provide physical care (.95); caring for self in relation to addiction (.81); social role (.77); child's past, present, or future growth and development (1.00); spending time together, sharing activities (.78); receiving love (.84); regrets or negation (1.0). In this study, two categories - regrets/negative responses and providing structure/discipline - were dropped due to a lack of response.

Meaning

Responses to Meaning questions were collapsed into a quantitative index of meaning, and rated according to the Meaning rating scale, developed by the author for the purposes of this study. Providing a method by which to initially structure and organize the open-ended responses, the Mom's Project codes and categories were used to help guide the development of the rating scale. Details regarding the development and content of the rating scale are outlined in Chapter 3, under the section titled Reliability Analyses. The responses to Meaning questions, however, were ultimately coded using the Meaning rating scale. The information on the Mom's Project codes and categories that follows is presented for reference.

PMEAN 1

PMEAN 1 asks: "What would you say are the advantages of having children and being a mother?" Initially, eleven categories were developed for coding responses to this question. The following categories were created: no advantages (1.00); providing social, emotional support (.73); teach values, educate, supervise, discipline (.69); fulfillment of social roles (.65); focus on the child's growth and development (.85); receiving emotional, social support (.96); generational continuity, immortality, networking, connection (1.00); focus on mother's personal growth and development (.77); sharing cultural and family activities (.67); sharing experiences, quality of relationship, spending time together (.67); religious and, or spiritual (.67). Due to low frequencies for each category, two of the categories related to sharing, spending time together - sharing cultural, family activities and sharing experiences - were integrated together. In the end there were ten categories.

PMEAN 2

PMEAN 2 asks: "Could you give me an example of something that makes you feel really good about being a mom?" Ten categories were developed for coding responses to this question, but only nine fit the context of this study. The following categories were created: providing emotional support and love to child (1.00); accomplishments of child - school and social (1.00); providing concrete services, doings things for child (.92); spending time with kids, sharing experiences together (1.00); kids are O.K., happy, grew up well (1.00); teaching, taught kids well (1.00); social roles of

motherhood (1.00); receiving love, support and help services from child (.87); negative example (.89); personal goals (.92). The "negative examples" category was dropped from this study due to a lack of response.

PMEAN 3

PMEAN 3 asks: "What would you say are the disadvantages of having children and being a mother?" Eleven categories were developed for coding responses to this question, nine of which fit the context of this study. The following categories were created: no disadvantage seen in being a mother (.73); costs, expenses, financial (1.00); hassles, loss of personal time and freedom, added responsibilities, personal life change (.83); problems with embedded roles (.73); emotional and physical suffering because of external factors, focus on mothers (.68); children's negative behavior, children's developmental changes (.70); mother's physical changes, physical disability (.73); mom's behavior adversely affecting kids or herself, doubts about ability to be a parent (.79); supervising, disciplining (*); mom's mental health or negative emotions, drugs, custody issues (.88); father-related disadvantages, relationship problems (1.00). In this study, the " father-related disadvantages" and "relationship problems" categories were dropped due to a lack of response.

PMEAN 4

PMEAN 4 asks: "Could you give me an example of something that makes you feel really bad about being mother?" Ten categories were developed for coding responses to this question. Nine were appropriate for use in this study. The following categories

were created: drug, alcohol use (1.00); lack of contact, custody (1.00); can't provide financially (.92); mom's behavior negatively affects children, discipline issues (1.00); child focused, children's negative characteristics or behavior (1.00); external factors, things not in her control (1.00); issues surrounding father of children (.87); regrets about her relationship with her children (.89); hassles, personal inconvenience (.92); nothing (1.00). In this study, the "regrets about relationship with children" was dropped due to a lack of response.

PMEAN 5

PMEAN 5 asks: "In what ways has motherhood changed your life?" Twelve categories were developed for coding responses to this question, nine of which fit the context of this study. The following categories were created: no life change (1.00); emotional positive affect: focus on mother (1.00); emotional negative affect: focus on mother (1.00); emotional affect: focus on child (.92); positive consequences: activities, relationships (1.00); negative consequences: loss of freedom, restrictions, financial (1.00); positive consequences: change in habits, cessation of deviance (1.00); status, social roles (.87); career and/or life choices (.89); body or physical changes (.92); spirituality, religiosity (*); positive consequences: understanding, controlling, dealing with addiction (*). In the present study, the following categories were dropped due to lack of response: spirituality/religiosity, career/life choices, body/physical changes

PIMP0 and DSOc

Questions PIMP0 and DSOc were developed by the author. As a result, content categories were also developed by the author. In both cases, the process proceeded as follows: Responses for each question were carefully reviewed. Category and code development was initiated and completed by taking into account meaningful units within each response. After codes were complete, they were applied to the first 20 responses for each question. The responses were then coded by an independent rater. For the PIMP0 question, inter-rater agreement was 91%. For DSOc, inter-rater agreement was 92%. Disagreements were resolved through discussion. The remaining responses were coded by the author.

PIMP0a asks: "Imagine that you have just been introduced to a woman who is thinking about having a child. What are the three most important things she should know about the experience of becoming a mother?" That question was followed with PIMP0b which asks: "What advice would you give her." Because responses to both questions were so similar in content as to be redundant, responses to the two questions were collapsed and analyzed as one. For coding the responses to this question, the following five categories were created: focus on practical issues; focus on life change; focus on emotional context of motherhood; and focus on rewards of having children.

DS0c asks: "Some women talk about specific things they do to keep their children from being exposed to drugs and people using drugs. What's your experience with this?" Four categories were developed for coding responses to this question. The following

categories were created: hides use from the kids; no experience, openly uses in front of kids; open use, opportunity to educate children; alternate patterns, hiding and open use.

In total, there were 12 open-ended questions. Responses to 9 of the questions were used in this study: the 5 PMEAN questions, Pway 1, Pimp 2, DSOc, and Pimp0a. Upon reviewing the responses to Reason 1-1a, it became clear that both the quality and content of the responses were not particularly conducive to qualitative analysis. Answers were short and, in many situations, it was difficult to get women to elaborate. It was determined, therefore, that the material would be more meaningful to the analyses in quantitative form. Responses were converted to quantitative data and used in the descriptive analyses.

Two questions, Reason 2 and Pimp 0, were not used in the analyses for two reasons. First, for both questions, there was very little variance in women's responses. Most likely, the wording of the questions was responsible for this. Secondly, content analysis revealed that responses were more likely to be influenced by the wording of the question, than the woman's experience. For example, Pimp 0 reads as follows: "Some women report that motherhood is really very important to them. Other women don't feel that way at all. What's your experience?" In 96% of the cases (n = 65, N = 68) women responded by saying, "It's very important to me." Probing for additional information did not promote further disclosure, and often resulted in women feeling confused as to whether or not they had answered the question "correctly." Responses to Reason 2 progressed in a similar manner. The wording of the question seemed to set the precedent

for the women's responses. In fact, 89% of the women responded to Reason 2 by saying, "I'd say do what they tell you to do" or some variation of this response (n = 58, N = 65). It was thought, therefore, that responses were not reflective of women's experiences, and so would not contribute in a meaningful way to the analyses.

Retention

Retention was defined using percentages as the method by which to standardize the dependent variable across all treatment sites. Specifically, each treatment program has different requirements and standards for program participation and completion. It was required, therefore, that the dependent variable be standardized in a manner which would account for these differences.

Retention data was gathered from treatment program records and defined in the following ways: (a) As a percentage based on the cumulative total number of days in treatment from admission through week 8, divided by the expected total number of days in treatment from admission through week 8 (total 8/expected total 8, retention at 8 weeks), (b) as a percentage based on the cumulative total number of days from admission through discharge divided by the expected total number of days from admission through discharge (total/ expected total, retention at discharge). For those women who were not discharged during the course of the data collection period (June 1, 1997 - June 1, 1998), the percentage based on total days from admission through discharge did not apply (see 2 above). A percentage was calculated, therefore, based on the total number of days from admission through June 1, 1998, divided by the total number of expected days from

admission through discharge. [12] As it represents the end of the data collection period, June 1 was used as the cutoff date. For the three NCA/LRA program sites, expected days in treatment was defined by the Executive Director of the agency. Given treatment length is often individually defined, expected days in treatment can vary. The Executive Director, however, felt that an average, based on the total number of days spent in treatment by those women who had successfully completed treatment, was an appropriate and meaningful index of "expected days." This process was used for the other two sites as well.

Additional retention related data was gathered by the staff at each of the 5 participating treatment programs. The information includes documentation of whether or not women had completed treatment according to program guidelines and, if women had been discharged prematurely, the reasons for discharge. These factors were also included in analyses in order to ensure accurate representation of retention.

Analyses

The goal of the present study was to explore the relationship between the importance, satisfaction and meaning of motherhood, parental adequacy, and treatment retention. Several analytic procedures were used to describe the sample, and examine the hypothesized relationships among variables.

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[12] Percentages over 100 (women who completed more days than expected at 8 weeks, and again at discharge, were rounded down to 100. There were no percentages over 100 in the analyses.

Descriptive Statistics

Descriptive statistics were used to characterize the sample using percentages, means, standard deviations and frequency rates.

Qualitative analyses

Open-ended interview questions were coded using content analysis. Content analysis, or thematic coding as it is sometimes referred, is a process of identifying themes which are consistently identified within interview text or answers to open-ended questions. Broad-based themes are collapsed into specific categories or codes which are used to categorize the data (Patton, 1990). After the data is categorized a number of methods can be employed to further analyze the information.

Correlational Analyses

Mediational relationships.

A mediational model assumes a three-variable system where two causal paths, one from the independent variable(s), and the other from the mediating variable, lead to the dependent or outcome variable (Baron & Kenny, 1986). There is also a path from the independent variable to the mediator. Therefore, before testing for mediation, three relationships must be intact: The relationship between the independent variable(s) and the mediator, between the independent variable(s) and the dependent variable, and between the mediator and the dependent variable (Baron & Kenny, 1993). A variable functions as mediator if the following conditions are met: (a) variations in levels of the independent variable significantly account for variations in the presumed mediator, (b)

variation in the presumed mediator must account for variation in the dependent variable, and (c) when the mediator variable(s) is controlled, a previously significant relationship between the independent and outcome or dependent variable no longer exists (Baron & Kenny, 1986). This analysis was used to test hypothesis 8.

Analyses were conducted in order to assess for an interaction effect between predictor variables. These analyses were used to test hypothesis 9.

Hierarchical Regression.

Two regression analysis, using a combination of hierarchical and standard regression procedures were conducted to analyze the relationship between the predictor variables and the two criterion variables. The results of these analyses were used to assess the degree of relationship between the dependent variable and the predictor or independent variables, the proportion of variance in the dependent variable predicted by regression, and the relative importance of the various predictor variables to the solution, testing hypotheses 1 through 7. In hierarchical regression, covariates are entered into the regression first in order to remove their influence in the equation. Independent or predictor variables are then entered into the equation. In this context, variables were entered in the following order: importance, meaning, satisfaction, and adequacy.

Assumption Violations

Regression scatter plots were analyzed for uncorrelated and normally distributed residuals.

Chapter 3

Results

Participation Rates

From May 1, 1997 through June 1, 1998, the data collection period, 72 women with children, in 5 substance abuse treatment programs in the Greater Lansing, Michigan area participated in the study. Participation consisted of completing an interview with one of the research team members. Eighty-eight percent of the interviews (n = 63) were completed in the first 7 months of the data collection period (May 1 through December 1, 1997). The remaining 12% (n = 9) were completed between January 1 and June 1, 1998. Sixty-six percent of the interviews (n = 48) were completed by two interviewers, the investigator and one other member of the interview team. The 4 other members of the team completed the remaining interviews (n = 24, 33%).

Across the three main program sites - Women's Day Treatment, IOP-E, and Glass House - participation rates were calculated from admission data gathered for the data collection period. Participation rates could not be calculated for the other two sites - Southland Counseling and Cristo Rey - as required data were not available.

During the data collection period, 78 women were admitted to Glass House, 28 of whom had children (36%). Of the 28 women with children, 27 were interviewed, resulting in a 96% participation rate. Glass House interviews accounted for 36% of the total interviews conducted. During the same time period, 52 women were admitted to the

Women's Day Treatment Program, 32 of whom had children (61%). Of the 32 women with children, 20 were interviewed, resulting in a 62% participation rate. Interviews conducted at Women's Day accounted for 28% of the total. Forty-four women were admitted to the Intensive Outpatient Program during this time period. Of these 44 women, 25 had children (57%), 18 of whom agreed to be interviewed. This constitutes a 72% participation rate, and 25% of the total interviews conducted.

Although data were not available from management staff to calculate participation rates for women from Southland Counseling and Cristo Rey, in total, these interviews accounted for 10% of the interview population (Southland Counseling, n = 4, and Cristo Rey, n = 3).

Although differences may exist between women who agreed to participate in the study, and those who did not, these differences were not documented empirically. It would have been unreasonable to request, from those who refused to participate, their reasons for declining. Based on informal conversations with women who did not participate, however, women generally reported not wanting to be distracted from the rigors of their treatment program, or strongly intimated that they were not yet ready to talk about their children. The reasons behind the women responses were not readily apparent. Given the high participation levels found in this study, however, there was no compelling reason to believe that participants were not representative of the population in general.

The Women: Who are they?

The women in this study ranged in age from 22 to 52 (M = 35). They were mostly white (n = 44, 66%), or black (18, 25%). Hispanics (4, 6%), American Indians (3, 4%), and other minority populations (3, 4%) constituted a small percentage of this population. Women were asked to think about who they are, what they are like, and what is important to them, and then describe themselves (Pway 1). Women often had a difficult time describing themselves, and in many cases, had to be prompted to do so. Interestingly, despite the circumstances of their situation, women were likely to describe themselves positively, using three major themes or categories: positive personality traits involving interactions with others (n = 44, 65%), traits related to children and being a mother (n = 18, 27%), and personality traits emphasizing personal control over their own lives (n = 16, 24%). Negative traits were related to specific social characteristics or their addiction.

As noted, it was important for women to have positive relations with other people and, in general, women received much of their sense of self by interacting with others. This was often done, however, at their own expense:

> I am a very caring person about other people. I tend to take on other peoples problems rather than my own - dealing with my own. I want to fix everything for everybody. I am a care taker. When I get my head on straight, if I can, I want everybody to be better too.

> If I got something somebody needs, or I see somebody needs some help, or somebody doesn't have any place to live, I am always the person to speak up and help out.

> I care very deeply about other human beings. Like I get very frustrated at meetings because I want to be the perfect listener and listen to people and if I hear anything I want to be able to give feedback after the meeting and stuff like that.
>
> I'm a pretty nice person. I'm a caring person. I care about a lot of people and things... I don't like to be mean to people. All in all, I'm an ok person. I don't think about myself very much though. I don't believe I'm a rude or bad person. I think I'm all right.

Women frequently identified themselves in relation to their role as mother, and with their children. In general, when talking about themselves this way, women were positive, but realistic:

> I consider myself a mother, loving and caring. I want more for my son than what I had when I was young.
>
> My whole life is centered around my kids. When they took them I was crushed. I didn't care no more. But, I love kids. It's still hard without my kids. I'm not whole without my kids.
>
> I am a nice mom. I am a very good mom. I guess, basically, I am an all around type of mom. Very caring. I take care of my kids.

In addition, despite current life circumstances, women talked about themselves in a way that suggested they felt some sense of control over their lives:

> I'm very goal oriented as far as trying to get through working, and going to school, and taking care of my son, all of that, and come to treatment.
>
> I don't take anything. I'm independent. Don't get rattled. Dare me one way, I do the exact opposite.
>
> I am very strong. I am a good worker... I am fairly independent. Those are my better qualities.

Not always this positive about themselves, however, women used negative terms to describe themselves in relation to social and agentic characteristics (n = 19, 28%) and

their addiction (n = 8, 12%):

> [I am] mean and disrespectful [to others].
>
> I ain't going to say nice because I ain't nice [to anyone]. I like being left alone.
>
> I am very emotional, very sentimental. I cry way too much. There is a lot of time, most of the time, I would rather be alone... Actually, now I am too lonely because other than these classes, I have nobody... Like I said, I cry a lot when I'm alone, which is most of the time.
>
> Deep down inside, I love too much. I trust too much. And so, in just about every situation I've been in, people that I love, or things that I love, get yanked out from under me, like my kids. I only did what I thought was the right thing. And then I get shot down.
>
> What am I like? I'm a time bomb because I'm an addict recovering. That's hard. I am in recovery but I could walk away any time. That's scary... I do what they tell me. I am an alcoholic. I will always be an alcoholic.
>
> When I am drinking it is like I don't really care. I am kind of nasty. I say things I don't mean. Not to my child but to my husband. Or, I know that I lost my temper with my child. I never hit her or anything but I was very inconsistent when I was drinking. One minute it would be yes and the next minute it would be no. There was no consistency there.

Education, employment and income

Many of the women came from families headed by parents with high school degrees (n = 54, 75%), or less (n = 29, 41%). Only 16% (n = 11) had parents with college degrees. This is not surprising, however, given the average age of the women in the study (M = 35). Although not highly educated, many of the women had either graduated from high school (n = 27, 37%) or had a high school equivalency or GED degree (n = 23, 32%). Fourteen percent had a college degree (n = 10), 5 associate's, 2 bachelor's, 2 master's, and 1 law degree. Most women were not students at the time of the interview

(n = 67, 93%), but of the 5 women enrolled in school, 3 were in full-time.

As is often the case with a population that is mostly high school educated, income was low. Current monthly household income ranged from $0 to $5600 (M = $1,249, SD = $1890). Given the range ($14,000), and the number of women with no income at all (n = 38, 53%), the median ($763) seems a better representation of this sample than the mean. Although most women had no income at all, even those who were working, or had some consistent means of income, were living on very limited incomes, somewhere between $80 - $460 per month (n = 8, 11%), or $500 - $900 per month (n = 13, 17%). This information clearly portrays a group of women subsisting on very little income. In fact, a full 81% of the participants in this study were living on less than $10,800 per year (n = 59). Of the remaining participants, 11% (n = 8) were living on monthly incomes between $1000 - $2000, while 6 women (8%) were in the $2500 - $5600 range.

It is important to note the wording of the income question as it may have contributed to a bias in response. Specifically, the wording of the question - "What is your *current, monthly* income?" - fails to gather information regarding a woman's employment status prior to their entering treatment and may, therefore, reflect only their current situation. For example, although 53% of the women in this study reported no current monthly income, 58% (n = 41) reported having worked in the month prior to the interview, with 40% (n = 29) having worked full-time, and 18% (n = 13) having worked part-time. In addition, of the 43% (n = 31) who reported being unemployed in the last

month, only 8% (n = 6) had been without work long enough to qualify for unemployment. For many of these women, the demands of a full-time treatment program, in addition to existing child-care and other responsibilities, often constrain their ability to remain employed during the time they are in treatment. And in fact, in some situations – the residential program in particular – women were not allowed to work for the first 30 days of their program. In addition, in general many women enter treatment after their addiction has escalated out of control, a time when they are generally unable to work. For these reasons, the present data may not be an accurate representation of women's income, but may instead reflect only their present circumstances. Rewording the question to reflect *average, annual* income may have produced data reflective of women's general life experience.

Given the high numbers of women without an income, it was expected that there would be equally high numbers of women receiving public assistance. But, this was not the case. In fact, only 26% (n = 19) of the women were receiving Aid to Families with Dependent Children, and 36% (n = 26) were receiving food stamps. Another 21% reported living in public, subsidized, or Section 8 housing (n = 15). The rest either owned, rented or resided with family members. But again, for reasons noted above, this information may be more reflective of a woman's current life situation than to a long-term pattern of unemployment and dependence upon public assistance. And, in fact, there was evidence to support this.

First, 97% (n = 70) of the women in this study reported having worked for pay at

some time in their life. Secondly, most women had held steady jobs before being laid off, fired or quitting for any number of reasons: Approximately 28% (n = 21) had held the same job for 5 or more years. Another 54% (n = 39) had worked at the same job between 1 and 4 years. Only 16% (n = 11) had worked 7 months or less at their longest, steady job. Unfortunately, regardless of tenure, most women had worked in jobs which were service-related - clerks, waitresses, babysitters, cashiers. These jobs are often characterized by low pay, limited benefits, and inflexible hours, especially for women with small and school aged children.

It seemed obvious that most women were working because they had to support themselves and their families. Most women did not receive financial help or support from spouses, partners, family, or friends. Of the 24 women (33%) living with a spouse or partner at the time of the interview, only half (n = 12) were receiving financial support from that partner. And, despite the fact that, in total, there were 113 fathers responsible for the children in this study, only 8 of whom resided in the home, only 19 women (26%) were receiving child support. In 10 of the 19 cases, women were getting significantly less child support than the court had ordered. Only 5 women (7%) were occasionally supplementing their own financial resources by accepting help from family or friends.

Family

The majority of the study participants were not married (72%) and many had never been (46%). Of the 17 women (24%) who were married, 9 were separated at the time of the interview (12%). Twenty-six women were divorced (36%) and only one was

widowed. Eighteen women were living with a partner to whom they were not married (25%).

In order to participate in the study, women were required to have at least one minor child for whom they had legal custody, regardless of whether the child was currently living with the mother. As such, all participants had children. In total, women had 195 children, equally male and female (n = 97, 50%, respectively). Eighty percent of the women interviewed had between one (n = 14, 19%) and three (n = 17, 24%) children, with the majority having two (n = 26, 36%). The average was 2.7 children per mother. It was uncommon for women in this group to have more than three children, although some did (n = 15, 21%). Only two women had what could be considered very large families. One had eight children, the other nine. In most cases, when women had more than one child, there was also more than one father (n = 38, 52%). In fact, the 195 children represented in this study had 113 fathers, or 1.7 children per father.

In general, the women's children were very young. [13] In fact, at the time the mother was interviewed, 31% of the children were under 4 years of age (n = 60), with thirty percent of this group under one year of age (n = 18). Of the remaining child population, 21% (n = 41) were between 5 and 8, 20% (n = 39) were between 9 and 12, and 15% (n = 30) were between 13 and 19 years of age. Nine of the women's children were between 20 and 27 years of age. All of these women, however, also had younger

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[13] The interview is set up to gather information on up to 5 children for each woman, from youngest to oldest. For those women with more than 5 children (n = 3), information regarding the living arrangements of the older children is not available.

children who were the focus of the interview.

Most women did not have custody of their children and had limited contact with those children. In fact, only 35% of the women in the study had custody of at least one minor child (n = 28). A full 70% (n = 50) reported that at least one of their minor children were not living in the home but were instead in court ordered placement, either foster care or the home of family members. Although 46 women reported being allowed to see their children either in their home (n = 10), at a court appointed destination (n = 16), at the home of a family member (n = 12) or at the treatment facility (n = 8), the majority saw them less than twice a week (n = 34, 74%), for two hours or less (n = 30, 65%).

Women were asked to rate themselves as parents, using a 5 point scale (PADEQ1o) (N = 71). On average, women thought of themselves as "average parents" (M = 3.05, SD = 1.2). The majority, however, felt less confident, reporting "some trouble being a parent" (n = 27, 37%). Almost equal in number to those reporting having trouble parenting, were those women who thought they were " better than average" or "very good" parents (n = 22, 32%). Only 2 women (3%) felt they were "not very good" at being parents.

Addiction and treatment

The data indicated that crack (n = 31, 43%) and alcohol (n = 28, 39%) were the primary drug of choice for most women. Of the women remaining, 8% were addicted to marijuana (n = 6), 4% had problems with heroin (n = 3), and another 4% (n = 3) reported

prescription pills as their drug of choice. Women began using on a regular basis around the age of 20 (M = 20, SD = 6.5) and had continued, off and on, into their adulthood. Many women (n = 66, 92%) reported periods of non-use, often during their pregnancies. Interestingly, based on the results of comparability analyses, there were no significant differences on motherhood variables (Satisfaction, Importance, Meaning, Adequacy), or retention or completion rates, based on drug of choice (crack vs. alcohol).

As expected, women in the study had fairly severe substance abuse problems. The DAST is designed to infer addiction severity based on the number of substance related problems the person is experiencing. When interpreting scores on the DAST, it is important to look for high scores (range is from 0 - 20) as the severity of problems related to addiction increases with an increased score. In turn, higher levels of related problems are associated with increased levels of substance abuse or addiction. With scores of 13 or higher, almost half of the women (n = 35, 49%) were experiencing substantial to severe levels of substance related problems. The mean score (M = 12.32, SD = 3.7) provided further evidence of a notably impaired population. Thirty seven percent of the women scored between 9 and 12, "clear evidence" of a moderate to high level of addiction. Only 8% (n = 6) scored in the moderate range, between 6 and 8. Interestingly, 3 women had scores of 5 or less. Five is often used as a cut-off to screen for non-substance abusers (Skinner, 1982). Given the present context, however, it may have been the case that women didn't understand the question, answered the question based on their current sober status (given they are in treatment), did not feel comfortable discussing the extent

of their addiction, or were in denial about it.

With the exception of Southland Counseling, across programs women were more likely to be mandated to treatment than to have entered without external pressure, and to have been mandated by Family Court.[14] In total (N = 68), 76% of the participants were mandated to treatment (n = 52) by either family court (n = 28, 41%), probation or parole (n = 20, 30%), or a family member, therapist or psychiatrist (n = 4, 10%). The former category was considered "mandated" because, despite the lack of a legal threat, in all situations women were made aware of impending consequences, by those who could carry them out, should she not comply. Family members threatened to keep women's children, with or without her consent, until she entered treatment. In situations involving therapists or psychiatrists, women were informed that Child Protective Services would be called, or family members alerted to the severity of the situation, should she refuse to enter treatment. Given the perceived severity of the consequences in these cases, women reported feeling significant pressure to comply, and subsequently, as if they had been mandated to treatment.[15] Only 15 women (21%) claimed to enter treatment on their own.

Despite the threats and mandates propelling women into treatment, they were not

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[14] Although women from Southland Counseling seemed to differ from the other women, it is likely this information is misleading. In total, approximately 300 women are enrolled in outpatient services at Southland Counseling. Four women were interviewed for this study, less than 1% of the population. It is quite likely that differences noted here are not representative of the Southland Counseling population. In addition, Southland was recruited as a study site based in part on information provided by the Clinical Director which suggested that women were very similar to women at the other 4 program sites.

[15] This information was reported and documented anecdotally.

particularly successful once they arrived. According to data provided by the NCA/LRA management staff, and excluding those women who were still in treatment at the end of the study (n = 10), approximately 60% of the women did not complete treatment (n = 38). Women from Glass House and Women's Day Treatment were the least likely to complete, although the difference was not statistically significant ($F(3, 72) = 1.88$, $p = .14$). While 56% percent of women at Glass House (n = 15), and 80% at Women's Day (n = 16) did not complete, only 33% dropped out, or were prematurely discharged, at both Cristo Rey (n = 1) and IOP-E (n = 6), respectively. In the majority of cases where women do not complete, most leave against staff advice, otherwise known as "walking out" (n = 17, 45%). Unable to meet the demands of the program to which they were admitted, others are referred out to a higher level of treatment (n = 7, 18%). Very few are asked to leave for not complying with the rules (n = 3, 8%).

It is interesting to note, however, that there were statistically significant cross-site differences in addiction severity ($X^2 = 3.12$, $p<.04$). Yet, despite information which suggests that addiction severity impedes retention, in this context there are no statistically significant differences in completion rates. A pattern is evident, however, as women at Glass House and Women's Day have the lowest completion rates and the highest levels of addiction. But, this information can be easily explained by the fact that both Day and Residential treatment programs were developed for women with higher levels of addiction than those assigned to outpatient settings. These differences, therefore, are not surprising. Completion data was not available for women at Southland Counseling as, at

the end of the data collection period, all 4 participants were still active in treatment.

Looking at retention rates as measured by the two levels of the dependent variable, more women had 100% retention at 8 weeks (n = 24, 33%) than at discharge (n = 19, 26%). At 8 weeks, 60% of the women (n = 43) had completed at least 80 percent of their treatment days but, at discharge, only 42% had completed the same percentage of days (n = 30).

Women as Mothers

Satisfaction

When asked to report using a 5 point scale how satisfied they were as mothers, in general, women felt mostly satisfied (N = 71, M = 40, SD = 6.7). As evidenced by scores on the two subscales of the Satisfaction inventory, however, women were mostly satisfied with their overall relationship with their children (M = 31.4, SD = 5.0), but mostly dissatisfied with their ability to care and provide for their child (M = 11.3, SD = 3.3). They report feeling mostly satisfied with the way their children have turned out (M = 4.4, SD = 1.0) and how they feel when they are with their children (M = 4.4, SD = .91). Least satisfactory is the amount of time women spend with their children (M = 2.6, SD = 1.5). This is not surprising, however, in light of the fact that most women did not have custody of their child(ren) at the time of the interview.

Importance

In this section of the interview, women were asked to respond to 10 different roles, using a 5 point scale, with higher scores indicative of higher levels of importance.

Although scores could potentially range from 8 to 40, the range was 25 to 40. Most women had a total importance score between 35 and 40 (n = 42, 58%), implying that most of the roles were very to extremely important to their sense of self. The three most important roles were being a mother, taking care of oneself, and being a family member, in that order, all roles related to family. This implies that family roles were of central importance to the women. Mean scores on both subscales demonstrate, however, that roles related to family (M = 19, SD = 1.5), including being a mother, and those related to individual roles (M = 16, SD = 2.4), are both important to women. The least important role was having a close relationship with a husband or partner.

When asked what was most important to them about being a mother (PIMP 2), women most often cited the opportunity motherhood provides to *give* love and emotional support to their children (n = 19, 30%). The content of these child-centered responses reflect an understanding on the mother's part of the importance of being there for their children, and meeting their needs, both physically and emotionally:

> Just being there. Just watching them grow up and being there. Instead, I am here and they are there. That's wrong.
>
> Being there for my children. Right here, right now I'd have to say being there for my children, staying off drugs. [Being there for them] Emotionally and to be there to attend to their needs. That's a difficult question to answer [because I'm not there]. That's very painful.
>
> Knowing my kids are secure in knowing that I'm there. That I love them. That I'm doing this for them.
>
> I guess my love. My love for that child. There is no way to explain the gut instincts and the love that comes from being a mother... You can never, ever love anyone, another mate or another human being like a mother loves their own

> children. It is a human instinct for one. It is the mothering, the nurturing. Mothers love forever. It changes a little bit. Children grow. They go their own ways. They get taken away. But, you cannot take that love, that being, away from a mother.
>
> Loving my children first of all. That's a very wonderful feeling to love your children. To take care of them. To help teach them the right from the wrong. Being that person that they depend on.

Also important was the love and emotional support women *receive* from their children. In fact, receiving was almost as important as giving (n = 18, 28%):

> Just having my kids. Giving them love and them loving me back.
>
> For me personally, [it's] the need to be needed by someone else.
>
> I think it would be just the love. Because kids can love you no matter what and there's nothing you ever do would make them hate you. What do they call that? Unconditional love. That's what I get from my kids.
>
> That my child loves me. That unconditional love is so great. It is like no matter what, they still love you. I am learning that. I used to give in to her more because I would feel like she wouldn't love me any more, and I couldn't handle that.
>
> Just having a friend. I think of my daughter as a friend to me. To have her so that I can talk to her. I don't have friends. She is my only sole friend that I have. That is the way I feel. She is my sole friend. I help her through things. She is helping me so far through all of this.

The focus on giving and receiving love and support lends credence to how important the mother-child relationship was to the women in this study. It also helps explain why the two most common examples women gave to describe what made them feel bad about being a mother (PMEAN 4) were the two things that took them away from their children, physically and emotionally: addiction (n = 25, 39%), and lost custody or limited contact (n = 14, 22%).

About their addiction, and its effect on their relationship with their child, women felt guilty and ashamed:

> [I feel ashamed about the] Drinking. Having to be put in a mental ward at a hospital. Being put in Glass House... I am breaking a promise to myself for one thing that I saw how awful it was for my mother to drink and I swore I would never drink. Here I am, doing the same thing to him and not being there for him. It makes you feel bad, ashamed.
>
> Putting drugs, alcohol and relationships above my children, and getting them taken away as a result. That's so shameful.
>
> ...My addiction progressed to the state where it wasn't what I wanted to do but it was my way of dealing with life, fixing with myself. I felt that bad. And there's emptiness with that. My children weren't enough to fill the emptiness. And, I've always felt so bad about that and I always felt, "How could you leave your kids like that?" And, I do love them but when you're caught up in whatever it is you're trying to fix inside of you. Nothing else matters.

They felt similarly about not being there for their kids:

> Right now I feel bad because I not there for my twins [they're in foster care]. I feel like I'm missing out on being a mom and they're missing out on having a mom.
>
> Well, I feel I let them down because they got taken away...That and them just not understanding makes me feel bad. Because I don't know how to make them understand, cause they are just little. I let them down because they can't be with me and that's what they want. I guess I feel bad because they didn't ask for this. They didn't ask for any of this.
>
> One thing that makes me feel guilty and bad is that I am the mother of five children and was not able to keep them. I failed and it's taken me a long time to get to that point... I missed out on their life... I wasn't there when they needed me. When they cried out for me, I would walk away. I felt disappointed in myself. I told the judge, "You should have put a bullet in my head when you took my kids." That just took the cake.
>
> I failed. I feel like I let them down because they got taken away and we need each other.

Addiction and Children

Despite the importance of the mother-child relationship, and feelings of guilt and shame about their addiction, in most cases women were not able to keep their addiction from their children (n = 59, 82%). Women employed a variety of strategies, however, to minimize their child's exposure to their addiction (DSOc, N = 66). The most obvious way to do this was to hide one's use from the children (n = 39, 58%):

> I would make them go in the other room. You know, tell them to go outside. Especially with that crack stuff. You don't want your kids to see you doing that, you know.
>
> I drank after she went to bed and while I was cooking dinner. You know, it was never in her face.
>
> I would take her to a sitter or make sure she wasn't in the house or make them go outside, or I'd go in the car. I didn't want it around my kids.
>
> Well, when my children were home, if I was going to smoke it in the house, they would have to go in the basement, play outside, or somewhere not around the adults. They could stay in their room and play.

Obviously concerned about using in front of their children, but more ambivalent about how and why to do that, other women vacillated between hiding their use from their kids, and using in front of them (n = 17, 26%). Interestingly, their ambivalence was more often related to the type of substance they hid, as opposed to their reasons for hiding it. Their uncertainty about the right thing to do frequently manifested in some kind of compromise: attempts to hide their drugs, but not their alcohol, or to hide their use from younger children, but not the older ones.

> We never smoked marijuana in front of them. But my daughter knew I drank. I did it in front of her.

> He would never see me doing it (crack), but he'd see my buy it and all that. It got to the point where he knew I was using, but I'd never use it around him.
>
> The younger ones never knew, and I'd never use in front of my oldest. But, when he came in [from outside], I would have the joint rolled already and it would be sitting on the table... But I don't think I ever smoked it in front of him.
>
> We didn't use with the [younger] boys around. We would go in our bathroom... I would come out of the bathroom and I was high... He [the older step-son] didn't know what drug I was on, he just knew I was on something. He would say, "You need to stop shooting them drugs into your veins." But, my boys were kind of, more or less, too young. I think they might have known, even though I didn't use in front of them, but they never brought it to my attention [they way the older boy did].

Only one woman acknowledged the obvious: that her attempts to hide her use were probably not working:

> I didn't have crack heads hanging out at my house or that kind of thing. But, I did have many suppliers and they, of course they don't smoke or use any way, but I did try to keep it real under lock and key when my kids were there.... Most of the time if... if I would have a friend over and we were getting high and the kids were there, I never did throw my kids outside because I seen that happen. We would just go like in the bedroom, shut the kitchen off, or something like that and do it in there. We would make sure that they were watching TV or something and there was no chance [they would see us]. Although, I was in real self denial. Real self-denial. So, I just don't know what good it did.

At times, women reported being open with their children about their problems with drugs and alcohol, but did so for different reasons. Some used their experience as a means to educate their children (n = 16, 24%):

> I've been honest with her up to this point [about my problem]. [I think she handles it] pretty good. Or at least she seems to. She needs to know so she can make her own decisions.
>
> I let him try marijuana when he was 11 years old. I gave him information so it wouldn't be taboo for him, get rid of the temptation.

> I would make sure they knew about the consequences, what would happen if they were doing drugs and got caught with drugs in their possession. I would also make sure they knew the things that could happen to them if they ended up using. Like with me, I just learned that marijuana takes blotches out of your brain. I told them that too.
>
> I've told them everything based on their ages, abilities, how much they choose to accept. I think it's important for them to understand.

There were those women, however, who were open with their use, but in a way that reflected a lack of understanding or consciousness of the impact of their use on their children (n = 10, 15%):

> I never really hid my drinking from anyone in my family. Not anybody. I didn't really think about hiding drinks. I didn't care who was watching, you know. They couldn't tell I had a problem, my kids I mean.
>
> She was exposed [to my drinking]. Yeah, I was doing it around her and stuff. But, she was probably too young to know.

Quality of Life

Women were asked to report how they felt about their life as a whole, both before and after the interview, on a 7 point continuum from terrible to delighted (N = 72). At both times, most women felt mixed - equally satisfied and dissatisfied - about their life as a whole (N = 72, 47.2%, respectively). And, although women felt better about their life before the interview (M = 4.3, SD = 1.3) than they did after (M = 4.0, SD = 1.4), the difference was not significant (t = 1.39, p = .17). It is interesting to note, however, that women were *less* likely to report feeling mostly satisfied, pleased or delighted after the interview (n = 21, 29%) than they were before the interview (n = 26, 36%). And, similarly, women were *more* likely to feel mostly dissatisfied, unhappy or terrible after

the interview (n = 16, 22%) than they were before (n = 12, 17%). Despite the lack of statistical significance, this data suggest that women clearly felt some negative emotional impact after talking about themselves in relation to their addiction and their children.

Reliability Analyses

Before quantitative analyses were conducted, the measurement model was empirically validated. In this context, a low subject-to-item ratio prevented the use of factor analytic procedures for testing the internal consistency of the instrument. As a statistical procedure, factor analysis becomes fairly unstable with small sample sizes and so, as a general rule of thumb, one should have at least 300 cases for factor analysis (Tabachnick & Fidell, 1996). The "10-to-1 rule" - 10 subjects for every one item - is another common "rule of thumb" used to determine whether or not factor analysis can be implemented. Applying the 10-to-1 rule in the present context, a sample of 400 would be necessary for factor analysis (40 items x 10 subjects = 400). Instead, reliability was assessed by examination of alpha coefficients, and item statistics, including inter-item correlations, item scale correlations, item means, and item variances. Skewness and kurtosis statistics were also examined to check item distributions. For all scales, internal consistency (alpha) was slightly lower in this study than those reported for the Mom's Project. These results are likely due to low subject to item ratios and high error variance. When the ratio of subjects to items is relatively low and the sample size is limited, correlations among items can be influenced by chance to a fairly high degree, reducing alpha levels (DeVillis, 1991). In addition, high error variance might be expected in a

population characterized by low levels of education, severe substance abuse, and other psychological and emotional problems.

The levels of some of the reported alphas are relatively low. Theoretically, alpha can take on values from 0.0 to 1.0 (DeVillis, 1991) but, in general, alpha rarely takes on these extreme values. Although there are levels of alpha which are more acceptable than others, it has been suggested that an acceptable range of alpha is based more on personal experience and subjective groupings of alpha levels than on any rational basis (DeVillis, 1991). For example, Nunnally (1978) suggests a value of .70 as a lower acceptable bound for alpha. It is not unusual, however, to see published scales with lower alphas (DeVillis, 1991). In fact, DeVillis (1991) adheres to a continuum whereby .60 is the lowest acceptable alpha level and .90, the highest. The final results of the reliability analyses are presented and discussed below.

Importance

Overall, the Importance scale was designed to assess the importance of being a mother, and the centrality of social roles, personality characteristics, and feelings in the mother's life (Mowbray, Oyserman, & Ross, 1995). The 8 statements on the Importance scale make up two subscales. The Family subscale (Importance-Family) was designed to assess the importance of a variety of familial roles, while the Individual subscale (Importance-Individual) evaluated the importance of roles related to the individual or self. Originally this scale had 11 items. One item - how important is your mental illness - was excluded because it did not fit the context of this study. Two additional items - how

important is being a student and how important is being a worker on a job - were eliminated from the present study after descriptive analyses indicated that most women were not students, nor were they employed. For these reasons, these items were deemed irrelevant to the context of the women's lives.

The Family subscale includes items b, c, e, and g, items related to family roles. The Individual subscale includes items a, d, f, j, items related to personal or individualistic roles. Initial analyses of the two subscales produced alphas which were low to moderate (Individual, $\propto$ = .28; Family, $\propto$ = .58), despite high item-total correlations for the items on the Family subscale and moderate item-total correlations on the Individual subscale. Further analysis of item and skewness statistics for both scales indicated negatively skewed item distributions.

In an attempt to eliminate the negative skew, which can decrease alpha levels, items for both scales were recoded in a positive direction and item responses were then log transformed using the 10LOG function in SPSS. Subsequent analyses indicated an increase in alpha for the Individual subscale (Individual, $\propto$ = .43), and a reduction in the skewness of the distributions. Unfortunately, the log transformation subsequently reduced the item-total correlations for the Family subscale and, more importantly, had no influence on the relationship between the Family and Individual subscales and the dependent variables: correlations were not significant regardless of whether transformed or untransformed scores were used (correlations for all scales with the two dependent variables are presented in Table 1, located at the end of this section). The lack of any

significant relationship between the items on the Individual subscale and the dependent variables also precluded the use of these items as individual predictors: an option pursued given the low alpha for this subscale. For these reasons, and because transformed data are much more complicated to interpret than untransformed data, the untransformed data were used in the analyses.

Meaning

This section of the instrument uses a series of 5 questions to understand the centrality of the parenting role and its meaning for the mother. Questions concern events surrounding advantages and disadvantages of having children, examples of something that makes a woman feel good, and bad, about being a mother, and how motherhood has changed a woman's life. Before exploring the reliability of this scale, it is important to understand how the Meaning rating scale was developed.

Development of the Rating Scale for Meaning

The meaning of motherhood is a construct important to the integrity of this study. As there was no quantitative index of this construct for use in regression analyses, one was developed for this purpose. The following section outlines the method by which the rating scale was developed to collapse open-ended Meaning responses into quantitative categories.[16]

First, the Mom's Project codes and categories were used to help organize the data into meaningful units. This step was instrumental in guiding the development of the

[16] Descriptions of categories and examples are in Appendix D.

rating scale. Secondly, the first 20 responses to each Meaning question were read multiple times in order to further clarify overarching themes, and to obtain a standard by which Meaning could be defined on a continuum, from low to high. Erikson's theory of self-identity (1968) provided a framework through which women's responses could be understood within a developmental context. That is, responses which were self-focused were thought to be less sophisticated developmentally, and, therefore, lower in meaning than those focused on either the children, or the relationship between mother and child. Emergent categories were tested against the responses of the first 20 interviews and discussed with a colleague familiar with the study. A rating scale was created, based on a 4 point Likert type scale where 1 = not meaningful or negative, and 4 = extremely meaningful.

Content analysis revealed that motherhood meant different things to different women, and, was meaningful based on the context through which they defined their experience. For example, many women talked about motherhood as a significant, but negative, experience. Other women talked about the experience of motherhood, but only in relation to themselves; what being a mother meant to them. Still others talked about motherhood in relation to their children; motherhood was about what they could do for their children, what it meant for them to be there for their children, to help their children grow and learn. This level of Meaning was interpreted as more sophisticated from the former, as women understood their experience in relation to their children, not simply themselves. And finally, women talked about motherhood in terms of reciprocity - the

give and take required between a mother and her child(ren). This level of Meaning was thought to be the highest, as women understood their role as mother at a level beyond the scope of the individual - either the individual mother or individual child - and within a relational context including both mother and child.

In the end, the Meaning continuum, from low to high, was as follows: 1 = motherhood as negative, or low; 2 = motherhood as me, the individual, or somewhat meaningful; 3 = motherhood as children, exclusive of the mother herself, or very meaningful; and 4 = motherhood as reciprocity, or extremely meaningful. Categories for total scores - calculated by adding together the scores from each Meaning question, one through five - were as follows: 5 - 8 = low meaning; 9 - 12 = somewhat meaningful; 13 - 16 = very meaningful; 17-20 = extremely meaningful. Mean scores for the total scale indicate that, in general, motherhood was "somewhat meaningful" to the women in this study (M = 11, SD = 3.5). In fact, 47% of all Meaning responses were rated as two (2) (n = 147).[17] A rating of two (2) characterizes motherhood as "somewhat meaningful" and describes responses that are mother-focused: children and motherhood are meaningful because they give something to the mother exclusively: purpose, esteem, love. Examples of these responses follow:

> It is like you have somebody to take care of and laugh with. You get to have memories of the stuff that they do... When they do something good or you get a compliment from other people on how well behaved she is or what ever, you get to feel good about that.

---

[17] There were 317 total Meaning responses: PMEAN 1(N = 64); PMEAN 2 (N = 62); PMEAN 3 (N = 64); PMEAN 4 (N = 64); PMEAN 5 (N = 63).

> I feel like [I] always have some one. Like I said, we talk a lot... She's my friend. Gives me a purpose in life, a reason to live. Like I said, I wouldn't be here if it weren't for her.
>
> I like it when other people notice my children. I like hearing, "your children are so well-behaved," "they look so cute." It's just something I like about being a mom. I like having other people notice my children. It makes me look good as a mom.
>
> I can't really do like I used to - get up and go. Sometimes that's hard for me, not doing what I want to do. I have to think about them now. That's hard.

It is easy to see how these responses differed from those given a rating of four (4), relationship focused responses:

> The fact that I'm an alcoholic and I wasn't giving my daughter the attention she needs from her mom, the attention she needed. And that I was three months pregnant and I could not stop... The fact that what I was doing was affecting my kids' lives was wrong. As a mother I should have known that.
>
> Letting my children down right now [is hard]. That's one of the major problems... Not being able to protect him then when they need it... This time around I used with this child inside of me. I said, "I can't do that." I had to protect my child from my own self. Mothers are not supposed to have to do that. My child is more important than that.
>
> Right now, he's having a rough time with me being here, away from him. The drinking. And I've been incarcerated and for short lengths of time, I was away from him. I missed his birthday when I was in jail. I should be there for him. That's what it's about. Him. Not me. Him.

As noted in the Methods Section, inter-rater reliability was conducted to determine the validity of the Meaning rating scale. For each question, 26 responses were randomly selected and coded by the author and a trained independent rater. Across all categories coded, there was 96% agreement. Disagreements were resolved by discussion.

Reliability analyses for the Meaning scale indicated a low to moderate alpha (.57),

but a normal item distribution, and a significant correlation with DV-8 (-.26, $p<.01$). Further examination of item statistics suggested that alpha would not be improved by eliminating any of the 5 items. No further analyses were conducted.

Adequacy

The Adequacy section of the instrument used 14 questions to measure a woman's sense of maternal competence and adequacy. There were two Adequacy subscales. The Stress subscale (Adequacy-Stress) is comprised of items a, b, c, d and o, items related to the women's sense of competence, role restrictiveness, and social isolation. The Responsibility subscale (Adequacy-Responsibility) includes items e through n, items related to the degree of responsibility a woman feels for her child, and her subsequent sense of competence and control.

Initially, alpha for the Stress subscale was moderate ($\propto = .65$) and item statistics were examined to identify problem items or possibly, a skewed distribution. Although the distribution was normal, one item (PADEQo) was negatively correlated with three other items. Steps were taken to eliminate the negative correlations and subsequently, the effect the item might be having on alpha. First, item PADEQo was positively recoded and a reliability analysis was again completed. The recode eliminated the negative inter-item correlations. A subsequent review of item-total statistics, however, indicated that alpha would increase significantly if this item were eliminated. Eliminating this item from the scale increased alpha from .51 to .70.

The Responsibility subscale was not skewed and had a fairly robust alpha level ($\propto$

= .77). Examination of the item statistics, however, showed that item I and item E had low item-total correlations (I, r = .17; E, r = .24). After eliminating these items, alpha increased to .79.

Satisfaction

The Satisfaction scale is comprised of 11 statements that make up two subscales. The Relationship subscale (Satisfaction-Relationship) relates to a woman's satisfaction with her relationship with her children and includes items a - h. The Caring/Providing subscale (Satisfaction-Caring/Providing) measures a woman's satisfaction with herself as a caretaker or provider, and includes items i -k.

The Caring/Providing subscale was internally consistent as evidenced by an alpha of .78. The Relationship subscale, however, had an initial alpha of .65. Item statistics did not indicate problems between items, but the distribution was slightly skewed. In an attempt to eliminate the skew, responses were positively recoded and log transformed. Although alpha did increase (.70), the transformed data did not correlate with the dependent variables. In fact, it didn't matter whether the transformed or untransformed data were used, the scale did not correlate with either dependent variable. If the transformed data had resulted in a significant correlation with at least one of the dependent variables, there would have been a compelling reason to use the transformed data. In addition, using the untransformed data allows interpretation to remain consistent with the manner in which the constructs were originally conceptualized. For these reasons, and because an alpha of .65 is acceptable, the untransformed data were used in

the analyses.

Table 1
Correlations of Predictor Variables with Dependent Variables

Retention	Importance Family	Importance Individual	Meaning	Satisfaction Relationship	Satisfaction Caring/ Providing	Adequacy Stress	Adequacy Responsibility
8 weeks	r = .08	r = .11	r = -.26 [a]	r = .10	r = .17	r = .15	r = .30 [a]
Discharge	r = .09	r = .14	r = -.15	r = .13	r = .13	r = .12	r = .30 [a]

[a] $p<.01$

Regression Analyses

Covariates

Prior to the regression analyses site, age, monthly income, mandated to treatment, ethnicity, education, and addiction severity were correlated with the dependent variables to evaluate their role as covariates. Results showed that Site 2 (IOP-E), to the exclusion of the other sites, correlated significantly with retention at discharge ($r = .23$, $p<.05$). Addiction severity ($r = .26$, $p<.03$) and age ($r = .21$, $p < .03$) correlated significantly with retention at 8 weeks, but not with retention at discharge. All three were treated as covariates in the analyses.

For both analyses, regressions were performed using three strategies for coping with missing data: listwise deletion of cases with missing data, pairwise deletion of cases with missing data, and mean substitution for missing data. For all three options, effect sizes were similar. Presented here are the results obtained using the mean substitution strategy. This choice was made for two reasons. First, listwise and pairwise methods

result in a substantial loss in degrees of freedom. As such, effect sizes, though similar to those obtained through mean substitution, are less likely to reach significance. Mean substitution, however, retains high and consistent degrees of freedom, increasing the potential for significant effect sizes. Secondly, the number of substitutions required was very low, further supporting the decision to proceed with this option.

Retention at 8 weeks

Hypothesized relationships between retention and the predictor variables were explored using a combination of hierarchical and standard multiple regression to assess the unique contribution of the various predictors to the explanation of variance in the dependent variables, retention at 8 weeks and again, at discharge. The first equation appears in Table 2. In this analysis, retention at 8 weeks was regressed onto importance, meaning, satisfaction and adequacy variables. For this analysis, the covariates - addiction severity and age - were entered into the equation first in order to remove the variance accounted for by these factors. This step constituted the hierarchical part of the regression analysis. Age and addiction severity accounted for approximately 10% of the variance. The regression equation for the covariates, also presented in Table 2, was significant. The following predictors were then entered in one block, constituting the standard part of the regression analysis: Importance-Family, Importance-Individual, Meaning, Satisfaction-Relationship, Satisfaction-Caring/Providing, Adequacy-Stress, and Adequacy-Responsibility. Mean substitutions (S) were made for Satisfaction-Relationship (S = 1), Satisfaction-Caring/Providing (S = 1), Adequacy-Stress (S = 3),

Adequacy-Responsibility (S = 1) and Meaning (S = 10).

In this analysis, the predictor variables, and the covariates, together accounted for approximately 39% of the variance (Mult R = .62, $R^{2.}$ = .38, Adj $R^{2.}$ = .29). As seen in Table 2, Step 3, however, Meaning and Adequacy-Responsibility were the only significant predictors. The change in R^2 from Step 2 (after both age and addiction severity were in the equation) to Step 3 was 29.2%: the amount of variance accounted for by the predictor variables. The Meaning variable was responsible for 10.6% of that change (F (1, 62) = 10.68, $p < .01$), and Adequacy-Responsibility was responsible for 10.6% (F (1, 62) = 10.61, $p < .01$), indicating that the five other predictors *together* accounted for only 7.07% of the variance in retention at 8 weeks.

As evidenced by the negative values of both Beta and T for Meaning, an inverse relationship exists between Meaning and retention at 8 weeks. This suggests that the lower the Meaning of motherhood, the higher the retention level at 8 weeks. Similarly, the positive relationship between Adequacy-Responsibility and retention at 8 weeks implies that the more responsible a woman feels for her child, indicative of a higher sense of competency and control, the higher her retention level at 8 weeks.

For this equation the distribution of residuals was evaluated for assumption violations. The distribution was slightly mesokurtic and a bit negatively skewed, mostly as a function of the ceiling effect in the data; approximately one third of the sample had 100% retention. There was also a bit of heteroskedasticity at the upper end of the distribution. Again, a function of the set of cases with 100% retention. Since regression

is fairly robust, however, neither of these issues is grossly problematic. Using the

Table 2

Mean Substitution Regression of Retention at 8 Weeks onto Predictors: Importance-Family, Importance-Individual , Meaning, Satisfaction-Relationship, Satisfaction-Caring/Providing, Adequacy-Stress, and Adequacy-Responsibility

Step 1 - Entered Covariate Age
Equation for Age

Variable	Mult R	R^2	F	Sig F	Beta
Age	.21	.04	3.24	.07	.21

Step 2 - Entered Covariate Addiction Severity
Equation for Addiction Severity + Age

Variable	Mult R	R^2	F	Sig F	Beta
Addiction Severity	.32	.10	3.81	.02	.24

Step 3 - Entered Predictors
Results of Significance Tests for Regression Equation

Variable	T	Sig T	Coeff B	SE B	Beta
Importance Family	1.3	.20	.03	.02	.14
Importance Individual	1.5	.14	.02	.01	.15
Meaning	- 3.27	.00[a]	- .04	.01	- .35
Satisfaction Relationship	.28	.78	.00	.01	.03
Satisfaction Caring/Providing	1.7	.09	.02	.01	.21
Adequacy Stress	1.4	.17	.01	.01	.15
Adequacy Responsibility	3.2	.00[a]	.02	.00	.34

[a] significant predictor

transformed data would have eliminated both the skew and the presence of heteroskedasticity. But, as mentioned earlier, though it would not have affected the effect size, the transformed data may have affected its significance and certainly, would have made interpretation more difficult.

Retention at discharge

The results of the second regression analysis appears in Table 3. In this analysis, retention at discharge was regressed onto the importance, meaning, satisfaction and adequacy: the same predictors used in the prior regression analysis. As Site 2 (Intensive Outpatient Program - Evening) was the only variable (and the only site) significantly correlated with retention at discharge, it was entered into the regression equation first; the hierarchical step in the regression analysis. Site 2 accounted for approximately 5% of the variance in retention at discharge. The regression equation for Site 2, presented in Table 3, was significant. The following predictor variables were entered next in a single block, constituting the standard step in the regression analysis: Importance-Family, Importance-Individual, Meaning, Satisfaction-Relationship, Satisfaction-Caring/Providing, Adequacy-Stress, and Adequacy-Responsibility. Mean substitutions (S) were made for Satisfaction-Relationship (S = 1), Satisfaction-Caring/Providing (S = 1), Adequacy-Stress (S = 3), Adequacy-Responsibility (S = 1) and Meaning (S = 10).

For this analysis, the predictors, and the covariate, accounted for 23% of the total variance (Mult R = .48, $R^{2,}$=.23, Adj $R^{2,}$ = .14). As seen in Table 3, Step 2, however, Adequacy-Responsibility was the only significant predictor for retention at discharge.

Table 3
Mean Substitution Regression of Retention at Discharge onto Predictors: Importance-Family, Importance-Individual, Meaning, Satisfaction-Relationship, Satisfaction-Caring/Providing, Adequacy-Stress, and Adequacy-Responsibility

Step 1 - Entered Site
Equation for Covariate Site (Intensive Outpatient Program - Evening)

Variable	Mult R	R^2	F	Sig F	Beta
Site IOP-E	.23	.05	3.9	.05	.23

Step 2 - Entered Predictors
Results of Significance Tests for Regression Equation

Variable	T	Sig T	Coeff B	SE B	Beta
Importance Family	.68	.49	.02	.02	.08
Importance-Individual	.44	.66	.01	.02	.05
Meaning	- 1.5	.12	- .02	.01	- .18
Satisfaction-Relationship	1.1	.28	.01	.01	.14
Satisfaction-Caring/ Providing	.74	.46	.01	.01	.10
Adequacy Stress	.94	.35	.01	.01	.11
Adequacy Responsibility	3.0	00.[a]	.02	.00	.34

[a] significant predictor

The relationship between Meaning and retention, though significant for retention at 8 weeks, was not significant for retention at discharge. From Step 1 (Site 2 entered) to Step 2 (all other predictors entered), the change in R^2 was 18%: the amount of variance

accounted for by the predictor variables. Adequacy-Responsibility was responsible for 11.18% of that change, indicating that all other predictors *together* accounted for only 6.8% of the variance in retention at discharge. The positive relationship between Adequacy-Responsibility and retention at discharge suggests, as did its relationship with retention at 8 weeks, that the more responsible a woman feels for her child, indicative of a higher sense of competency and control, the higher her level of total retention.

The distribution of residuals was examined for this equation as well. Assumptions of uncorrelated and normally distributed residuals were proved tenable. That is, the distribution appeared normal, relationships were linear, and there was no evidence of heteroskedasticity.

Considering the relationship between Meaning and retention at 8 weeks, it was expected that a similar relationship would be present for retention at discharge. In its absence, the scatter plots for Meaning and retention at both 8 weeks and discharge were re-examined and, noting the ceiling effect in the distribution for retention at 8 weeks, the possibility of a spurious relationship was considered (Kirk, 1990). At 8 weeks, the distribution indicated that mothers with low Meaning clustered together at the high end of the retention scale ($M = .93$, $SD = .008$). On the contrary, women with high Meaning scores were more widely dispersed across the low end of the retention axis ($M = .35$, $SD = .21$). At high levels of retention (above .75) the relationship between Meaning and retention at 8 weeks was significant and negative ($r = -.41$, $p < .05$). At low levels of retention, however, the relationship between Meaning and retention at 8 weeks was

almost non-existent (r = .04). In addition, there was a wide disparity in standard deviations between the distributions. This information, taken together, implied that the relationship between Meaning and retention at 8 weeks might be statistically spurious, a function of the people with high retention. This would also explain the lack of a significant relationship for Meaning and retention at discharge. For retention at discharge, retention was more evenly distributed, and so the effect disappeared.

To explore further the characteristics of women with low Meaning, and to determine if, and how, they might be different from women with high Meaning scores, Meaning was dichotomized into low and high Meaning, and ANOVAs were computed for demographic variables such as Race, Age, Education, and Income, and the predictor or motherhood variables—Importance, Satisfaction, and Adequacy. The lack of any significant difference between women with low Meaning scores and women with high Meaning scores on demographic or motherhood variables was not only interesting, but provided further evidence of a potentially spurious relationship between Meaning and retention at 8 weeks.

Testing for Mediation

According to Baron and Kenny (1986) three significant relationships must exist before a variable can be evaluated as a mediator: a relationship between the independent variable(s) and the mediator, between the independent variable(s) and the dependent variable, and between the mediator and the dependent variable (Baron & Kenny, 1993). All but one of these assumptions was violated. The only significant relationship was

between the proposed mediator (Adequacy-Responsibility) and the dependent variables. Although Meaning was correlated with retention at 8 weeks, it was not significantly correlated with Adequacy-Responsibility, and so violates the first assumption ($r = .10$, $p<.20$). Violation of any of the assumptions of mediation, as is the case here, is evidence sufficient to reject the hypothesized relationship.

Testing for an Interaction

Analyses were also conducted to explore the possibility of an interaction effect between Adequacy-Responsibility and Meaning. In other words, that the effect of Meaning on retention is dependent on the level of Adequacy-Responsibility. Or, put another way, that Meaning and Adequacy are synergistic: The two together account for variance that the separate main effects can not explain.

First an interaction term was computed— Meaning x Adequacy-Responsibility—and entered into a regression analysis. Second, Meaning and Adequacy-Responsibility were dichotomized into high and low Meaning and an ANOVA was performed for both levels of the dependent variable. Neither of these strategies yielded a significant effect for the interaction.

In the absence of any interaction effect, the relationship between the Completed variable (an alternative measure of retention), and Adequacy-Responsibility and Meaning was also explored. The significant relationship between the two predictors and the Completed variable (Meaning, $r = -.24$, $p < .05$; Adequacy-Responsibility, $r = .24$, $p < .02$) suggests that women who completed treatment were more likely to have lower

Meaning and higher Adequacy scores than those who did not. This statement requires caution, however, as there is no evidence of an interaction effect, and Meaning did not predict retention at discharge.

Summary of results

In summary, the results of the main regression analyses clearly support a relationship between Adequacy-Responsibility, one measure of adequacy, and retention, as this relationship was significant for both levels of the dependent variable. The relationship between Meaning and retention, however, is less clear. Meaning predicts retention at 8 weeks, but does not predict retention at discharge.

It is also clear that Adequacy does not function as a mediator, and an interaction effect was not empirically supported in this study. The empirical relationship between Meaning, Adequacy-Responsibility, and the Completed variable suggests that perhaps women completing the program are more likely to have low levels of Meaning and high levels of Maternal Adequacy. In the absence of an interaction effect, and in the presence of a potential spurious relationship between Meaning and retention, however, it is unclear how or if these two variables influence each other, and subsequently, retention. This statement, therefore, should be interpreted with caution.

Chapter 4

Discussion

The broad goals of this study were twofold. First, this study was a step towards developing an understanding of substance addicted women as mothers by gathering information regarding their attitudes, feelings, and beliefs about children and motherhood. The second goal was to make a contribution to the retention literature, on behalf of substance addicted mothers, by exploring the relationship between various mother related constructs and retention in mandated treatment: something that has not been explored in this population until now. To some degree, both were accomplished.

Substance Addicted Mothers and Their Children

Contrary to existing stereotypes portraying substance addicted mothers as uncaring, inadequate, and unable or unwilling to put the needs of their children before their own (Eliason & Skinstad, 1995; Finkelstein, 1993; Luthar & Walsh, 1995), motherhood was very important to the women in this study. In fact, consistent with the findings of others, motherhood was found to be the most important role for women, having as its most important task providing love and emotional support to the children (Colten, 1983; Davis, 1994; Kearney et al., 1994; Rosenbaum, 1979; Woodhouse, 1992). This is not to say that women don't struggle with their role as mother. Many women understood all too well the connection between their addition and their parenting difficulties. They spoke frequently of the consequences of addiction on their children's

lives: the physical and emotional absence, the lack of money and material objects, the inability to "be there" for their children. They also shared the strategies they employed while negotiating their mothering responsibilities and their addiction, "defensive compensation" strategies (Kearney et al., 1995). In this study, as in others, women frequently attempted to protect their children by hiding their use, using only when children were away, or out of the house. This method obviously required planning on the part of the mothers in order to ensure that children were with friends or family members or, at the very least, out to play when substance use was imminent. They were, however, willing to do what was necessary (Kearney et al., 1995). Although some would disagree, defensive compensation strategies clearly demonstrate a level of parental responsibility, and care and concern for the welfare of the children, that is often thought lacking in substance addicted mothers.

In fact, taken together—the importance of children in women's lives and defensive compensation strategies—these factors display clear evidence that, despite their addiction, motherhood plays an integral role in the lives of these women. In response to this claim, however, skeptics may point to the number of women in this study who failed to complete treatment as evidence to support their contention that regardless of mothers' feelings about their children, they still love their drugs more: Maternal feelings don't negate their desire for drugs. If you think carefully about the results of this study, however—the fact that importance, meaning and satisfaction were not related to retention, drug of choice, or addiction severity—an alternative interpretation emerges.

Perhaps motherhood variables and addiction are not related at all: That they are, in fact, mutually exclusive. Of course, addiction may interfere with a woman's ability to be a good parent. That is not under debate. To suggest that motherhood and addiction are related in a way in which one influences the incidence, intensity or meaning of the other, however, is simply not supported here. And, although further exploration of this issue is warranted, if accurate, it provides information that challenges the current practice of using children as collateral in exchange for a mother's sobriety. With continued interest and exploration of this group, however, we may find important, theoretically supported and empirically substantiated explanations for their decisions and behaviors. Only then might we feel be willing to stop accusing substance addicted mothers of not loving their children, or putting their drugs before their children's needs.

It was expected that women would be more satisfied as mothers than this study was able to demonstrate. Perhaps this is due more to the circumstances of the mothers' current situation including loss of custody, the demands of treatment, and subsequent feelings of guilt and shame, than to their true feelings about motherhood. Isolated and alienated from their children - their most important relationship - women become depressed and frustrated (Wobie et al., 1997). These feelings, in turn, are exacerbated by a tremendous sense of grief associated with losing their mothering responsibilities (Kearney et al., 1995). Unable to perform the most central task of mothering—caring and providing for your children on a day-to-day basis—mothers without custody are more likely to feel dissatisfied with the mothering role, and their relationship with their

children (Kearney et al., 1995; Wobie et al., 1997). Unfortunately, negative feelings, especially those related to loss of custody, can distract a woman from engaging in treatment activities, increasing the likelihood of premature termination (Wobie et al., 1997). Perhaps, if mothers were allowed to continue to care for their children while recovering from their addiction, feelings of depression, frustration, and anger would dissipate, and mothers could better concentrate on the demands of the treatment program.

Interestingly, while there is evidence that there are cultural differences among whites, African American, Hispanic, and other minority groups that manifest in different parenting values and practices (Festinger, 1996; Keller & McDade, 1997), this was not the case here. Race was not responsible for the qualitative differences in women's experiences of motherhood. In fact, across race, motherhood and children were important, meaningful and satisfying. Recall, however, that women were not asked to report on their parenting practices but were encouraged to talk about their feelings, thoughts, attitudes and beliefs about motherhood. Culture may, in fact, dictate or influence parenting practices and values. Nonetheless, this influence may not necessarily generalize to the emotional aspects of motherhood. Ruddick (1989) suggests that motherhood actually gives rise to something she calls "maternal thinking" which is characterized by certain cognitive processes that occur with the experience of mothering; processes that are heavily influenced by emotion. Perhaps, at an emotional level—at the level of thought and feeling—the experience of motherhood transcends the influence of race and culture, and is experienced collectively, rather than diversely. Although

plausible, and certainly interesting, this explanation remains rather speculative. If true, however, it could provide a vehicle through which women of all racial, ethnic and cultural backgrounds could relate to one another.

One can not understand the feelings of the women in this study without integrating the context of their lives, including the problems that may precipitate the need for substance abuse treatment and child placement. Living on little income, opportunities restricted by low levels of education and training, and without social, emotional, and parenting support from family members or steady partners, it is not surprising that these mothers are often compromised by emotional and psychological difficulties in addition to the physical ramifications of chronic substance use. Their service needs, therefore, extend beyond just substance abuse treatment and child placement: they also need child-care, parenting classes, health and mental health care, vocational services, and support groups, among others (Tracy, 1994). Treatment programs which integrate these services, while including the children, can promote a mother's sense of empowerment and control, while supporting and encouraging her in her most important role—mother. Perhaps it is time to build into child welfare decisions and treatment programs factors which allow women to keep their children while recovering from addiction (Horn, 1994).

Now, this is not to say that all women with substance abuse problems should be allowed to parent while they are recovering. Or, to parent at all. Many women are so comprised by their addiction that their children become vulnerable to abuse, neglect, and serious accidents, to name a few. Circumstances, therefore, including a rigorous

assessment of a woman's ability to properly care for her child's physical and emotional needs, her need for, and access to, social and financial support from family and friends, her current living arrangement, and any history of child abuse or neglect, should all be given serious consideration in the decision making process. For those women for whom parenting is a realistic and desirable goal, however, steps should be taken to allow her the opportunity to parent while recovering.

Substance Addicted Mothers and Retention in Treatment

This study also intended to make a contribution to the retention literature on behalf of substance addicted mothers. Up until this point, there have been many factors studied in relation to retention, including individual characteristics, social, psychological and emotional factors, and legal involvement, among others; all in an attempt to identify factors which motivative and maintain individuals in substance abuse treatment (Condelli & DeLeon, 1993; Condelli & Dunteman, 1993; Davis, 1994; Joe, Chastain, & Simpson, 1990; Kane-Caviola & Rullo-Cooney, 1991; Kelly, Kroop & Manhal-Baugus, 1995; Siddal & Conway, 1988; Simpson & Joe, 1993; Williams & Roberts, 1991). Most of these factors have demonstrated an equivocal relationship with retention. This study makes its contribution to the retention literature in two ways. First, by substantiating a recently discovered link between women's self-perceived maternal adequacy and treatment compliance (Kearney et al., 1994). And secondly, by discovering, though not substantiating, a potential new relationship—the one between meaning of motherhood and treatment retention.

Retention and Adequacy

Self-perceived maternal adequacy was first linked to retention in a study focused on the parenting strategies of crack addicted mothers (Kearney et al., 1994). In this study, women who believed they were competent as parents were subsequently more likely to fight to regain custody of their children. That is, they complied with court-ordered demands, including substance abuse treatment. The same relationship is uncovered here: the more adequate women feel, the longer they stay in treatment.

The relationship between feelings of adequacy and subsequent behavior finds support in the literature. Bandura (1977) and Maddux et al. (1984) clearly demonstrate that changes in behavior are positively related to a sense of self-efficacy, adequacy, and control. They find that individuals who *believe* they are competent are more likely to initiate and successfully complete some specified behavior (Bandura, 1977; Maddux et al., 1984). Health psychologists have also documented this relationship, finding patients more willing to comply with treatment demands when their sense of self-efficacy and control is fostered, and they are given the opportunity to express their viewpoint about their situation, including their negative feelings (Atkinson & Butler, 1996). In addition, and most relevant to this study, a very similar relationship has been documented within the context of women's experiences with child welfare agencies. It has been shown that mothers are more likely to comply with court-mandated activities, when they feel competent to make decisions regarding themselves and their children, and they perceive themselves as having some control over how decisions are made and implemented

(Atkinson & Butler, 1996).

But, approximately 60% of the women in this study did not complete treatment. This finding implies that many of the women in this study do not feel adequate as parents: and, in fact, many women did not. It seems then, if we want to increase the potential for change in substance impaired mothers, we must find ways to encourage their feelings of self-efficacy and personal adequacy. But, how do we accomplish this feat?

According to Marlatt (1985), self-efficacy and positive behavior, including positive mother-child interactions, and a reduction in the risk of relapse, are strengthened by repeated experiences of success. Substance addicted mothers, however, are more likely to be familiar with failure, than with experiences of success (Kearney et al., 1995; Levy & Rutter, 1992; Tracy, 1994). Negative attitudes towards substance abusing mothers are pervasive among child welfare workers, and within the community. These attitudes often set the tone for negative interactions between substance addicted women, practitioners, physicians, community members, and others. (Tracy, 1994). In some situations, substance addicted mothers have been reluctant to seek help due to negative experiences with unsympathetic health and social service providers (Polland & Ager, 1990). Even more important, however, is the detrimental influence these attitudes have on child placement decisions (Atkinson & Butler, 1996; Kearney et al., 1994; Tracy, 1994). Judges and child welfare workers are more likely to recommend placement for children whose mothers use substances, even when there is no evidence that abuse or neglect is involved (Eliason et al., 1995).

It seems, therefore, that before we can increase women's feelings of self-efficacy and control, we must first change the nature of their experiences. This may prove an untenable task, however, unless we focus our attention on educating those who have access to, and influence over, substance addicted mothers including judges, child welfare workers, treatment program staff, social workers, physicians, and health care workers. We could start by re-defining addiction as a complex, chronic and relapsing disorder, encompassing a continuum of behaviors and levels of use (Horn, 1994). Interventions could then be planned accordingly. As chronic disorders require multiple and/or ongoing treatments, *over time* (Cusack, 1995; Prochaska, DiClimente & Norcross, 1992), the likelihood of relapse could be built into a long-term treatment plan to help women anticipate relapses, and perhaps even seek protection for their children by sending them to relatives or close friends (Horn, 1994). Kinship networks - networks of extended family members and close friends - might be an appropriate, and more accessible alternative to foster care, offering children the stability of a consistent placement when parents relapse, while enhancing a sense of control for mothers (Horn, 1994). Finally, it is important to realize that recovery from drug or alcohol addiction is never an easy task, under the best of circumstances (Horn, 1994). When you have low income, single parents, who may also be suffering from psychological and emotional distress, and who lack social, emotional and financial resources, however, the chances of long-term success are remote. Comprehensive follow-up services in the home greatly increase a mother's chances of success (Horn, 1994).

Once we have provided women with opportunities for success, competence can be encouraged through practice. If we expect women to be sober *and* adequate parents, it makes sense to integrate the two into the treatment milieu, allowing children to physically reside with their mothers instead of harboring them in foster care. Programs that provide mother-child residency or participation offer important opportunities for enhanced maternal competence and success by allowing women to maintain their status as mother, learn parenting skills, and have access to positive role-models and feedback from staff and other mothers (Szuster, Rich, Chung & Bisconer, 1996; Wobie et al., 1997). In addition, studies of such programs report positive findings including increased parenting skills and appropriate mother-child interactions, less depression and higher self-esteem, enhanced feelings of control, and effective treatment outcomes (Laken & Hutchins, 1996; Stevens & Arbiter, 1995; Strantz & Welch, 1995; Szuster et al., 1996; Wobie et al., 1997). Although programs which allow children are more likely to be residential facilities, many of the basic tenets of such programs could be integrated into day and outpatient programs, with only minor modifications.

Retention and Meaning

In this study, mothers with low Meaning[18] had higher levels of retention at 8 weeks. Not only was this unexpected, but the relationship was not evident with retention at discharge. Examining the scatter plots revealed that the relationship between Meaning and retention at 8 weeks was the result of a subgroup of the population with high

[18] Note: The single word Meaning is used instead of "meaning of motherhood."

retention and low Meaning, evidence of a spurious relationship.

The findings here, however, might also be attributed, in part, to the manner in which Meaning was conceptualized. Recalling the process, content analysis of mothers' responses to open-ended questions was used to understand the unique essence of Meaning within this population. The context through which women described motherhood as salient - the context of the self, the children, or the relationship between mother and child - emerged as the foundation from which Meaning was defined. Erikson's theory of self-identity (1968) was used to make sense of this information. This theory posits self-identity on a developmental continuum whereby at low levels of maturity an individual understands herself only in relation to the self. But, as she matures, she is able to understand herself in relation to others. At the most sophisticated and mature level of self-identity, she is able to integrate the self as well as others. On a continuum of low to high, therefore, Meaning was judged based on whether a woman described motherhood in relation to herself, her children, or the relationship between herself and her children. The fact that this construction of Meaning *emerged* from the responses of substance addicted mothers is important to note. Its relevance to other groups of mothers is not evident from these findings. It is also not clear whether this is the most appropriate way to operationalize the Meaning of Motherhood. As defined in this study, Meaning clearly requires both conceptual and empirical validation.

It may also be the case that the manner in which the dependent variables were operationalized and measured, was not the best way to capture retention in this study. In

past studies, retention is often defined dichotomously and was based on whether or not a woman completed treatment: an obvious way to differentiate those who drop out from those who stay. If applied here, dichotomous dependent variables would have decreased the amount of information gathered, eliminating the opportunity to re-define retention as a continuous process, not a one-time event. This issue should be carefully considered, however, in future studies.

Despite evidence to the contrary, what if the relationship between Meaning and retention is not spurious? How could it be that women with low levels of Meaning—those who think of motherhood only in relation to themselves—have higher levels of retention than women with higher levels of meaning?[19] Until now, Meaning has not been studied in relation to retention in treatment and, as a result, supporting literature is limited. Years of experience working with this population, however, has provided the author with a framework from which to understand and interpret their behavior. Using experience as the framework, a speculative explanation materializes.

In practice, many substance abuse treatment programs, including those in this study, progress from a curriculum which demands self-focused participants, to a comprehensive curriculum that requires participants to focus outward as they deal with issues related to children, partners, and family members.[20] There are two reasons for this

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[19] This relationship is reported at 8 weeks only.

[20] Much of this information comes from working in the 3 NCA/LRA treatment programs, active participation on the NCA Quality Control Team, and numerous conversations with staff, and management personnel.

type of programming (Monti, Abrams, Kadden & Cooney, 1989). First, it is thought that women need to focus on themselves early in their sobriety in order to understand and take responsibility for their addiction and its consequences, thereby reducing the risk of relapse. Secondly, it is not until women have had enough "sober time" that they are thought stable enough physically, emotionally, and psychologically to deal with everyday life stressors, including relationships with children, family members and partners (Monti et al., 1989). In addition, external factors may distract women from fully engaging in treatment activities (Wobie et al., 1997).

It may be the case that, being self-focused, women with low Meaning scores are better able to distance themselves from external concerns about family, children and other relationships throughout treatment, and focus on program activities. Being more relationship focused, women with high Meaning scores may find themselves attentive early in treatment, but emotionally distracted when relationship issues are integrated into their program. Although plausible, this explanation does not fully integrate the context of motherhood. Using this explanation as the ground work, a second interpretation emerges: one that integrates the context of motherhood.

As we know, motherhood is often the central role for substance addicted women: the role by which they define themselves (Colten, 1982; Davis, 1994; Kane-Caviola & Rullo-Cooney, 1991; Kearney et al., 1994; Luthar & Walsh, 1995). When children are forcibly removed from a mother's care, therefore, she may experience intense feelings of anger, guilt, shame, and failure (Colten, 1982; Kearney et al., 1994). Knowing she must

focus on treatment in order to be successful, and that reunification is contingent on treatment success, mothers distance themselves from their emotions, and comply with treatment demands (Kearney et al., 1994). Perhaps initially, they are successful. At the point in treatment where parenting becomes an issue or relationships the focus, specifically relationships with children, negative feelings resurface, particularly for women with high Meaning. The depression, anger and frustration women feel about being away from their children, reduces their motivation to change, leaving them vulnerable to premature termination and relapse (Tracy, 1994; Wobie et al., 1997). Women with low meaning, however, may find themselves protected from relapse and treatment drop out, at least for a while, by their ability to remain self-focused.

Although it is not clear whether Meaning is actually related to retention, there are a number of factors that require further exploration. For example, how would low Meaning - a self-focused definition of motherhood - play out in a woman's relationship with her children? Could it be the case that low Meaning enhances retention but results in dubious parent-child relationships? What are the differences between mothers with low Meaning and mothers with high Meaning? And, if the relationship between low Meaning and retention were empirically validated, at least at 8 weeks, would we then encourage women towards low levels of Meaning? Or would there be a way to support and teach women with high Meaning scores to balance treatment activities *and* relationship issues, perhaps by allowing their children to reside with them in treatment? Furthermore, are there are other ways of conceptualizing and measuring the construct of

Meaning of Motherhood? And, if so, would there exist a similar relationship with retention?

Clearly there are some issues surrounding the relationship between Meaning and retention. Future studies might focus first on understanding exactly what this concept means. Only after that can we then understand the relationship between Meaning and behavior.

Practical issues

While the focus of this study was on the relationship between specific mothering characteristics and retention, motherhood variables accounted for only 29% of the variance in retention at 8 weeks, and 18% of the variance in retention at discharge. Clearly, there is variance unaccounted for by the factors in this study. There are other variables including specific characteristics of the women, the particular context of her past and current life, and factors related to the treatment programs themselves, which, though not evaluated in this study, may nonetheless be related to retention rates. For these reasons, they are noted here.

Characteristics of the women

"Women who abuse substances are more likely to have been victims of sexual and physical abuse in childhood, to have a parent who abused drugs and alcohol, and to have been introduced to drugs by a male partner" (Lakens & Hutchins, 1996, p. 3). When predicting retention, therefore, variables related to motherhood may be secondary to emotional and psychological issues such as depression and anxiety, traumatic life events

including sexual and physical abuse, and current, often chaotic, living situations that sometimes include partners who are addicted themselves (Alamo, Stephens, Llorens & Orris, 1995; Britt et al., 1995; Lakens & Hutchins, 1995; Finkelstein, 1993; Longshore et al., 1993; Lundy, 1995; Wallen, 1992; Williams & Roberts, 1991). By itself addiction can deplete the limited resources of an addicted mother. When it exists in concert with emotional and psychological problems, however, day-to-day activities, including the demands of parenting and treatment, may become further and more seriously compromised.

Sexual and physical abuse, whether during childhood or in the context of adult relationships, is an experience all too common for many substance addicted women (Blume, 1990). Although not directly explored in this study, to some degree the context of women's lives, including their childhood, and current and past romantic relationships, surfaced during interviews. Women often referred to instances of abuse that included parents, siblings, neighbors, and partners. In fact, one woman had given birth to two of her own father's children. Although the dynamics between abuse and addiction are not clear—Does the addiction numb the anxiety and depression that stem from the abuse? Or, does the addiction suggest a lifestyle that puts women at higher risk for victimization?—the consequences are serious. More likely to suffer from depression, anxiety and personality disorders, feelings of guilt and shame, and low self-esteem, women with a history of sexual and/or physical abuse often have difficulty making decisions, setting personal boundaries in relationships with family, children and romantic

partners, and feeling a general lack of control over their lives (Laken & Hutchins, 1995; Britt et al., 1995). In addition, as substances are sometimes used to cope with negative feelings—coping mechanisms that are long-standing and resistant to change—it becomes reasonable to suggest that a woman's ambivalence about giving them up might manifest in premature discharge from treatment.

Although families can exert a negative influence on their children—women are often abused within the context of their own families— families can also have a positive influence on a woman's life, including her ability to remain in treatment. For example, there is a long-standing belief that behaviors, including parenting behaviors, are somewhat inter-generational: Women tend to develop parenting styles that mimic those by which they were raised. Women who consider themselves to be adequate, competent parents—those women with high maternal self-adequacy scores—may, therefore, be more likely than women who feel inadequate to have come from families where consistent and fair parenting was the norm. In addition to providing firm and consistent standards, stable families are often more willing, and able, to provide the kind of support—social, emotional, and psychological—a woman may need when her addiction has escalated out of control, and she is fighting for her children. While mothers are in treatment, families can serve as relative-foster care placements, or temporary guardians, for children. Relative-foster care, often referred to as kinship care, provides a level of stability not found in nonrelative-foster care placements. Through these types of social support and family involvement, women are more likely to develop or maintain the

emotional strength necessary to cope with day-to-day problems and stressors, including treatment, and later, the unfamiliar lifestyle associated with a drug-free existence (Kelly et al., 1995).

Women who were sexually or physically abused are also more likely than women who were not abused to experience a pattern of abuse throughout their lives, beginning in childhood and, over time, extending into adult, intimate relationships (Blume, 1992). Although not directly evaluated in this study, woman often talked about intimate relationships characterized by mutual and frequent substance use, intense emotions including verbal and physical abuse, and "on-again, off-again dynamics." For substance addicted women, romantic relationships are often developed and maintained within the context of their addiction, putting the relationship at risk should the woman decide to get sober (Kane-Cavaiola & Rullo-Cooney, 1991). Partners, especially addicted ones, are often extremely resistant to their significant other's attempts at sobriety, attempting to sabotage her treatment program through punitive, abusive and unpredictable behaviors (Kane-Cavaiola & Rullo-Cooney, 1991). For reasons that are beyond the scope of this discussion, however, many women are unwilling to give up their relationship, and instead, leave treatment.

And finally, although the relationship is tentative, addiction severity and age have also been linked to retention (Alemi et al., 1997; Britt et al., 1995; Condelli & DeLeon, 1993; Copeland & Hall, 1992). Given the profound social, emotional and physical consequences associated with severe addiction, it has been suggested that severity

actually impedes positive outcomes. It has been further suggested that severity is linked to the type of drug used (Britt et al., 1995; Condelli & DeLeon, 1993). In this context, however, the data demonstrated three related findings: (1) there were no differences in retention based on drug of choice, (2) drug of choice was not related to addiction severity, and (3) women who were more severely addicted were actually *more* likely to stay in treatment. Without a more thorough analysis of these issues, it is difficult to draw any conclusions. One might suggest, however, that at some common level of addiction—most of the women in this study were moderately to severely addicted—the influence of the specific drug of choice may actually fall away, along with the potential differences related to it, and become secondary to the consequences of the addiction itself. Whatever the explanation, empirical support for the relationship between severity and increased retention provides an element of promise and hope: Perhaps those who need treatment the most, are those who are getting it.

The relationship between age and retention is also interesting. Citing less stable support networks, such as healthy marriages and adult employment, it has been suggested that younger women, those under 28 years of age, are more likely to drop out of treatment than are women over 30 (Alemi et al., 1995). The positive relationship between retention and age found here suggests some type of relationship but, again, it is difficult to elaborate on this finding without further analysis. One thing is clear, however: the relationship between age and retention can not be explained by "healthy marriages and adult employment" in this study: most women were not married (and never had been)

and were not employed (although most had been). With age, women experience a host of important emotional, psychological, and physical changes, any of which might work to influence her life choices.

Clearly, a variety of factors, including motherhood variables, may play a role in a woman's decision to remain in treatment, or not. Integrating these variables into a comprehensive study of motherhood and retention would be an important, though complex, first step in determining the unique contribution of each variable to both motherhood and retention in treatment. If we are to develop treatment programs that are appropriate to the physical, social, emotional and psychological needs of substance addicted mothers, however, we must first have an thorough understanding of this population. A more thorough examination of the contribution of these variables to retention in treatment seems warranted.

Treatment program factors

Though not evaluated within the context of this study, elements of the treatment program, such as the physical and social environment, staff, and program content, may all play an important role in retention, though their contribution is not well understood (Bell, Richard & Feltz, 1995; Finkelstein, 1993; Laken & Hutchins, 1996). When treatment takes place in an environment in which women feel comfortable and supported, such as a family-like environment, they are more likely to stay in treatment (Bell et al., 1995). Emotional safety and support are also critical environmental components. If women do not feel safe within the treatment milieu discussing the intimate details of their lives, it is

not likely they will procure the skills and insight necessary to obtain, and maintain, sobriety (Laken & Hutchins, 1996).

Having the opportunity to influence women's individual progress in treatment, while setting the tone for the program environment, staff also play an integral role in treatment retention. For example, in one of the data collection sites in this study, women spoke frequently and angrily about the amount of gossip that went on both in and outside the treatment center. Staff were often implicated in initiating and encouraging this behavior and when confronted by clients, staff became angry and punitive. As evidenced by low retention rates, and high staff turnover, the environment was not conducive to staff-client relationships, staff and client satisfaction, and ultimately treatment outcomes. [21] This example speaks clearly to the importance of staff training and supervision: training must address the needs and lifestyles of addicted mothers, issues related to cultural sensitivity, and ways to encourage a sense of trust and understanding with clients. Staff must be forced to confront their attitudes regarding this population and learn to be flexible and open-minded (Laken & Hutchins, 1996). Supervision must be rigorous and consistent, and provide outlets for staff to voice concerns, frustrations, and accomplishments. Although beyond the scope of this study, the relationship between staff and retention demands further attention.

The content of the treatment program is important as well. Despite the fact that

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[21] Though reported anecdotally, this information was reported consistently enough to warrant concern. For ethical reasons, information was presented to NCA/LRA management staff. Confidentiality was *always* upheld on the part of the management staff, and the author.

women define themselves through their relationships with others, traditional treatment programs still focus on the woman as an independent entity rather than on the broad and interdependent roles women play (Finkelstein, 1993; Lakens & Hutchins, 1996). For example, one of the programs represented here does not allow women to have contact with partners and children for the first 30 days of treatment, unless there is a court order. Many women found this unacceptable: they reported feeling trapped by concerns regarding their children - "Do they think I've abandoned them?" - and the demands of the program. Furthermore, it has been shown that incorporating women's relational needs into the treatment protocol increases the likelihood that she will stay (Stevens & Arbiter, 1995; Wobie et al., 1997). Unless the content of the treatment is specifically oriented to the clients it is serving, treatment outcomes for gender specific programs may be no different than those from traditional treatment programs (Bell, Richard & Feltz, 1995; Laken & Hutchins, 1996; Roberts & Nishimoto, 1996).

Methodological Limitations

In any study, there are methodological limitations which need to be addressed. This section outlines those relevant to the present study.

The design

This study used a correlational design to examine motherhood in relation to treatment retention. In general, a correlational design is utilized when trying to discover whether two or more variables are related to one another. Although methodologically rigorous and acceptable by design, there are methodological issues related to using a

correlational design. First, a correlational design does not allow for causal inferences: despite discovering a relationship between meaning and retention, and adequacy and retention, there is no way to know whether one actually causes the other. More importantly, however, is the issue of the "third variable" (Cozby, 1985). The "third variable" holds that despite empirically validated relationships - like the ones identified here - there may not be *any* direct causal relationship between the variables of interest because some other variable - the third variable - unaccounted for by the measurement model is responsible. The lack of a control or comparison group makes this issue more relevant. While important, these limitations should not minimize the implications of the present findings but encourage a next step: further examination of the constructs and relationships uncovered here employing an experimental, or quasi-experimental, design.

The type of design also affects the generalizability of the results. In the absence of a comparison or control group, it is difficult to generalize results outside of the confines of the study in which they were obtained. In addition, the limited geographic context of this study compromises the generalizability of its results. States have the right to create and enforce their own child welfare and drug laws. As a result, the lives of substance addicted mothers may be influenced and controlled differently in different parts of the country, and even the world. Legal and treatment systems may respond differently across states, making it difficult to compare one mother's experience with another. For example, women are less likely to seek treatment in states which have instituted laws against the use of drugs during pregnancy. Other states do not allocate state funds for

fees associated with substance abuse treatment. These factors require important consideration in future studies of substance addicted mothers.

Measurement issues

The majority of the instrument used for this study was taken from the Mom's Project. Although similarities have been noted between mentally ill and substance addicted mothers, the differences across studies in reliability indices for scales measuring Importance, Satisfaction, and Adequacy, suggest there may be some important differences. Designed to measure motherhood variables for mentally ill women, perhaps the instrument is more sensitive to their experiences, beliefs, and perceptions. Differences in sample size - the Mom's Project is significantly larger than the present study - may also be an issue. Sample size affects the reliability of an instrument as well as the ability to detect significance in effect size. Increasing the sample size may have produced higher alpha levels, although reliability levels were acceptable for all but the Importance scale, the results of power analyses conducted for this study indicated that the present sample size a number sufficient to detect a small to moderate effect.

Unfortunately, sample size presented an ongoing challenge during the course of this study, for a number of reasons. First, despite the informed predictions of the NCA/LRA management staff, the study failed to reach the anticipated number of participants after six months of data collection. Citing recent changes in the availability of State funds to pay for substance abuse treatment, in concert with Michigan's implementation of the Welfare Reform Initiative, NCA/LRA management staff felt that

fewer women were being referred to treatment and, of those being referred, newly mandated work requirements meant fewer were available to attend. It became necessary, therefore, to identify two additional program sites. This proved a difficult endeavor.

Secondly, despite experience working with a substance addicted female population, the author over-estimated the number of admissions for women with children. Although participation rates were fairly high among women who had children, the number of mothers admitted to treatment was less than had been anticipated. For example, despite the fact that Women's Day Treatment had the largest percentage of women with children, 40% of the population was childless.

And finally, because of these issues, the data collection process was prolonged from six months to one year, and the study became vulnerable to problems which can occur naturally, with the passage of time. For example, the initial excitement with which the study had been received by program staff weakened over time and, towards the end, staff became less willing to interrupt group time for interviews. Staff turnover posed a unique challenge: Each time someone new was hired, interview staff had to shift focus, spending time to educate new program staff about the study and it's procedures, while simultaneously recruiting and interviewing participants. In addition, over time it became more and more difficult to maintain a high and consistent level of communication with interview staff, an integral part of a successful research project. Anticipating these issues in future studies might help minimize their effect on study procedures, including desired sample size. As sample size is crucial to the integrity of most any study, factors which

threaten to constrain sample size should be taken seriously.

High levels of error variance - or individual differences - also need consideration when working with a vulnerable population. The intellectual, emotional, and psychological resources of this population may be compromised not only by chronic substance use, but other factors including depression and anxiety, low levels of education, and experiences of physical and sexual abuse. These factors may limit a woman's ability to respond appropriately to questions: she may feel pressure to participate, may not understand the questions or concepts, have difficulty processing information, and may be vulnerable to responding in a socially desirable manner.

Interviews may elicit a wealth of unique information about an individual, over and above what one might obtain from a paper-and-pencil survey report. Interviews present several problems, however, that may affect the reliability of the data obtained. The two most important and relevant factors here are interviewer bias and response sets (Cozby, 1985). Interviewer bias can affect the outcome of an interview in a number of ways. An interviewer may inadvertently show approval or disapproval to a participants responses or through specific probes may lead the participant to respond in a certain manner. Participants may also respond in a socially desirable way, providing answers from a particular perspective rather than providing answers which are directly related to the questions. In this context, women may have reported socially acceptable attitudes and behaviors, afraid, perhaps, of the potential implications of openly discussing their actual behaviors. This is not an uncommon phenomenon. Study participants have been known

to report attitudes and behaviors that are contrary to fact, especially in situations in which the participant has something to lose. And, response sets and interviewer bias can both influence study results. In order to minimize the occurrence of these problems, therefore, these issues were routinely examined and discussed during interviewer training, and revisited during supervision.

And finally, this area lacks strong theory which precludes the development of strong measures. Without strong theory it is difficult to determine which independent and dependent variables are important, and how they should be measured and analyzed. In addition, regression solutions are extremely sensitive to the combination of variables included (Tabachnick & Fidell, 1996). That is, whether or not an independent variable is important is determined by the other independent variables in the set: another important argument for choosing the "correct" independent variables. In addition, regression assumes IV's are measured without error. In social science research, however, this is an impossible task (Tabachnick & Fidell, 1996). Ultimately, we would want to choose the most reliable independent variables as possible. Again, however, that is difficult when theory is lacking.

Summary and Conclusions

Despite its limitations, this study has made a significant contribution to our understanding of substance addicted mothers, and to the retention literature. It has uncovered information which will hopefully prove useful in future treatment programming, and child welfare and child placement decisions. But, we have to act on

what we know. We must encourage retention by first relinquishing our negative attitudes towards substance addicted mothers, replacing them with informed understanding, fueled by the reality of women's lives and struggles, not myths and stereotypes. We need to expand our definition of addiction to include chronicity and relapse in order to encourage practitioners and clients alike to liberate themselves from traditional perspectives, whereby treatment is a one-shot cure and non-compliance a sign of pathology and/or an inability, or unwillingness, to change (Atkinson & Butler, 1994). Broader definitions will encourage broader treatment programs, where the relational aspects of women lives can be integrated, allowing children to reside or participate in treatment with their mothers, and family members to play an active role in a woman's recovery. Through this plan women can develop a sense of adequacy and control over themselves and their children, while freeing up valuable resources for an overburdened foster care system.

As plausible and encouraging as this scheme might be, however, there is much work to be done in this area. Theory must be developed that can guide future studies. Constructs must be rigorously and empirically defined and validated so that we know what to look for, what to measure. Measurement needs further exploration. It is the hope of this author, however, that we continue to make inroads into this controversial, yet important, issue. For, if nothing else, we owe it to the children.

APPENDICES

APPENDIX A

CONSENT FORM

CONSENT FORM

This interview is a dissertation project conducted by Susan Chibnall, a doctoral candidate at Michigan State University. The study is intended to gather information about mothers in substance abuse treatment. Participation in this interview will require you to spend approximately 1 to 1.5 hours completing this interview. The interview will ask you to answer questions and/or respond to statements about your attitudes, beliefs, and behaviors as a mother. Your decision to participate in this interview will in no way jeopardize or influence your treatment program.

1. Your involvement in this project has been fully explained to you and you freely consent to participate. You realize that you may discontinue participation at any time without penalty to yourself or your treatment program. You can also refuse to answer any questions without consequence.

2. You understand that if you decide to participate, your involvement will be limited to completion of this interview, which will ask you to report on your attitudes, beliefs and experiences as a mother.

3. You have given permission for this interview to be audio taped. You understand that once the interview has been transcribed, the tape will be destroyed.

4. You understand that **any information** you provide within the context of this interview **will be held in the strictest of confidence.** In addition, your interview will be labeled with a number, not your name. This will protect your confidentiality. You also understand that a master list exists which links your name with your assigned number. You have been further assured that this list is only accessible to the research team.

5. You understand that when this project is finished, a report summarizing the findings will be presented to the National Council on Alcoholism/Lansing Regional Area, but any information will be presented in summary form. You understand that "summary form" means that at no time will organizational leaders, staff or employees have access to individual interviews or interview results. You further understand that the information presented in this report will be used to help organizational leaders understand your experiences.

6. You understand that participation in this project will pose no risk to your treatment program, your children or your self.

Participant/Date

_____

Project Staff/Date

_____

APPENDIX B

INTERVIEW PROTOCOL

PLEASE FILL OUT THIS PAGE BEFORE BEGINNING THE INTERVIEW

Project ID: _____

Date of Interview ____/____/____

Place of Interview: _____

Time Interview Started _____:_____

Time Interview Ended _____:_____

Name of Interviewer: _____

Interviewer Number: _____

Interviewee Number: _____

First, I'd like to ask you a general question.

QOL 1) Which of these best describes how you feel about your life as a whole? [HAND RESPONDENT SCALE.] Terrible. Unhappy. Mostly Dissatisfied. Mixed. Mostly Satisfied. Pleased. Delighted.

1 = Terrible.

2 = Unhappy.

3 = Mostly Dissatisfied.

4 = Mixed. Equally Satisfied and Dissatisfied.

5 = Mostly Satisfied.

6 = Pleased.

7 = Delighted.

****

DEM2) In what month, day, and year were you born?

_____/_____/_____
MONTH / DAY / YEAR

Were you born in the United States?

1 - YES 5 - NO (GO TO DEM3)

DEM3) In what country were you born?

_____

How long have you lived in the United States?

_____

DEM 4) What would you say is your ethnicity or nationality?
INT: If respondent cannot think of one, just circle DON'T KNOW. It's okay if she does not know.

_____

97 - NONE 98 - DON'T KNOW

INT: If participant responds with an exact choice from question 5 below, circle the response in question 5, write in the response in the blank on question 4 and do not ask question 5.

DEM 5) Do you consider yourself primarily White, Black, American Indian, or Asian?

1 - WHITE/CAUCASIAN 2 - BLACK/AFRICAN-AMERICAN

3 - AMERICAN INDIAN OR ALASKAN NATIVE

4 - ASIAN OR PACIFIC ISLANDER 5-HISPANIC OR SPANISH

6 - OTHER (specify: _____)

DEM 6) What is the highest grade of school or year of college you have completed? (Please circle one number)

00 01 02 03 04 05 06 07 08 09 10 11 12

DEM6a) Did you get a high school diploma or pass a high school equivalency test?

1 - YES DIPLOMA OR EQUIVALENCY (GED)

5 - NO

DEM 6b) Did you get a college degree?

1 - YES 5 - NO

DEM 6c) WHAT IS THE HIGHEST DEGREE YOU HAVE EARNED?

1 - ASSOCIATES	5 - LAW
2 - BACHELORS	6 - PHD
3 - MA	7 - MD
4 - MBA	8 - OTHER: _____

DEM 7) What is the highest grade of school your mother completed? (*INT PROBE: What's your best guess? Do you know if she finished high school? grade school?*)

00 01 02 03 04 05 06 07 08 09 10 11 12

some college graduated college 98 (DON'T KNOW) GED

DEM 8) And what is the highest grade of school your father completed? *(INT PROBE: What's your best guess? Do you know if he finished high school? grade school?)*

00 01 02 03 04 05 06 07 08 09 10 11 12

some college graduated college 98 (DON'T KNOW) GED

DEM 9) In the past month, were you working for pay? (If yes,) How many hours a week did you work?

1 - FULL-TIME (> 30 HRS/WK) (# HRS ____)

2 - PART-TIME (11-29 HRS) (#HRS ____)

3 - PART-TIME (10 OR FEWER, DAY WORK) (#HRS ____)

4 - PART-TIME (IRREGULAR) (#HRS ____)

5 - NO

DEM 10) Are you a student? (If yes) Are you a full-time or part-time student? (If part-time) Are you enrolled in more than one class and part of a degree or certification program?

1 - FULL-TIME STUDENT IN COLLEGE, TECHNICAL, OR VOCATIONAL PROGRAM

2 - PART-TIME STUDENT IN COLLEGE, TECHNICAL, OR VOCATIONAL PROGRAM

3 - ENROLLED IN A SINGLE CLASS, NOT PART OF A DEGREE OR CERTIFIED PROGRAM

4 - NO

DEM 11) Are you retired? 1 - YES 5 - NO

DEM 12) In the past month, were you unemployed? 1 - YES 5 - NO

DEM 13) In the past month, did you volunteer? 1 - YES 5 - NO

DEM 14) In the past month, did you keep house? 1 - YES 5 - NO
(IF WORKING, SKIP DEM15)

DEM 15) Have you ever worked for pay? 1 - YES 5 - NO
(IF NO GO TO DEM18)

DEM 16) How long did you work at your longest steady job?

_____ YEARS _____ MONTHS

INT CLAR: longest steady job for pay, not most recent job

DEM 17) What is your current occupation? or What was your occupation at your most recent job? _____

DEM 17a) What are/were your primary job duties?

_____

DEM 17b) Describe your place of work.

_____

(What do/did they make or do where you work/ed?)

_____

DEM 18) Currently, how much do you receive monthly from these sources:
_____ AFDC (Aid to Families with Dependent Children)
_____ SSI or SSDI (Supplemental Security Income/ Social Security Disability Income)
_____ State Disability or Unemployment (circle one)
_____ Child Support
_____ Food Stamps
_____ Your wages
_____ Your spouse's or partner's wages
_____ Help or support from family or others:
who? (relationship):_____
who? (relationship):_____
_____ Any other sources of income?
(explain):_____

INT: Write in dollar amount received from each source or check (?) if respondent receives support but does not know how much.

DEM 18a) Do you live in public, subsidized or Section 8 housing?

1 - YES 5 - NO

DEM 19) What is your total monthly household income? Including all sources mentioned above.

$_____ (If don't know, estimate: $_____)

INT: Dollar amount should be the sum of amounts in DEM18.

DEM 20) Are you currently married?

1 - YES 5 - NO

DEM 21) Are you currently living with a partner?

1 - YES 5 - NO

INT CLAR: In other words, do you live with a boyfriend or someone you have a romantic relationship with?

DEM 22) Are you separated, divorced, or widowed?

1 - SEPARATED 2 - WIDOWED 3 - DIVORCED

4 - NONE

****

CHD 1) How many children do you have including natural, adopted and step children? _____ [IF 1 CHILD GO TO CHD4]

CHD 2) Do all your children have the same father?

1 - YES (GO TO CHD4) 5 - NO

INT: If 2 children, say "Do both of your children have the same father?"
INT: If 2 children, and R. answers "no" to CHD2, write 2 on line for CHD3 and do not ask CHD3.

CHD 3) How many fathers do your children have? _____

CHD 4) Starting with your youngest child, could you give me the child's name? Is that a boy or a girl? How old is he/she? Do you have legal custody of him/her? Does he/she live with you now? (If child not living with mom) Do you have any child care responsibilities for him/her? [KEEP GOING FOR EACH CHILD]

Name of child	**Male or female?**	**Age of Child**	**Custody? (Y/N)**	**Living with? (Y/N)**	**child care responsibilities? (Yes, No or N/A)**

(INT: IF ANY CHILDREN (UNDER 18) DO NOT LIVE WITH THE RESPONDENT, ASK CHD5)

CHD 5) People often give a number of reasons why their children do not live with them. Which of these apply to you?

[HAND RESPONDENT SCALE. READ ALL RESPONSES, CIRCLE ALL THAT APPLY]

1 - DON'T HAVE CUSTODY OF THE KIDS.
2 - DON'T HAVE A PLACE TO LIVE THAT IS SUITABLE FOR CHILDREN.
3 - PARENTING IS TOO HARD.
4 - IT'S BETTER FOR THE KIDS TO LIVE WITH SOMEONE ELSE RIGHT NOW.
5 - OTHER (SPECIFY)
_____

(IF CHILD(REN) DOES NOT LIVE WITH RESPONDENT, ASK CHD6)

CHD 6) How often do you see your child/ren?
_____
Where do you see your child/ren?
_____

How much time do you spend with your child/ren each week?
_____

CHD 7) Do you live with anyone else besides your children? _____

[IF NO, GO TO PWAY1]. Please list the names, relationship to you, and ages of the other members of the household. (after she lists them:) Do you provide care for any of them?

Person	Relationship	Age	Provide care (Y/N)

****

I'd like if we could talk about the reason you are here.

(INT: You are trying to understand if she is here voluntarily or has been mandated by some external source. REMEMBER YOU ARE AFTER THE PROCESS OF EVENTS WHICH LED TO HER ENTERING THE TREATMENT PROGRAM.)

REASON 1) How did you come to be in this treatment program? *(INT PROBE: " In other words, are you here because you wanted to be here or because someone else is requiring you to be here?")*

REASON 1a) Do your children have anything to do with your being here? *(Int: If yes, ask "What do your children have to do with your being here?"*

REASON 2) Sometimes social services and/or family court intervene in the lives of women and their children. They often do this if they suspect abuse, neglect or sometimes, if a parent uses drugs. When they intervene, they often remove the child(ren) from the home and place the mother in drug treatment if she uses, or parenting classes if she is abusive. If I were a mother and the judge in family court had just told me I had to participate in drug treatment in order to regain custody of my children, what advice would you me? What would you tell me to do so that I would get my kids back?

(*Int Probe: If she only gives one brief response such as "I would do what I was told" say, "What does that mean specifically?" You are trying to get at the kind of thoughts she has about this system and what needs to be done in order to either comply or not.*)

REASON 2a) So, I would get my kids back if I did what you just described?
_____Yes _____No)

If no, what else would I have to do?

Now, I'd like to ask you some questions about yourself that are not related to your being here.

PWAY1) In thinking about who you are, what you are like, and what is important to you, how would you describe yourself? *INT: If she is having trouble with this question say, "Give me five words which would describe you."*

_____
_____
_____
_____
_____
_____

PIMP 1) When you think about what you are like, tell me how important each of the following is in making you the person you are now.

[HAND RESPONDENT THE IMPORTANCE SCALE] Please answer the following questions using this scale, where 1 = not at all important; 2 = not very important; 3 = somewhat important, 4 = very important; and 5 = extremely important

INT PROBE: For each question, if R. does not understand or is hesitant to reply, use the probe ?How important is _____ in making you the person you are now??

INT: Ask all questions even if you think they do not apply. If R. thinks that do not apply (i.e., she is not a student), circle 0.

HOW IMPORTANT IS...

PIMP 1a) being a friend

1 2 3 4 5 0

PIMP 1b) being able to take care of yourself
INT CLAR: Taking care of yourself physically, mentally, and emotionally

1 2 3 4 5 0

PIMP 1c) being a family member
INT CLAR: Family includes family of origin and current family.

1 2 3 4 5 0

PIMP 1d) having a close relationship with your mate
INT CLAR: Mate is a boyfriend, husband, or romantic partner

1 2 3 4 5 0

PIMP 1e) being a mother

1 2 3 4 5 0

PIMP 1f) being able to enjoy yourself

1 2 3 4 5 0

PIMP 1g) being a provider for your family's needs

1 2 3 4 5 0

PIMP 1h) being a worker on a job

1 2 3 4 5 0

PIMP 1i) being a student

1 2 3 4 5 0

PIMP 1j) having a close relationship with God or a higher spiritual power

1 2 3 4 5 0

****

The next series of questions are about being a parent.

PIMP 0) Some women report that motherhood is really very important to them. Other women don' t feel that way at all. What's your experience?

(INT PROBE: How important is motherhood to you?) PROBE FURTHER IF NECESSARY

PIMP 0a) Imagine you have just been introduced to a woman who tells you that she is thinking about having a child. What are the 3 most important things she should know about the experience of becoming a mother?

(INT: This situation is hypothetical. If R. says she has never experienced the situation, tell her that you do not expect that she has direct experience with the situation, but she should imagine she is in the situation and describe what she would say.)

PIMP 0b) What advice would you give her?

(INT: If she asks who you are talking about, remind her of the woman in the scenario above. INT: If she asks advice about what, respond with "Advice about motherhood.")

_____
_____
_____
_____
_____
_____
_____
_____
_____

PIMP 2) What about being a mother is most important to you?

_____
_____
_____
_____
_____
_____
_____

****

PSAT 1) Now I have some questions about how satisfied you are with your parenting experiences in general with all your children.

[HAND RESPONDENT THE PARENTING SATISFACTION SCALE]

Please answer the following questions using this scale, where 1 = very dissatisfied; 2 = somewhat dissatisfied; 3 = neither satisfied or dissatisfied; 4 = somewhat satisfied; and 5 = very satisfied.

INT: If different satisfaction levels for each child, say "How satisfied are you overall as a mother about _____ with/for all your children?

How satisfied are you with...

INT: Say "child" if only one child.

PSAT 1a) your relationship with your children?

1 2 3 4 5

PSAT 1b) the way your children have turned out thus far?

1 2 3 4 5

PSAT 1c) the amount of time you spend with your children?

1 2 3 4 5

PSAT 1d) the way you act when you are with your children?

1 2 3 4 5

PSAT 1e) how you feel when you are with your children?

1 2 3 4 5

PSAT 1f) the way your children feel about you?

1 2 3 4 5

PSAT 1g) your ability to teach and guide your children?

1 2 3 4 5

PSAT 1h) your ability to properly discipline your children?

1 2 3 4 5

PSAT 1i) your ability to care for and protect your children?

1 2 3 4 5

PSAT 1j) your ability to provide your children with everyday things?

1 2 3 4 5

PSAT 1k) your ability to provide your children with special things like presents or family outings?

1 2 3 4 5

****

Now I'm going to ask you to talk about your experiences as a mother.

PMEAN 1) What would you say are the advantages of having children and being a mother? (benefits)

PEAN 2) Could you give me an example of something that makes you feel really good about being a mother?

PMEAN 3) What would you say are the disadvantages of having children and being a mother? (drawbacks)

PMEAN 4) Could you give me an example of something that makes you feel bad about being a mother?

PMEAN 5) In what ways has motherhood changed your life? *INT PROBE: How has having children changed your life?*

****

PADEQ 1) In the following questions, I will ask you to rate how much you agree or disagree with the following statements about your parenting.

[HAND RESPONDENT AGREE/DISAGREE SCALE.]

Please answer the following questions using this scale, where 1 = strongly disagree; 2 = somewhat disagree; 3 = neither agree or disagree; 4 = somewhat agree; and 5 = strongly agree.

INT: Say "child" instead of children if she has only one child.

PADEQ 1a) I often have the feeling that I can not handle my children very well.

1 2 3 4 5

PADEQ 1b) I find myself giving up more of my life to meet my children's needs than I ever expected.

1 2 3 4 5

PADEQ 1c) I feel trapped by my responsibilities to my children.

1 2 3 4 5

PADEQ 1d) Sometimes I feel alone and without friends because I spend so much of my time with my children.

1 2 3 4 5

PADEQ 1e) There is no such thing as good or bad children, just good or bad parents.

1 2 3 4 5

PADEQ 1f) When my children are well-behaved, it is because I am a good parent.

1 2 3 4 5

PADEQ 1g) Parents who can't get their children to listen to them don't understand how to get along with their children.

INT CLAR: It's the parents' fault if they can't get children to listen.

1 2 3 4 5

PADEQ 1h) My children's behavior problems are no one's fault but my own.

1 2 3 4 5

PADEQ 1i) Anyone could be a good parent if they just work hard at it.

1 2 3 4 5

PADEQ 1j) Children's behavior problems are often due to mistakes their parents made.

1 2 3 4 5

PADEQ 1k) Parents whose children make them feel helpless just aren't using the best parenting techniques.

INT CLAR: When children don't do what parents want, it's because parents haven't figured out how to get them to behave well.

1 2 3 4 5

PADEQ 1l) Most children's behavior problems would not have developed if their parents had better parenting skills.

INT CLAR: Children's behavior problems are primarily caused by poor parenting skills.

1 2 3 4 5

PADEQ 1m) I am responsible for my Children's behavior.

1 2 3 4 5

PADEQ 1n) The misfortunes and successes I have had as a parent are the direct result of my own behavior.

INT CLAR: My behavior has directly caused my misfortunes and successes as a parent.

1 2 3 4 5

PADEQ 1o) [HAND RESPONDENT SCALE.]

Next, I would like you to look over these choices and please choose the statement that best describes you as a parent.

1 - I AM NOT VERY GOOD AT BEING A PARENT.
2 - I AM A PERSON WHO HAS SOME TROUBLE BEING A PARENT.
3 - I AM AN AVERAGE PARENT.
4 - I AM A BETTER THAN AVERAGE PARENT.
5 - I AM A VERY GOOD PARENT.

****

People have different experiences with drugs and alcohol. Some people use drugs frequently without experiencing problems related to their use. Others use them frequently and experience all sorts of problems related to their use. I am interested in knowing if any of these questions apply to your experience. Again, it is important for you to remember that any information you give me today will be held in the strictest of confidence. It is important that we understand what your experience has been.

DS0) First, could you tell me what you would say is your drug of choice. (INT: If she gives you more than one, ask for her primary drug of choice.)

_____

DS0a) At what age did you begin to use on a regular basis. (INT: Regular means more than recreational use).

_____
_____
_____
_____
_____

DS0b) Do your children know about your substance abuse? If no, go on to DSOc.

(DS0b/yes) If yes, how do you know that they know? (*INT PROBE: What is it about their behavior, or the things that they do or say that tell you they know?*) *REMEMBER TO ASK THE NEXT QUESTION (DSOc).*

DS0c) Some women talk about specific things they do to keep their children from being exposed to drugs and people using drugs. What is your experience with this? *(INT: Are there things you do to keep your children from being exposed to your, or others, drug use?)*

****

This next set of questions deal specifically with alcohol and any illegal drug and overuse or misuse of prescription or over the counter medications. I will read the following statements to you. Tell me whether your answer is YES (1) or NO (5) or if it does not apply to your experience (0)

INT: Remember, you want her "using" experience. She may want to answer the questions according to her new "sober" status. Ask her to report for the times when she was using.

INT: If R. answers No consistently and is obviously getting frustrated because the questions do not apply to her, tell her how many more questions you have and that it should not take much time.

D1) Have you ever used alcohol or any drugs other than prescription medications or over the counter drugs?

1 5 0

D2) Have you ever used prescription drugs other than in the prescribed amount or frequency? *INT CLAR: For example, taking more than the doctor prescribed or taking the medication more often than prescribed.*

1 5 0

D3) Have you ever used more than one drug, including alcohol and prescription medications, at a time? *INT CLAR: For example, using alcohol and marijuana at the same time.*

1 5 0

D4) Have you ever had "blackouts" or "flashbacks" as a result of drug or alcohol use?

1 5 0

D5) Has your drug or alcohol use ever created problems between you and your family?

1 5 0

D6) Have you ever lost friends because you have been using drugs or alcohol?

1 5 0

D7) Have you ever neglected your family obligations because you have been using drugs or alcohol?

1 5 0

D8) Have you ever missed work because you have been using drugs or alcohol?

1 5 0

D9) Have you ever used drugs or alcohol when your children were around?

1 5 0

D10) Have you ever been in trouble at work or lost a job because of drug or alcohol use?

1 5 0

D11) Have you ever gotten into fights when you have been under the influence of drugs or alcohol?

1 5 0

D12) Have you ever engaged in illegal activities related to your drug use?

1 5 0

D13) Have you ever experienced withdrawal symptoms as a result of heavy drug or alcohol intake?

1 5 0

D14) Have you ever had memory loss or medical problems because you have been using drugs or alcohol?

1 5 0

D15) Have you ever been arrested for drunk driving?

1 5 0

D16) Have you ever consumed alcohol deliberately to get drunk?

1 5 0

D17) Can you get through the week without using alcohol or drugs other than those required for medical reasons?

1 5 0

D18) Are you always able to stop using drugs or alcohol when you want to?

1 5 0

****

QOL 2) Finally, how do you feel about your life as a whole? [HAND RESPONDENT SCALE.] Terrible. Unhappy. Mostly Dissatisfied. Mixed. Mostly Satisfied. Pleased. Delighted.

1 = Terrible.

2 = Unhappy.

3 = Mostly Dissatisfied.

4 = Mixed. Equally Satisfied and Dissatisfied.

5 = Mostly Satisfied.

6 = Pleased.

7 = Delighted.

****

Exact time now: _____

INT: This concludes the interview. But, before I go, I would to know if you have any questions for me?

Thank you very much for your participation.

****

INTERVIEWER: FILL THIS OUT IMMEDIATELY BEFORE LEAVING THE AREA.

X1. LENGTH OF INTERVIEW: _____ MINUTES

X2. DATE OF INTERVIEW: _____/_____/_____

X3. In general, what was the respondent's attitude toward the interview:

1. FRIENDLY AND INTERESTED
2. COOPERATIVE, BUT NOT PARTICULARLY INTERESTED
3. IMPATIENT AND RESTLESS
4. HOSTILE

X4. Who else was present during the interview? (Remember, if there was anyone at this interview, try to discourage it for the next time. There should be no one present but you and the participant)

1. NO ONE (GO TO X5)
2. SPOUSE
3. OTHER ADULTS
4. CHILD(REN)
5. ADULTS & CHILDREN

X4a. How much distraction was caused by (this person/these people)?

1. CONSTANT
2. SOME
3. A LITTLE
4. NONE

X5. What was the respondent's understanding of the questions?

1. EXCELLENT
2. GOOD
3. FAIR
4. POOR

X6. THUMBNAIL SKETCH

X7. ADD HERE COMMENTS ON THE RESPONDENT THAT MAY HELP US UNDERSTAND THE RESPONSES BETTER, OR THAT WOULD HELP YOU RECALL THE INTERVIEW.

X8. NOTE HERE QUESTIONS (BY NUMBER) THAT CREATED SPECIAL DIFFICULTIES OR THAT YOU THINK THE RESPONDENT DID NOT UNDERSTAND.

APPENDIX C

PMEAN RATING SCALE

CODES, CATEGORIES AND EXAMPLES

Rating Scale for Pmean 1 through 5[22]

Category	Example
(1) Focus on the negative: children take away from the mother; meaning of motherhood is low.	Having children meant never having my own identity; Can't go out dancing, you know. Somebody says, "Let's go get high" you can't do that anymore. It's a drag; You never get out of the hole. Never.
(2) Focus is on the mother, exclusive of the child: children are meaningful because they give the mother purpose; motherhood is acknowledged only by what it does for the mother; motherhood is somewhat meaningful.	There's no such thing as lonliness; It taught me how to be responsible; You have somebody to love you that's not going to reject you except for a damn good reason.
(3) Focus is on the children: motherhood is about what a mother can do for her children; motherhood is about guiding children, being there for them; motherhood is meaningful.	To be able to watch them grow up and become their own people; One of the best things to ever happen is spending time with them watching them grow. That's what being a mother is about. Your kids; It's about them.
(4) Focus is on the relationship between mother and child: Motherhood is about the relationship between mother and child; there is reciprocity; significance is for both mother and child, not one or the other; meaning is high.	It's very rewarding, having them love and care for them, and them loving and caring for you. It's beautiful; Together we do things that are very special. It's about togetherness.

[22] Questions are as follows: What are the advantages and disadvantages of having children and being a mother? (Pmean 1, N=62, and Pmean 3, N=64); Example of something that makes you feel good, and something that makes you feel bad about being a mother (Pmean 2, N=64, and Pmean 4, N=64); and How has motherhood changed your life? (Pmean 5, N=63).

APPENDIX D

QUALITATIVE CODES, CATEGORIES AND EXAMPLES

PWAY1

In thinking about who you are, what you are like, and what is important to you, how would you describe yourself?

Category	Examples
1. **Hobbies/Activities**: Specific activities or hobbies described by respondent that she likes to do or take up time in her life.	I like to read my book; I love to read. I love education; I love to explore and research; I am compulsive about exercise and exercise really helps.
2. **Focus on child or being a mother**: Answer includes reference to her child/ren or being a mother.	I love my kids. I'm a mother; Very, very family oriented. I always put the children first. ..It seems like everything has to do with the kids; I would say I'm a very good mother.
3. **Social role: role in life or relationship to others**: Reference to a specific social role or relationship besides mothering, like worker on a job, student, daughter, wife, boss, friends, etc..	I am a ... housewife, cook, everything.
4. **Personality: positive social characteristics**: Personality traits that involve positive interaction with others.	I'm a nice person. Kind to children and animals. Laid back. Friendly. Private; I am self-starting. I learn easy from other people. I am soft hearted. Very inventive.
5. **Personality: negative social characteristics**: Personality traits that involve anti-social behavior or non-interaction with others.	I guess I'm kind of a quiet person...I like to be left alone; I am hard headed; I am a frustrated person.
6. **Personality: moral characteristics**: Personality traits that reflect moral values or judgment of respondent's character.	I'm very honest. I've got a lot of patience; I think that I am a humane type of a person.
7. **Personality: agentic characteristics**: Personality traits the emphasize personal control over self and one's life.	I'm very goal oriented as far as trying to get through working and going to school and taking care of my son, all of that; I don't take anything. I'm independent. Don't get rattled. Dare me one way, I do the exact opposite.
7.1 **Personality: negative agentic characteristics**: Personality traits that emphasize lack of personal control over self and one's life; lack of self-confidence.	Right now it's a little hard for me to describe myself because I am having trouble with myself; Fucked up. Neurotic. Insecure. Emotional.

8. **Personality: happy/positive characteristics**: Personality traits that reflect happiness, cheerfulness, or an overall good attitude about oneself, not focused on interaction with others.	Lucky; Creative, energetic, industrious; I am happy. A little bit hyper, but happy.
10. **Focus on addiction**: Answer includes reference to respondent's addiction problem or problems related to it.	I am a dried drunk right now... an alcoholic; A drug addict. But, I am a good person.
11. **Don't know who I am**	I can't answer that right now because I am still trying to figure out who I am.
12. **Religiosity**: Responses that include reference to God, the Bible, church, spirituality or religion.	Who am I? A child of God. That's important to me. To live life the way God wants me to.

DSOc

Some women talk about specific things they do to keep their children from being exposed to drugs and people using drugs or alcohol. What's your experience with this?

Category	Example
1. Hides it from the kids: Response includes any reference to hiding use from the children; using in other rooms, when kids were away, etc...; not using in front of them.	We smoked in the basement, away from the kids; I hid it from them; I would take them to the sitter's, make them go outside; I never did it in front of them.
2. No experience with it; open about use: Response includes open use in front of children and others; no attempts to hide use; no reference to discussion with children.	I never really hid my drinking from anyone in my family... I didn't care who was watching; Nope, they stayed around and watched everyone drinking... I was open;
3. Open use as opportunity to educate kids: Response includes open use in front of the children but with conversation about use; children are given information about substances; idea is to expose them so they won't use, or be tempted to use, in the future.	I let him try marijuana when he was 11 yrs old. I gave him information so it wouldn't be taboo for him, get rid of the temptation; I've always been open and honest with her about it. She knows it's going to kill me but I have to be honest about it.
4. Alternate between hiding and doing it in front of them: Response includes attempts to hide it from the kids but, if not possible, mom would use in front of them; or drank in front of kids but wouldn't use drugs in front of them; or hide use from younger children but use in front of older children	With alcohol, I didn't really do anything... I didn't care if they knew. But with my drugs, I would hide or go in my basement; I ain't going to take her to a crack house or nothing (referring to the younger child). But my older daughter and I smoked a joint together when she was 13; For my smaller ones, I would go in the bedroom and shut the door. But with my older ones, I wouldn't sneak it; Sometimes I didn't hide it, but most of the time I tried.

PIMP 2
What about being a mother is most important to you?

Category	Examples
(1) Focus on the mother	
1.1 **Receiving love**: receiving love, support, empathy from child.	Her coming up to me and saying, "I love you mommy."; Being with her makes me happy; The need to be needed by someone else.
(2) Focus on child	
2.1 **Give love/emotional support**: Give love, understanding, nurturance, empathy, emotional support to children.	Being there for them through everything; Taking care of the baby. Make sure the baby is okay and that she is getting all the nourishment and everything she needs. Fulfill all of her needs; Knowing my children are secure in knowing I'm there. That I love them. That I'm doing this for them
2.2 **Provide physical care**: Giving children physical and financial security, including food, shelter, clothing and other material goods.	Taking care of them. Feeding them. Clothes on. They're not sick. They're healthy kids; I like to go shopping, buy clothes, and stuff like that for them
2.3 **Teach values/educate**: Seeing that children get the right direction and education; giving children good values or values of the mother.	I want him to grow up feeling love and compassion for other people; You've got to be a good example. Mother's have to set a good example for their kids. You know, keep them on the right road.
2.4 **Child's growth and development**: Focus on child's growth and goals for child - not focused on how mom will make it happen; hope for child's independence, education, happiness.	Just watching them grow... Saying new words coming out of their mouths; To see that my daughter succeeds. That she is happy. She wants to be a doctor. I don't care what she does. I just want her to be happy and independent.
(3) Focus on social context	
3.1 **Spending time together/sharing activities together:** Spending time with the child; enjoying each other's company.	Playing with them. Have activities with them. Have family time with them like watch a movie with them before bed time or what ever.

3.2 **Social role**: Focus on generic status of being a mother or being a good mother; activities of mothering - general vs. specifics of cleaning, teaching, feeding, etc.	To know that I am whomever created that life to begin with; I have developed a good sense of family history. I feel I have established a family.
(4) Focus on substance abuse problem	
4.1 **Caring for self/addiction, recovery related**: Focusing on controlling addiction to promote mothering; reference to addiction, substance abuse problems.	Being sober. Give her all of me, all of my attention; That I get clean and stay clean.

PMEAN 1
What are the advantages of having kids and being a mother?

Category	Examples
(1) Focus on the Mother	
1.1 Receiving emotional/social support from child: children's behaviors/actions that help mother in any way.	You have somebody to love that's not going to reject you except for a damn good reason; Just that you have somebody who loves you unconditionally; I feel like you always have some one
1.2 Focus on the mother's personal grow and development: pleasure, esteem; allowing full expression of mom's personality.	It's something that makes you grow when you teach them something and see them apply it; You learn more about you; You learn a great deal about yourself, the whole growth process of a human being.
(2) Focus on Child	
2.1 Providing social/emotional support: mothers' behaviors which help the child emotionally and physically; concrete services; taking care of another person	It's like you have somebody to take care of, someone to laugh with; You are able to give, love and teach. It is genuine and unconditional. This is something that you can love all of the time.
2.2 Focus on the child's growth and development: child's growth and goals for child - not focused on how mom will make it happen. Hope for child's independence, education, happiness.	Watching them grow; They are going to grow up to be the best people that they can be. They will go to college and get married and meet someone wonderful; There is just no other feeling like watching him do or achieve something. Or watch him do something that he is really good at; Seeing them succeed.
2.3 Teach values, educate, supervise, discipline: Giving children good values or mom's values. Moral instruction; discipline children, supervise their behavior.	The advantage is when my children were home, and I was teaching them; Trying to guide them in the right direction.

(3) Focus on Social Context	
3.1 Fulfillment of social roles: Describes activities and norms related to what is expected of individuals in particular roles; describes general achievements brought out by being a mother.	When they do something good or you get a compliment from other people on how well behaved she is or what ever; To me it was really enjoyable to spend time with my children and their friends and take them places, my days were planned around them. Going to their things at school and taking pictures. I got really close with their friends. I was the neighborhood mom and that made me happy.
3.2 Generational continuity, immortality, networking, connection: issues related to family growth, interdependence, and socialization	Just having a piece of me walking around; It's a reflection of yourself; The advantages are you have somebody that will eventually follow in your footsteps or you would hope to follow in your footsteps.
3.3 Sharing cultural and family activities and experiences, quality of relationship, spending time together	The advantage is that you get to share things with them; You get to do things with them. You keep yourself young. Can do puzzles, Barbie dolls, play with them.
(4) Other Responses	
4.1 Religious/Spiritual: participation in religious or spiritual activities, religious or spiritual teachings and messages	The spiritual growth.

PMEAN 2

Can you give an example of what makes you feel good about being a mother?

Category	Example
(1) Focus on the Mother	
1.1 Receiving love, support, and help services from the child: Feeling wanted and needed by children.	When she is glad to see me; Having someone to talk to, someone to turn to; I feel that they need me in their lives. They treat me now like I am a friend and not just their mother.
1.2 Accomplishments of child: school and social, including the child's school related or personal accomplishments - focus on mother and her part in child's accomplishments	When they bring home good grades. It makes me feel like I did something; When I've seen my kids happy, hug me, then I feel like I've done my part as a mother to them; Watching my son turn out so far the person that he is, because I raised him for thirteen years.
1.3 Personal goals: Includes statements related to specific goals that have been reached or have been established for the future.	I noticed that when I first became a mom, I didn't know much of anything... But, the more mistakes I made, I also learned from it.
(2) Focus on the Child	
2.1 Kids are O.K., happy, grew up well: Focus on children and outcome of children, rather than focus on the way she raised them.	When I go to his games and see him playing sports; Watching them grow up and turn into well rounded and well educated kids.
2.2 Providing concrete services, doing things for the child: Performing parental tasks that provide a service for her children.	I like to keep a nice clean home and keep my children clean...feeding them good and keeping them clean; Actually, just preparing a meal.
2.3 Teaching kids well: Teaching kids to be good human beings; focus on mom's role in child's outcome.	That's a reflection of what I've told her. I know this in my heart. I've instilled, she has her own identity and I can see all things I've taught in my children; Having guided them in the right direction.
2.4 Providing emotional support and love to child: Giving love and affection to children. Focus on relationship between mother and children.	When he looks and sees that I am there. That makes his day; Nurturing them. Listening to them. Seeing that their needs are met.

(3) Focus on Social Context	
3.1 Spending time with kids, sharing experiences together: Merely spending time with child or enjoying each other's company. Sharing cultural, family and other experiences together.	Spending time with them; We were always laughing and going places and doing things together; Sitting down at the dinner table eating, it is just, I don't know, wonderful.
3.2 Social role of motherhood: Focus on generic status of being a mother, being able to have kids, getting compliments about your kids or just having kids.	I like it when other people notice the children. I like hearing, "Your children are well-behaved", "they look so cute"; Just the miracle of birth.

PMEAN 3
What are the disadvantages of having children and being a mother?

Category	Example
(1) Focus on the Mother	
1.1 Problems with embedded roles: Mother has problems living up to the role. Feelings of failure, personal and social evaluation of their performance as mothers.	Not being ready to have a child. You are more apt to harm your child or abuse it, if you are not ready. I know. I wasn't ready; If you're not fully prepared, it's a lot of responsibility.
1.2 Emotional and physical suffering because of external factors: Focus on mothers' negative feelings related to the children's experiences.	The hardest thing was the worries, the worries about the children; It makes me anxious to make sure that he is satisfied, trying to be perfect. Always worrying that he is happy or okay.
1.3 Supervising, disciplining: Describes the mother's disciplinary acts as well as any other aspects related to supervision of the children.	I have a hard time disciplining them; I have to learn discipline. That is a real important thing - how to discipline children. I don't know how. Especially my son, he would just laugh at me when I would tell him to go do something. It was really frustrating.
1.4 Mom's behavior adversely affecting kids or herself, doubts about ability to be a parent: Negative consequences that parenting brings out.	When they turn out to be uncontrollable, you wonder if it is something that you done; When you fuck up. You not only humiliate and embarrass yourself or hurt yourself, but you hurt your innocent kids.
(2) Focus on Child: Children as a Hassle	
2.1 Hassles, loss of personal time or freedom, added responsibilities: Disadvantages that bring personal inconveniences such as changes in daily and social life and schedule changes.	You can't be spontaneous anymore; When you want on the spur of the moment to take off you can't do that because you have children; No free time. No extra money.
2.2 Costs, expenses, financial: Describes material consequences of being a mother.	Financially... it's hard.
2.3 Children's negative behaviors, children's developmental changes: Describes children's negative behaviors.	Taking care of them when they are sick and up all night. Listening to them whine; The mood swings of teenagers. Peer pressure.

(3) Focus on mother's addiction	
3.1 Mom's problems related to addiction including negative emotions, and custody issues: Issues related to mom's addiction and consequences of it.	The hardest thing was me using. Me feeling less myself. My children seeing me go through these things, seeing me wanting to commit suicide.. my low self-esteem. Who did they have?; Them getting taken away.
(4) Other responses	
4.1 No disadvantages	There aren't none.

PMEAN 4

Could you give me an example of something that makes you feel bad about being a mother?

Category	Example
(1) Focus on the Mother	
1.1 Mom's behavior negatively affects children, discipline issues: Mom feels lacking or worries about her ability to give her children emotional support and direction, not explicitly related to her substance use	I feel like I have let them down; I feel really bad when I discipline them I feel that I always over do it.
1.2 Can't provide financially: Mom finds it difficult or feels unable to care for her children's needs financially or physically.	There's also just the normal guilt that you don't have the money to give your kids stuff that other kids might have; Not being able to give them what they want.
1.3 Lack of contact or custody: Mom feels bad that she does not have custody of her children, her kids don't live with her or she does not see them as much as she would like.	One thing that makes me feel bad is that I am the mother of five children and was not able to keep them... I failed; I feel I let them down because they got taken away
(2) Focus on Child	
2.1 Children's negative behavior or characteristics: Focuses on the children's actions which bother her; children's negative life accomplishments.	That my daughter sasses sometimes. That makes me feel bad
2.2 Hassles, personal inconvenience: Reference to the inconvenience of having children because it restricts personal freedom, time to do other things, and time for self.	The stress. There is a high amount of stress; I don't have a good job or career like I want; When I have to go without things because they need something
(3) Focus on Life Circumstances	
3.1 External factors, things not in her control: Kids are negatively affected by circumstances beyond mom's control. Or external factors make her feel bad about being a mother, that is, not anything she or her children do.	When comments are made, downing you for the way that they are and they're things you couldn't help;

3.2 Issues surrounding father of children, sexuality: Mom feels bad about how her relationship with their father has affected the children, about not being able to provide them with a good male role model, or any issue about fathers to the children.	They wanted me to get back with their dad and I couldn't.
(4) Addiction	
4.1 Drug and alcohol related: Reference to her mental illness as all or part of what makes her feel bad about being a mother.	The fact that I'm an alcoholic and I wasn't giving my daughter the attention that she needed and that I was three months pregnant and I could not stop. That makes horrible guilt; Well, not being there for my children. That includes a lot because of drugs and staying a victim with abusive men
(5) Other responses	
5.1 Nothing	I don't feel bad about being a mom.

PMEAN 5
How has motherhood changed your life?

Category	Example
(1) a. Focus on the Mother: Positive	
1.1a Emotional Consequences: Related to self-esteem, life improvement, nurturance, emotional support; own evaluation of life and parenting; sense of personal worth and accomplishment; purpose, meaning in life.	I also feel better about doing things for others. It makes me happier to help someone than before I had children. I'm not as selfish as I was before I had children; It has given me the different facets to my personality that I wouldn't have without being a mother. I now have tolerance, patience and compassion.
1.2a Behavioral Consequences: Change in habits, cessation of deviance; positive changes related to quitting bad habits.	I became smart enough to divorce my husband. I became aware that there were consequences to my actions; Stopped doing crazy things.
(1) b. Focus on Mother: Negative	
1.1b Consequences: Loss of freedom, restrictions, financial: Changes related to freedom and free time, privacy, ability to go places; includes restrictions, problems, financial situation.	I went from a child to having to be a responsible woman almost overnight. I had to drop my life and become a mother; It slowed me down. Made me stay home.
1.2b Emotional Consequences: Negative feelings related to self-esteem, life improvement, nurturance, emotional support; own evaluation of life; sense of personal worth and accomplishment; all focused on mother's feelings.	I don't really know that I've been a mother. I've tried to be one at different times. So, the only way I can say motherhood has changed my life is that I always feel guilty because I haven't been one; It's stressful. The fighting is stressing me out.
(2) Focus on Child	
2.1 Emotional Consequences: Responses related to feelings scared and/or worried about kids well being.	A lot of emotion strain, a lot of hurt. They feel bad you feel bad. Any time they hurt, you hurt.

(3) Focus on Social Context	
3.1 Status/Social Roles: including additional or enhancement of roles and explanations about behavioral expectations in relation to those roles; concrete activities related to child care; personal growth as mother, adult, any other role.	I respect my mom a whole lot more. Being a mom made me realize what she went through. I appreciate motherhood.
3.2 Positive Consequences: Activities, relationships: Social activities the mother and kids engage in; changes to social relations.	I am never lonely anymore. With them I am a lot busier. Having them always around me.
(4) Addiction	
4.1 Positive consequences: Understanding, controlling, dealing with substance abuse issues; getting help for problem	It has given me the motivation to get sober; I'm not into drugs.
(5) Nothing's changed.	Ain't too much changed.

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