Substance Use and Motherhood: A Balancing Act

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Abstract

This thesis investigated the impact of race/ethnicity and socioeconomic status on attachment and style of parenting among mothers with substance use disorder. Case managers who work with mothers that have substance use disorder were recruited for interviews. The interview questions were related to the constructs of motherhood, maternal behavior, attachment styles, cultural and socioeconomic differences, and parenting and discipline styles of mothers with substance use disorder. The case managers' responses were coded based on the themes discussed in the literature review. The main hypothesis was that the degree of addiction can directly impact attachment styles and discipline styles of the mothers with substance use disorder while the variables of race/ethnicity and socioeconomic status reveal distinctions among mothers. This hypothesis was supported by the data collected from the interviews. Insecure attachments with children and neglectful parenting and discipline styles were common among mothers with a higher severity of the addiction. Differences due to culture and socioeconomic class were also observed. The age of the children revealed differences in types of attachment.

Introduction

Contrary to popular beliefs, not all mothers with substance use disorders fulfill the negative stereotypes that are appointed to them. The impact of race/ethnicity and socioeconomic status on style of parenting among mothers of infants and toddlers will be examined. Cultural differences among mothers of different races/ethnicities and socioeconomic status could reveal a diverse set of perspectives related to mothering abilities, strategies, practices, and style of parenting (Hardesty and Black, 1999). Socioeconomic status could impact the quality and quantity of resources available for mothers with substance use disorders. It is the researcher's belief that the degree severity of addiction directly impacts attachment styles and discipline styles of the substance-addicted mother. The attachment styles are secure, dismissive, preoccupied, and disorganized (Strathearn 2011). The discipline styles are laissez faire and authoritarian (Jackson 2013). For example, the more severe her addiction is, the more likely she is to form an insecure attachment with her child and the more likely the mother would as well as adopt a laissez faire discipline style (Jackson 2013, Kumpfer 1986).

Substance use and being a mother thus becomes a balancing act encompassing multiple factors, such as the degree of the addiction and different cultural values, custom, and life circumstances. This paper examined the interrelated factors of the neurobiological basis of addiction and maternal behavior, risk factors, issues for accessing treatment, race/ethnicity, socioeconomic class, attachment styles, discipline practices, constructs of motherhood, and a variety of mothering experiences of women who use substances and who are mothers to infants and toddlers. The hypothesis of this paper is that the degree of addiction can directly impact

attachment styles and discipline styles of the mothers who use substances while the variables of race/ethnicity and socioeconomic status reveal distinctions among mothers.

Substance Use Disorder as Explained by Genetic Epidemiology and Neurobiology

As the American Psychiatric Association (2013) stated in the DSM-5, substance use disorders (SUD) can be described as encompassing a range of symptoms and varying levels of severity from mild to severe. These symptoms can include drug taking and relapsing (American Psychiatric Association, 2013). A number of theoretical orientations have developed varying models to better understand the development of substance use disorders.

Genetic Epidemiology believes a history of family SUD contributes to an individual's likelihood of developing a SUD. Genetic epidemic research conducted by Compton, Thomas, Conway, and Colliver (2005) revealed a correlation between parental SUD and offspring SUD. If someone has the genetic disposition to SUD and they are in a stressful environment where substances are easily obtainable, the interaction of genetics and environment could result in that individual forming a SUD.

The core of SUD, according to the neurobiological perspective, is thought to be due to the ability of substances to pass through the blood-brain barrier and alter neurotransmitters such as dopamine and oxytocin (Herkov and Gold 2013). Dopamine is a part of the reward pathway within the brain. The ingestion of some substances escalates the amount of dopamine at the synapse in the brain by hindering reuptake of dopamine. Some substances, such as crack cocaine, can rapidly increase dopamine, which usually results in an intense and pleasurable high. However, as the effects of a dose dissipate, most addicts experience a noticeable withdraw of pleasure such that their mood is lower than prior to use of the drug. This creates a cycle whereby those suffering from addiction want to continue to use substances in order to obtain the same

level of dopamine or a greater level (Herkov and Gold, 2013, Malcolm, Barth, and Veatch, 2013).

Strathearn (2011) discovered that levels of the neurotransmitter oxytocin is reduced due to substance use. Oxytocin is directly connected to dopamine and is responsible for social bonding. Lower levels of oxytocin plays a role in a few of the withdrawal symptoms, such as social isolation. Malcolm, Barth, and Veatch (2013) found that among substance users, the first high is often believed to be the best high. Users of substances constantly attempt to reach this state again and encounter the feelings of the first high, which leads to extreme craving and drug seeking behavior, since they can never truly experience the powerful effects of the first high again. The neurobiological perspective views substance addiction as the result of altered neurotransmitters (i.e. dopamine and oxytocin), by substance(s), which triggers pleasurable feelings during the high and harsh withdrawal symptoms when the high is over. This process prompts the person to ingest more the substance(s).

Sociocultural Risk Factors Leading to Substance Use among Women

In addition to Genetic Epidemiology and Neurobiology, substance use disorder can be explained by the sociocultural theoretical perspective and risk factors associated with this orientation. From the sociocultural theoretical orientation, the use of some substances, such as crack cocaine and heroin, can also stem from social and environmental factors related to availability and cost as compared to other drugs (Herkov and Gold, 2013, Kearney, 1994, Trinh, 1998). The cost of crack cocaine is lower than the price of powder cocaine, which made it marketable and affordable for individuals in lower socioeconomic areas. Palamar, Davies, Ompad, Cleland, and Weitzman (2015) noted consummation of powder cocaine was linked to more elevated educational accomplishment and salary while the use of crack cocaine was

associated with decreased educational achievement and income. People in areas of low socioeconomic status have less wages and/or live in poverty. They are more likely to be marginalized from employment. People in these areas tend to use substances, like heroin and crack cocaine as a recreational drug and a form of escape from the hardships and stress in their lives. These areas of reduced socioeconomic opportunity usually have a high population of people of color. Such individuals may use substances as a way to cope the racism and prejudice they face in addition to using it as a form of escape from their socioeconomic status (Hardesty and Black, 1999, Hawthorne and Henderson, 2002).

There are a significant amount of risk factors that could be present in women's lives causing the development of an addiction to substances. As discussed previously, genetics and neurotransmitters are risk factors. Through genetics, a woman can have a predisposition for substance use. According to Strathearn (2011) and Lindberg & Zeid1 (2017), if a woman's dopaminergic pathways are not properly developed for optimal functioning, she will have a greater vulnerability to addiction to substances, such as crack cocaine, than an individual whose dopaminergic circuits are fully fostered. With poorly developed dopaminergic pathways, she could have a heightened sensitivity to the influence of substances like crack cocaine and could form an addiction faster, than someone whose dopaminergic pathways are fully developed, in an effort to feel the first high again.

Other risk factors are childhood and domestic abuse and the home environment. Trinh (1998) and Coyer (2001) affirmed that many women who used substances experienced various kinds of abuse (i.e. physical, sexual, and emotional) in their childhoods and many still face various forms of violence in their adult life, such as abusive relationships. These women tend to originate from dysfunctional families where neglect, substance abuse, child and spousal abuse

were extremely prevalent (Lindberg & Zeidl 2017). Growing up in a dysfunctional family with additional stressors causes psychological trauma. A number of women who suffer from psychological disorders, like depression and post-traumatic stress disorder (PTSD), due to the destructive aspects of their childhood may use substance as self-medication. It is common for these women to have poor coping mechanisms, low levels of self-esteem, and persistence feelings of hopelessness, worthlessness, and inadequacy. Boyd (1993) asserted that explicit paternal exposure to substances, such as substance, creates an environment where drug consuming behaviors are modeled in the home environment.

Cultural identification can be another risk factor for substance use among minority women. Depending on how women of color identify with their culture it can lead to drug use or help protect them from drug use. Beauvais (2014) stated that a woman who strongly identifies with her would be influence by that culture's beliefs and attitudes toward substance use while a woman who does not strongly identifies with the culture who not be as influence by the culture. If the culture has a strong negative view against substance use, it can act influence women to stay away from substance use. If a culture tolerates substance use or the use of specific substance, such as alcohol, it can influence women to participate in substance use. Women who be influenced by their culture because the culture sets the norms and expectation that women feel they should fulfill. The role of gender roles also comes into play with culture because some cultures would view substance use among the genders differently, such as some cultures being more open to men using certain substances as compared to women since are supposed to be nurturing caregivers to the children (Hardesty and Black 1999; Gunn and Canada 2015).

As mentioned before, a stressful environment causes many people to use substance as a recreational escape. As Boyd (1993) indicated, a lack of suitable and secure social support

creates feelings of loneliness and isolation among women. Women who abuse substances report greater levels of feeling isolated as compared with men who use the same substances (Boyd 1993). These women have difficulty maintaining positive peer relationships and times find themselves in abusive relationships with someone who also has an addiction. If these women have friends, they usually abuse substances which can act as a form of reinforcement for women to continue their drug use (Hardesty and Black 1999).

Problems with Accessing Treatment for Women who are Addicted to Substances

Some women with substance use disorder may want seek treatment but face some barriers among the different forms of treatment for substance use. Trinh (1998) identified the main types of treatment for substance abuse, which are outpatient treatment programs, intensive outpatient programs, residential treatment centers, and residential therapeutic communities. All four of these types of treatment offer a range of services and resources based on the level of severity of the addiction. Outpatient programs employ counselors, mental health centers, community-based organizations, and self-help groups to offer an assortment of services such as occupational training and counseling for substance abuse. This option is usually tailored for people with less severe addictions and is the least expensive. Intensive outpatient treatment programs offers services for clients 5-7 days a week but clients are allowed to return to their homes at the end of each day. Residential substance programs are geared towards people with more severe levels of addiction. Those in this kind of treatment are required to stay at the center for detoxification and therapeutic services for a few weeks to a month. Residential therapeutic communities are for those with extremely severe levels of addiction. This treatment lasts for months to a year and operates as a system of reward and punishment. There are a set of rules that all of the clients must follow. This form of treatment aims to offer structure to the client's lives.

It is not uncommon for an individual with a substance use disorder to experience care in several of these settings in their attempt to maintain recovery.

As Coyer (2001) acknowledged, treatment programs for substance abuse originally had models based on men and lacked the ability to properly attend to the needs of women. There are similarities among female and male drug use but there are also distinct difference that needs to be addressed in order for the treatment to effective. For example, men tend to use substances as a way to exert control over their lives so treatment methods utilized confrontational ways to make male clients aware of their substance problem. Using confrontational methods for women may be less effective, especially since a considerable amount of women realize they have a substance abuse problem but have not received proper treatment due to a variety of issues with treatment programs (Trinh, 1998).

Although drug addiction programs have improved over the years in an effort to make treatment more accessible, there is still a significant amount of barriers pertaining to the treatment of substance using women. Schacht (2013) identified the prenatal stage as a vital time to inform and educate women of the impact of substance abuse on themselves and their infants. Health providers could also refer the women to drug treatments programs and/or give them information on other resources that they could employ. Pregnant women who use substance may not be fully aware of the long-term outcomes substance abuse can have on themselves and their children.

As Coyer (2003) affirmed, a great number of treatment facilities are not prepared to treat pregnant women. Along with pregnancy comes a mixture of changes for the mother that needs to be examined and monitored by a medical professional who is specialized in prenatal care. Most people specialized in treating SUD do not have adequate training in prenatal care. Certain

changes, such as hormonal and emotional, could also negatively impact interactions and counseling sessions.

A majority of pregnant women who use substances do not receive substantial prenatal care, partly due to the fact that they do not go to the doctor because they fear the stigma of being viewed as a “bad” mom for consuming substance and are afraid of having their children removed from their custody. As Allen, Flaherty, and Ely (2010) asserted, there are a number of states and local regions that have laws mandating the evaluation of child abuse if the mother is suspected of abusing substance(s) and/or if the child has been exposed to drugs. There are also racial and socioeconomic biases that health providers express towards different groups of women. Eliason (1995) and Mahar (1992) discovered that poor black women are more likely to be reported for drug related child abuse even though rates of drug use are similar among all social classes and among black, Latina, and white women. Service providers, such as doctors and welfare agencies, rely on negative stereotypes and associations as justification for the biased treatment (Eliason 1995).

As previously mentioned, substance use is common in areas of lower socioeconomic status. Most of these women rely on welfare and other forms of government assistance, since they are more likely to be marginalized from employment. Without a sustainable income, these women cannot afford proper prenatal care, post postpartum care, and treatment for their substance addiction. They are often denied access to prenatal care due to being a welfare client (Maher 1992). Lack of transportation is another barrier to drug treatment, especially among women who live in rural areas where transit systems are rare and/or nonexistent and treatment centers are not within walking distance (Coyer 2001).

Allen, Flaherty, and Ely (2010) and Maher (1992) cited mothers with substance use disorders concern for their children as a barrier in receiving treatment. A large number of mothers with substance use disorders are single mothers and/or are in abusive relationships where they do not receive support. Most residential programs do not allow children to live in the treatment center with the mothers. It was previously stated that women with substance use disorders lack positive and supportive social support and peer relationships. They also tend to come from family households where various forms of abuse and neglect were rampant. If mothers do not have someone that they can trust and who has the time and energy to take care of their children while the mother receives therapeutic services, it is less likely that she will seek treatment. Trinh (1998) noted issues with outpatient treatment programs in relation to children. Mothers with substance use disorders may have trouble locating and affording appropriate day care for their children while they attend an outpatient facility. The schedules of many outpatient treatment programs conflict with children's schedule. There a couple of treatment programs that provide housing and child care but there is only a small amount of these facilities. In a nation-wide survey conducted in 2002, 34% of treatment facilities has programs with pregnant and post-postpartum women. Only 16% provide child care services at the facilities (Substance Abuse and Mental Health Services Administration 2002).

As explained by Hawthorne and Henderson (2002), there is lack of understanding of the assortment of norms among mothers of different races/ethnicities and different social classes. A number of treatment programs do not take into consideration the norms and challenges of people belonging to diverse races/ethnicities and socioeconomic class which causes effective treatment to be accessible (Hardesty and Black 1999). This lack of understanding and consideration causes non-white mothers and mothers of lower socioeconomic status to be a fearful of seeking

treatment for their substance addiction because of the possibility of misunderstandings among the services providers and the mother, which can have negative consequences. For example, forms of discipline vary among the racial/ethnic groups. Someone who unfamiliar with the way black parents discipline their children (i.e. spanking), could view their methods of discipline as abusive (which in some but not all cases they are) pertaining to that person's cultural norm of discipline. This scenario could result in a report of child abuse and the children being taken away from the mother, even though in that context there was no abuse present. The limited amount of resources a mother has access to because of her low socioeconomic status could hinder her ability to supply the basic needs for her children. Someone is unfamiliar with the challenges that people of lower socioeconomic status face, could view this scenario as the mother being a "bad" parent for not providing basic needs for children without taking into account the lack of resources (McGoldrick, Joe Giordano, and Garcia-Preto 2005). Mothers of different races/ethnicities and social classes who use substances would rather avoid seeking treatment than risk the possibility of seeking treatment and the occurrence of a misunderstanding that could result in their children being remove from their households.

According to McGoldrick, Giordano, and Garcia-Preto (2005), a mother's culture can influence her behavior which can be viewed as dysfunctional or abnormal to a therapist who does not understand the culture. For example, a common solution among the Puerto Rican culture for handling for child who misbehaves often is sending the child to live with extended family members in Puerto Rico, such as a grandmother or great-aunt, based on their views of the family and family support. A mental health provider may view this action as dysfunional because the child will be away from the mother which can negativity affect the child's development. By having knowledge about this culture and their beliefs, a mental health provider could work with

the mother to form a compromise so that the mother does not feel attacked for acting according to her culture and the child's development is not in jeopardy. The mental health provider may encourage the mother to strengthen the connectedness among the family members and herself and the child before the child is sent to live with them. By strengthening the connectedness before the child is sent off, the child would be able to adjust better to the new environment away from their mother. Their development would be not be as negatively impacted since the bond among the mother and child was strengthen which will aid in its maintenance instead of the bond diminishing.

As stated by McGoldrick, Joe Giordano, and Garcia-Preto (2005), cultural influences and beliefs can also affect clients' behavior in relation to accessing and receiving treatment. It is taught in the Puerto Rican culture for women to avoid eye contact, a mental health provider who is not aware of their cultural norm may view this behavior as the mother is trying to hide something. It is common among Latinos and black people to seek help from within the family, if they have family support, so they may not desire to seek treatment from substance use treatment centers. They also have a fear of being misdiagnosis, which has happened to black people in the past, due therapists misunderstanding clients' behavior (McGoldrick, Joe Giordano, and Garcia-Preto 2005, pp.96) Once in a session they may not be as open or cooperative as other clients. A therapist who is not familiar with their views of seeking outside treatment by attribute their behavior to being difficult when in reality they may be fearful and guard. If a therapist is aware of these beliefs that black and Latino have toward mental treatment, the therapist can work with the clients to help them become more open and receptive treatment.

Prenatal Substance Exposure

Limited access to effective treatment could have prenatal and long-term consequences on infants, if the mother continues her substance use. According to Schacht (2013), prenatal substance exposure negatively impacts the prenatal development of the infant, which causes long-term behavioral and cognitive effects**.** A selection of the consequences of prenatal substance exposure are inability to focus, intellectual delays, behavioral regulating issues, reduced social behavior, and low birth weight. Infants who are exposed to any substances during pregnancy experience withdrawal symptoms when they are born which causes parenting to become even more difficult, since the withdrawal symptoms poses another set of issues the mother may not be equipped handle (Schacht, 2013, Strathearn and Mayes, 2010).

Attachment Styles among Mothers with Substance Use Disorders and Infants/Toddlers

Substance use can affect attachment styles among mothers and their children, especially if the child had prenatal exposure to substances thus influencing the presence of behavioral regulating issues among infant and toddlers (Schacht 2013). Behavioral regulating issues among infants and toddlers can impact how they react to their mother and ultimately how mothers react to them. According to attachment theory, attachments are the patterns of relationships people have with the emotionally important people in their lives (Funder 2016). Strathearn (2011) identified numerous types of adult attachment styles that can influence maternal behavior and the mother-infant attachment. The main types of adult attachments are secure and insecure. Insecure attachments has three subdivisions which are: dismissive, preoccupied, and disorganized. Women with a secure types of attachment have the capability to incorporate emotional information (i.e. emotional states and imaged memory) and temporally-ordered information concerning cause and effect in order to make correct choices and foresee future rewards in order to form a close bond with others. Dismissive women usually minimalize emotional information

while rejecting their own emotions, intentions, and perceptions. They rely more on rules and well-grounded temporal sequences in predicting future rewards. Women with preoccupied patterns of attachment have a tendency to shape their behavior around emotional information (i.e. fear, anger, or desire) for comfort. They become preoccupied with their own emotions and perceptions while neglecting cognitive or temporally-ordered information. Disorganized women's behavior is usually chaotic and sporadic. They exhibit the behaviors of the previously attachments.

The attachment style of the mother and her maternal behavior can result in a mother-infant/toddler attachment style that reflects the influence of a combination of these two elements. Research conducted by Strathearn and Mayes (2010) showed that patterns of secure, dismissive, preoccupied, and disorganized attachment are common mother-infant/toddler attachment styles among mothers who use substances. Mothers with substance use disorders who have a secure form of attachment will most likely attend to their infants and/or toddlers physical needs (i.e. providing food, shelter, clean clothes, etc.) and will be available and receptive to their emotional needs. Attending to a child's emotional and physical needs will manifest into the patterns of a secure attachment. A secure attachment is consider the healthiest attachment form and the most beneficial for children.

As Strathearn (2011) and Lindberg & Zeidl (2017), declared, dismissive, preoccupied, and disorganized mother-infant/toddler attachments are forms of insecure attachment where parental care and maternal behavior are negligent, rejecting, hectic, and/or erratic. Insecure attachments are considered to be unhealthy and negatively affect children. Dismissive mothers with substance use disorder have been found to have lower levels of maternal warmth, which causes emotional neglect and a dismissive attachment. These mothers may be more concentrated

on satisfying their addiction and less focus on attending to the physical and/or emotional needs of their children. Preoccupied mothers will look to their infants/toddlers to fulfill their emotional needs instead of meeting the emotional needs of their children, which can also result in emotional neglect and patterns of preoccupied mother-infant/toddler attachment. The children's reaction(s) to them deeply affects the mothers' emotional state. As previously mentioned, the uses of substances can cause intense changes in emotional states (i.e highs and lows), cognitive abilities, and mental states. These fluctuations can create unpredictability in maternal behavior, which can generate a disorganized attachment style. If the children are exposed to all of the aspects of maternal substance use, they can experience the effects of these constant variations in her emotional and mental states without knowing what kind of behavior to expect from the mother on a day-to-day basis.

The cultural norms and values of different ethnicities can play a role the formation and maintenance of attachment types. According to Hardesty and Black (1999) and McGoldrick, Giordano, and Garcia-Preto (2005), Latinos value the family and the mother to elevated degree as compared with most American families. The strength of this cultural value is prevalent among Latinos in impoverished communities. The limited amount of resources causes Latino families in these areas to rely on their kin-network as they navigate their way through these situations. Many of their ethnic traditions and norms are centered on aspects of the family, which also included members of the extended family. In Puerto Rico, Mother's Day is a momentously celebrated holiday and is the second highest gift-giving holiday. Several of the mothers in Hardesty's and Black's (1999) study reported that they maintained strong bonds with their children, especially with their daughters, while consuming crack cocaine. There were times when the strength of the bonds fluctuated and other instances where the bonds became a form of insecure attachment. The

cultural values of family and motherhood plays a huge role in formation and maintenance of the bond. Daughters viewed themselves as extension of their mothers and viewed their mothers as extension of their grandmothers. The "grandmother-mother-child triad" enables Latinas to feel a strong connection with each other (Hardesty and Black 1999, pp. 610). Different ethnicities and socioeconomic classes adds other variables to the influence of attachment styles among mothers with substance use disorders and their infants and toddlers.

It is possible for the type of mother-infant/toddler attachment to change throughout development depending on the severity of the mother's substance addiction and its impact on her maternal behavior. For example, if an effective early intervention is employed to help the mother stop her substance use or if her substance use is moderate, the attachment style she has with her infant/toddler could possibly become a more secure attachment. If her addiction worsens, as her infant becomes a toddler the attachment style could become more insecure. As the level of their addictions changed, the women in Hardesty and Black's (1999) study stated that their maternal behavior changed which affected the form of attachment they had with their infants and toddlers. The same patterns can also be seen among the women in Kearney's (1994) investigation.

Substance Use, Neurotransmitters, and Maternal Behavior

As discussed previously, substance use has an effect on various neurotransmitters which can trigger the continued use of the substance. Dopamine and oxytocin are two neurotransmitters that are affected by substances but they are also two neurotransmitters that are directly linked to maternal behavior. Substances can alter these neurotransmitters' influence on maternal behavior. As acknowledged by Strathearn and Mayes (2010), dopamine acts a form of constant motivation and a facilitator for maternal behavior due to its role in the reward system. Mothers have declared they feel a sense of pride when they are able to execute maternal behavior that benefits

their children which causes them to continue to perform maternal behavior (Brown, 2006, Eliason, 1995, Hardesty's and Black, 1999). Oxytocin, which is also a hormone, is responsible for bonding among mothers and their children. This neurotransmitter plays a crucial role in the onset of the facilitation and maintenance of maternal behavior (Strathearn and Mayes, 2010).

Strathearn and Mayes (2010) found that substances can take over the dopaminergic system and reduce the level oxytocin in mothers. Substances can take over the dopaminergic system by shifting a mother's motivation away from executing maternal behavior to satisfying to substance craving. As stated by a selection of the women in Kearney's (1994) study, reaching a high by ingesting substances eventually became some of the mothers' primary motivation. A reduction in oxytocin in mothers can initiate less maternal warmth being expressed towards their children.

The degree of the influence of substances on these neurotransmitters and on maternal behavior depends on the level of their addiction. If a woman use substances in a moderate amount and only during a certain timeframe, such as only on the nights of the weekend, the effect of the substance(s) on her dopamine and oxytocin systems could be less and she could be able to exhibit some level of maternal behavior (if there were no abnormalities present in her neurotransmitters before drug use). If a woman uses substances in an excessive amount nearly every day of the week, the impact of substances on her neurotransmitters could be greater and her maternal behavior may become extremely impaired. The impact of substances on these neurotransmitters' influence on maternal behavior, which ultimately impacts mother-infant/toddler attachment styles since maternal behavior plays a role in the formation and maintenance of attachment.

Discipline/Parenting Practices

In addition to substance use affecting attachment styles among mothers, it can also influence parenting practices of mothers. Various mothers who use substances may adapt a laissez faire style of parenting or an authoritarian style of parenting. Jackson (2013) described laissez faire parenting as a form of parenting that allows the child to behave however they choose to with little to no consequences. Mothers with substance use disorders who adapt this form of parenting may not discipline their children effectively to correct deviant behavior in the children. They may also be neglectful of their children's range of needs, such as basic necessities and emotional support (Kumpfer 1986). Laissez faire parenting can be linked to a dismissive attachment or a preoccupied attachment. An authoritarian style could encompass the mother being too invasive, controlling, and harsh in punishment, which can sometimes turn into becoming abusive (Jackson 2013).

In several cases, mothers with SUD may alternate between both parenting approaches depending on the current condition of the mother. Mothers have conveyed that while they were under the influence of a substances, their children were able to do deviant behavior without any repercussions. If the children did the same deviant behavior while the parent was sober they were sometimes disciplined severely for the deviant behavior (Kumpfer 1986). There were occasions where the reserve happened and mothers adopted an authoritative style of parenting while they were under the influence of substances and adopted a laissez faire type of parenting while they were sober. Some mothers threatened to punish their children for deviant behavior but they admitted that they rarely followed through with the threat of discipline. This instability in parenting could be linked to a disorganized attachment. At some point in their addiction, usually the early stages, some mothers communicated that they maintained a balance between the parenting approaches, instead of leading towards one extremes. Some mothers stated that they

used the discipline styles based on the context of the situation and what they felt was the best method to address the behavior in the specific situation (Brown, 2006, Hardesty and Black 1999, Kearney, 1994). Having a balance between the parenting styles can be associated with a secure attachment.

"Good" Mom vs. "Bad" Mom Based on United States' Standards

According to Allen, Flaherty, and Ely (2010), the concept of motherhood, in the United States, can be classified into two categories, a "good" mom and a "bad" mom. This perception is based on historical, gender, and societal standards for what is expected of a mother. The understanding of a "good" mother also varies among groups of people as a function of race and socioeconomic status. A practice that is considered to be evidence of "good" mothering among one group of people can be perceived as a form of "bad" mothering by another group of people and vice versa, due to differences in lifestyles and cultural traditions and norms.

The construct of motherhood build on the interpretation of what is considered to be a "good" woman in the United States. As Gunn and Canada (2015) indicated, the double standards, racial biases, and socioeconomic biases of the "good" woman concept revealed a number of unrealistic and discriminatory standards. The characteristics of the "good" woman is one who upholds extraordinary moral standards, innocence, sexual purity, trustworthiness, etc. This notion tends to portray white middle and upper class women as the ideal societal standard while viewing poor black women as the unideal deviant based on inaccurate stereotypes of both those living in poverty and black women (Allen, Flaherty, and Ely, 2010, Gunn and Canada, 2015). The differences in the methods non-white women and lower class women use to navigate their lives due to their racial and class struggles and standards are not seen or accepted as

alternative ways to be “good” women, they are rejected and perceived as ways of being “bad” women.

As asserted by Gunn and Canada (2015), the “good” mother notion emphasizes and builds on the interpretations of the “good” woman. In addition to the depicting the characteristics of the “good” woman, the “good” mother is portrayed as married, educated, and has access to resources (e.g. money, time, social support, and health). The “good” mother is supposed to be the backbone and moral guide of her family. Her role as a mother comes first as compared with her other roles. The “good” mother is self-sacrificing and selfless. The needs of her children should be placed before her own needs. She devotes her time and energy toward nurturing her children. The same racial and class bias that exist among the portrayal of the “good” woman are present in the representation of the “good” mother (Allen, Flaherty, and Ely, 2010). Mothers who do not fully and properly execute this “good” mother role according to these standards are seen as deviants and as “bad” mothers.

As evident in Maher’s (1992) and Eliason’s (1995) research, the difficulties of being a single mother, being a mother of color, and/or living in poverty are not taken into consideration when examining who is a “good” mother. Women living in these situations are still held responsible for their children’s well-being, if they cannot fully provide for their children they are criticized and perceived as “bad” mothers. Mothers living in impoverished neighborhoods are viewed the “undeserving poor,” (Gunn and Canada, 2015, pp. 282) because people see them as lazy, and therefore, not worthy of government assistance. Black women who utilize government assistances are viewed as “Black welfare queens,” (Gunn and Canada, 2015, pp. 282) because people believe they are lazy and taking advantage of the welfare system instead of working at job to earn an income and provide for their children. As mentioned before, gaining employment in

these areas is very difficult. The challenges of gaining stable and sustainable employment in these areas, due to racial and socioeconomic bias, are not inspected when criticism of mothers in these locations occur.

In addition to the criticisms and stereotypes previously mentioned, mothers with substance use disorders are also stigmatized for their substance use. Mothers with substance addictions are viewed as selfish and improper caretakers who neglect to put their children's needs before their own crack cocaine needs (Gunn and Canada, 2015). A number of substance using mothers are single mothers. If these mothers are also living in poverty and/or are non-white, they endure multiple layers of criticism. They are viewed as deviants who have "violated" multiple traditional norms associated with being a "good" mother in the U.S.

Mothers who use substances, live in impoverished locations, come from diverse ethnic backgrounds, and/or are incarcerated for their crack cocaine use expressed similarities of what the U.S considers a "good" mother and in their interpretations of what is believed to be a "good" mother. As previously mentioned, they may have alternative methods, different from the techniques employed by white middle and upper class women, in order to perform the "good" mother role.

Allen, Flaherty, and Ely's (2010) conducted an investigation of incarcerated women who were arrested for their substance use and who were also mothers of infants and toddlers to explore the stigmatization the mothers faced for being incarcerated and their past use of substances. The incarcerated women, of diverse ethnic backgrounds who lived in poverty prior to their arrest, expressed similar notions of what they believe to be a "good" mom, which meant meeting the emotional and physical needs of their children. Some of the women in the study explained that while they had their children in their custody they expressed love and pride in

their children. They attended to their infants' and toddlers' emotional needs to the best of their abilities and formed strong bonds with their children.

A couple of the mothers also made sure that their children had food, clean clothes, shelter, and other basic necessities. To provide essential necessities for their infants and toddlers and to meet the expectations of a "good" mother while being addicted to substances, some of these impoverished women had to make use of government assistance. These mothers had to employ government assistance, such as welfare, so that they could fulfill the standard of offering basic necessities to their children. This research suggests that women who use substances believe in similar expectations of parenting but due to their circumstances they may utilize other techniques to fulfill the standards (Allen, Flaherty, and Ely 2010).

The Latina mothers in Hardesty's and Black's (1999) investigation conveyed similar practices and beliefs. Even though the belief and practices were based more on an ethnic influence, at the center of their beliefs there were still notable similarities with the U.S expectations. Some of these resemblances, that the mothers stated, were putting their children's emotional and physical needs first and viewing themselves as the back bone of their families. If a mother thought about her substance needs before making sure all of her children's needs were meant, she was viewed as an irresponsible mother among the mothers in the study and others in the greater population. Motherhood is viewed as the supreme measure and rite of passage into womanhood among the Puerto Rican mothers in the study and other Latinas. Motherhood gives Latina women a valued place in their community, since it is central to their identity as a woman.

Brown (2006) discovered that the standards of what is considered a "good mother" and a "bad mother" varied among several races/ethnicities and socio-economic status groups. Certain structural factors, such as racial discrimination and poverty, could cause African-American

mothers in rural areas to use different ways of parenting, as compared to other European Americans in urban areas, focused on the issues apparent in that neighborhood and based on the resources available to the mothers. For example, due to the amount of violence in low income rural areas, mothers would teach their children how to defend themselves and survive by fighting back if someone harms them. From the perspective of African-American mothers in rural areas, this lesson is a form of protecting the children and teaching them how to survive in this subculture but it could be viewed differently by those who are not from this geographic location and are not aware of the norms and issues of this subculture. Those who are not familiar with the area could view this style of parenting as harsh and as "bad parenting" without recognizing the importance of this style of parenting for survival in these kinds of neighborhoods. These research studies suggest some mother who use substances share similar views of what the U.S deems a "good" mother but there could be differences in the way the characteristics of being a "good" mother is expressed due to race/ethnicity and socioeconomic status.

Various Experiences of Mothering Infants and Toddlers While Using Substance

The interacting the variables of biological influences, attachment styles, parenting and discipline styles, and sociocultural influences can create different experiences of motherhood while using substances. Substance use impact motherhood in numerous ways, especially when factors such as race/ethnicity and socioeconomic class are considered. Substance use can cause some mothers to be neglectful and/or abusive toward their children. In other cases, some mothers who ingest substance may greatly value motherhood and try to be what is considered a "good mother" corresponding to U.S. societal standards. Some of the mothers in Baker's and Carson's (1999) research portrayed this by avoiding exposing their children to drugs by not using while

their children are in the house. Some mothers also buy necessities first and make sure their children are taken care of financially before spending the remainder of the money on drugs.

A sizeable amount of drug-addicted mothers in several investigations stated that they formulated mothering strategies and techniques to satisfy their expectations of being a “good” mother while being addicted to crack cocaine (Brown, 2006, Coyer, 2001, Hardesty and Black, 1999, Kearney, 1994, Sterk, 1999). By employing these strategies, some of the mothers were able to exhibit an assortment of maternal behaviors and build bonds with their infants and toddlers by creating a balance between their drug consumption and their role as a mother. These techniques reflected the variety of cultural values of the women’s racial/ethnic groups, the norms and struggles of living in impoverished neighborhoods and their beliefs pertaining to motherhood.

These strategies could be defined as “defensive compensation,” (Kearnery, 1994, pp. 355). It is the process of protecting children from substances and other elements associated with the drug life, safeguarding one’s identity as a mother, and trying to make amends for the negative outcomes of substance use on mothering. The mothers used strategies to help them fulfill their mothering role and attend to their children’s needs in spite of being abdicated to substances. Each mothering strategy involved several methods used by a range of mothers and multiple methods employed in conjunction to achieve the overall execution of the strategy. The mothers stated their personal and social resources played a role in the success of these techniques being implicated.

Brown (2006) cited one of the first strategies was making sure to keep children physically separate from the substance and to keep drug consumption concealed so that the children would not witness the mother’s crack cocaine addiction. Some of the mothers with substance use

disorders wait until their children were asleep in another room in order to ingest the drug. Other mothers left their infants and toddlers in the care of day care workers, babysitters, and/or relatives. Kearney's (1994) study revealed that when it was time to visit their children's day care centers and settings where children would be, mothers made sure that their physical appearance did not show their substance use. Mothers avoided telling other people about their drug use. They would only admit to drug use to relatives as a last resort if they needed someone to take care of their children while they entered a treatment program or to hospital staff while they were in labor.

The management and budgeting of money from welfare checks and paychecks allowed the mothers to make sure their children's basic needs were being fulfilled, which was another strategy. As affirmed by Sterk (1999), some mothers with substance use disorders separated money that would be expended on food, clothes, and bills and spent the reminder of the money to purchase crack cocaine. Others mothers brought necessitates and paid their bills as soon as they received their checks in order to avoid the risk of spending all of the money on drugs. Kearnery's (1994) research found that planning out their time, energy, and crack cocaine use permitted mothers to be able to give infants and toddlers their time and energy at peak hours and when the children needed it most. For example, some mothers restricted their crack cocaine consumption to only evenings so that they can get an adequate amount of rest in order to take care of their children the next morning.

As another strategy, mothers attempted to relocate and isolate themselves from the influence of the drug world. They isolated themselves in their household to escape the temptation and violence of the drug community. They eluded contact from social workers because they

feared that their mothering practices would be misinterpreted based on their substance use and their children would be removed from the household (Kearnery, 1994).

According to Hardesty and Black (1999), the cultural traditional gender roles of Latinos aided crack-addicted mothers in taking care of their children. By depending on the fathers to work, the mothers were able to stay in the house to care for infants and toddlers. This gender role allowed the Latina mothers who use crack cocaine to be physical and emotionally available for their children while relying on the income from the father to secure their basic needs. The Latina crack cocaine using mothers rejected some of the standards of what the U.S. depicts as a "good" mother (i.e. white middle and upper class women) to manage their identity as a mother. They followed the expectations and customs of their ethnic and socioeconomic background. They portrayed the family's and culture's values and traditions to their children. To maintain their children's moral character, they utilized an assortment of discipline commonly used in their culture. As mentioned before, utilizing welfare is seen as a violation of being a "good" mom in the U.S. Among those living in poverty, where unemployment is prevalent, using forms of government assistance is the next legal option. The mothers accepted this alternative and still viewed themselves as "good" mothers according to their circumstances. As discussed before, there is "grandmother-mother-child triad" within Latino families. This family system allowed mothers who used crack cocaine to depend on their mothers or other women within the family to take care of their children as their addiction worsen or as they entered treatment. The "grandmother-mother-child triad" was usually a smooth transitional system for children's adjustment, since it is common for children to have multiple maternal figures within the family due to the importance of family among this ethnic group.

Although some of these mothers' devised strategies that would allow them to exhibit maternal behavior, there were instances in which some of the techniques were not executed in the exact fashion the mothers hoped for and thus did not have the results the mothers expected. An example of this was hiding their substance use from their children. There were occasions when the children came out of their rooms unexpectedly and caught their mother consuming drugs (Brown, 2006). Another instance was ineffectiveness of discipline in some cases because if the toddler's behavior continued mothers did not always follow through with the warning, they adopted a laissez faire form of discipline. Many of the mothers also admitted that over time as their substance addiction worsen and escalated, they relied less on these strategies. As Coyer (2001) identified, one of the techniques to suffer first was being emotionally present and available for their children. Some of the mothers were able to maintain providing basic needs for their children, but their capability to offer emotional support for their children decreased (Sterk, 1999). Through continued use of substances it became difficult for the mothers to maintain the balance they created and their bonds with their children declined. In some instances, mothers relied on strategies less often or eventually stopped depending on their original strategies as their substance addiction took over. (Hardesty and Black, 1999, Kearney, 1994). Mothers tried to lessen their drug ingestion but without proper supportive interventions, this task was not achievable for all. The failure to apply the strategies resulted in some previously secure attachments to weaken and become insecure.

Kearney (1994) cited that as mothers' addiction intensified and their maternal behavior suffered, the mothers performed one ultimate strategy in order to order to protect their children from the negative parts of their drug use. Some of the mothers voluntary gave up custody to their infants and toddlers when they started to view themselves as unfit mothers. The children were

either placed with family members or in foster care based on the mothers' hopes that they would receive adequate care away from the influence of illicit substances. When the children were placed in other households, some mothers started to seek treatment for their addiction either to regain custody of their children or to maintain some kind of presence in their children's lives as they matured. Some mothers hoped to rebuild, maintain, or for the first time establish a form of strong bond with their children by placing their children with a trusted individual as they entered treatment.

If children were involuntarily taken away from the mothers' custody the mothers' addictions intensified to a greater degree because the choice was their own choice. In many of these cases, children were a reason and motivation to lessen and/or to stop drug use. Some mothers tried to seek help so that they could be fully available to their infants and toddlers, if the children were removed from their home before interventions had a chance to be applied mothers lost motivation to continue seeking treatment.

This investigation examined the impact of race/ethnicity and socioeconomic status on styles of parenting among mothers who use substances. This project's methodology comprised of literature review augmented by personal accounts obtained from interviews. Trends and critical analysis were expected to reveal similarities and differences in the women's experiences. My hypothesis was the degree of addiction can directly impacts attachment styles and discipline styles of the mothers who use substances while the variables of race/ethnicity and socioeconomic status will reveal distinctions among mothers.

Method

Participants

Every organization that serves mothers with substance use disorder in Berks County was contacted through phone call and/or email. Most of the agencies did not reply. A reason for the agencies not replying could be that these organizations were community based. They are low-staffed and overworked so hosting interviews could have been too much to add to their already overloaded case work. Those that did reply either wanted a graduate level student to conduct research or someone who was already working for the company due to protecting the confidentially of the mothers.

Family Resources Specialists (FRS) employed at Family Concerns[1] were enlisted for this study. Family Concerns is a small provider agency located in Berks County that works with other agencies to help individuals and their families manage various problems, such as substance use and juvenile delinquency. FRS have similar responsibilities as social workers. FRS are case managers that help people cope with problems and issues they are having by connecting them to other agencies that are specialized in aiding people gain resources such as housing, job placement, volunteer agencies, etc. The participants consisted of two white American women who work as the case workers for mothers with substance use disorders. This study was approved by the Albright College IRB.

Materials

Based on information gathered in the literature review, open and closed ended questions were created to conduct structured interviews. The questions were related to the construct of motherhood, maternal behavior, types of attachment, discipline styles, and general parenting practices of mothers with substance use disorder. The questions for professional staff were phrased to ask about their general observations pertaining to their clientele. A list of the questions can be seen in Appendix 1.

Procedure

Before beginning any of the interviews, participants read and signed informed consent forms. A copy of the informed consent can be seen on Appendix 2. Any questions or concerns they had were addressed. Mandated reporting was communicated both verbally and within the informed consent. Participants were clear that any information mentioned that denotes danger to a child would be reported to the agency of employment (i.e. Family Concerns).[1]

The interviews were face-to-face and about 20 minutes long. The recorded interviews were then transcribed and participants were given pseudonyms in the transcription. Content analysis was used to code the information attained from the interviews and sort through the data to look for common trends and similarities. Coding is used in a qualitative analysis to identify major variables and themes that interact with each other to create a bigger picture of what specifically is being studied. The major themes identified from the interviews that were translated into the following codes were: parenting and discipline, attachment, child responses, race/ethnicity and socioeconomic status, and the impact of substance use. These codes were based on the studies discussed in the literature review (Brown 2006, Allen, Flaherty, and Ely 2010, Gunn and Canada 2015, Hardesty and Black 1999, Jackson 2013, Kumpfer 1986, Strathearn and Mayes 2010, Strathearn 2011).

Results

As mentioned before, two interviews[2] were conducted and information was gathered from these interviews. The information was then sorted into the previously mentioned codes. The following findings are analyzed by each of the individual codes (e.g. parenting and discipline,

[1] The name of the organization was changed to protect confidentiality.
[2] The names of the caseworkers were changed to protect confidentiality.

attachment, child responses, race/ethnicity and socioeconomic status, and the impact of substance use).

Parenting and Discipline

In response to a question about the mothers' basic level of understanding of parenting, both Charlotte stated the following:

> The mothers do not have a basic understanding of parenting, they are lacking a lot of skills. They don't feel confident as parents because a lot of their lost custody of their children. They are some that parenting is not priority so it hard to determine their knowledge and takes a little bit longer sometimes. Some mothers were not aware of the behaviors that they had that were harming to the child. This was determined through observation as parents or give example of situation and ask how moms would handle the situations.

This suggests that before entering the program at Family Concerns, mothers with substance use disorder tend to lack a basic understanding of parenting. This could be due to substance use and/or other factors that could possibly interact with the substance use including the poor parenting they themselves received.

In response to a question about what characteristics describe a "good" mom and her roles, Tracy felt that:

> Key aspects of parenting are being nurturing and affirming. Other aspects are having a gentle touch, hugging, complementing, and praising the child. Redirecting behavior appropriately by not using any type of physical discipline. A characteristic of a good mother is definitely empathic. Other characteristics are being able to negotiate and compromise with the child. Also being able to manage stress and take care of themselves cause that the tough part of being a mom, self-care. She would take a role on as a mom pretty much 24/7, possibly a spouse, a caretaker to someone else, a leader, referee, and a nurse. Juggling a schedule is also important. Some characteristics of a "good" mother is someone who is caring, loving, good listener, and who has empathy for their children. They put themselves in the children's place while setting boundaries and limits with the children. They give children praise for being who they are and what they do.

The characteristics and roles described above mirror some of the characteristics mentioned in the literature review including empathy and being nurturing. Charlotte mentioned similar

characteristics such as being empathic and affectionate and praising the child. This shows that Tracy and Charlotte beliefs of what makes a “good” mom is representative of the U.S. standards, which aids Tracy and Charlotte in determining the maternal behavior of their clients.

In response to a question about discipline styles, Tracy and Charlotte said had similar responses which were:

Some mothers disciplined their children physically. While others neglected the children and didn’t do anything. The agency has more neglect cases and being passive than physical. Well a lot of them use timeout, verbal discipline that is either appropriate or a little inappropriate in the way that they do it. Some mothers physically hit their children.

The response above show the use of different methods of discipline among mothers with substance use disorder, which was also stated in the literature review. There seems to be a trend of laissez-faire style of discipline, since it was stated that there are more cases of neglect and mothers being passive.

In response to a question about cultural and/or family influences of parenting and discipline styles, Charlotte said the following:

> Most times they [mothers with substance use disorder] don’t know how to parent because they weren’t raised in a proper way. Their parenting style is how they were raised so now we are dealing with two generations of inappropriate parenting. A lot of them are also doing what they were thought and what they did growing up and it’s almost like “well this is how I was raised and this is how I am raising my children.” Whether it’s is positive or negative approach.

Tracy gave a detailed example of influence of the Hispanic culture:

> What I have found with my Hispanic clients is they are more likely to physically discipline children. A mother spanked a child in front of me and told me it was a part of her culture to do that versus doing a timeout or other types of discipline.

Mothers with substance use disorder seem to draw on the parenting and discipline styles of their parents and in some cases their culture, which was previously mentioned in the literature

(McGoldrick, Giordano, and Garcia-Preto 2005). The Hispanic culture seems to rely more on an authoritative style of discipline.

When asked about improvements in mothering behavior when mother completed the program, Charlotte mentioned:

> I see a lot of improvement in a lot of the mothers after Family Concerns becomes involved. The nurturing parenting classes teaches them to be nurturing and about discipline. They work on themselves and their self-worth. A lot for the mothers, those who done drop out, a lot of them improve and are more aware of some of the behaviors that they had that were harming to the child.

Mothers seem to gain a form of confidence in their ability as they work on themselves and increase their self-worth. By learning about being nurturing and other methods of discipline, mothers improve on their abilities and behaviors.

From these interviews, it can be suggested that most of the mothers lack basic parenting skills which could be due to their substance use. The mothers' ways of parenting and discipline seems to be influenced by culture and the examples of parenting that they learned from their families which could also account for the discrepancies among the Tracy's and Charlotte's idea of parenting and discipline and the way the parenting and discipline styles of the mothers. By not having a proper understanding of general parenting practices in addition substance use, some mothers became overwhelmed with parenting. They were neglectful to their children in some cases. With the guidance of Family Concerns, mothers seem to learn ways of parenting that aligned more with the FRS view of mothering.

Attachment Styles

When asked about the observed different attachment styles and bonds mothers with substance use disorder have with their children, Charlotte said the following:

> Most of the times it's hard for mothers to bond with their children. But a lot of them lack the skills of bonding, like the emotional skills of being who they are and interacting with children in a normal way. Some of them are very strict they issue commends other mothers are very passive where when the child is with them. They are on their phone

> instead of bonding with the child. They have a dismissive attachment style. With an addicted mom raising an infant, most times they are left to cry. If they are awake and hunger and mom is using a lot of times they are left alone to cry and then the mother become involved with services. The mom is more passive by leaving the child alone to cry.

Mothers seem to exhibit the behaviors of different attachment styles, which can be influenced by a variety of factors, such as how their parent raised and the parenting behavior they observed. Although there seems to be more observed dismissive attachments and the most of the mothers seem to lack the emotional basis to bond with their children.

Tracy discussed the signs she saw of some secure attachments:

> During supervised visits, some mothers would be happy to see the child. They would praise the child and say statements like, “I appreciate you” and “I’m happy to see you.” They would give the children hugs and show them affection talking in a raised tone of voice and not just monotone. The mothers expressed themselves in a positive way.

Some mothers seem to be able to exhibit behaviors related to a secure attachment and emotional bonding to children by praising them and showing affection. Mothers’ ability to do this could also be influenced by different factors, such as how their parent raised and the parenting behavior they observed.

In addition to lacking an understanding of parenting, some of these mothers seem to lack the ability or skills to form secure attachments with their children. Some mothers may not know how to build a secure attachment and what it entails. Substance use could also take their energy and attention away from forming and maintaining a secure attachment with their children, as substance use becomes a priority. The differences in observed attachment styles reflect what was stated in the literature review, which was mothers with substance use disorder tend to display different forms of attachment.

Children’s Response

When asked about how children react and respond to their mothers, Tracy said the following:

> Most times with toddlers their attachment is the same whether the mother is using or would not have been using because they fully understand that mom is not fully there or mom is not doing what mom is supposed to be doing. And a lot of times they don't realize until about middle school when they learn more and learn what parenting really is that they realize maybe something is going on [as in the mom's substance use]. Whereas a child at that age may have more of a secure attachment to the mom. Until about the age of 6, children would react to their moms in a positive way. They are sometimes clingy to the mother or want to be picked up. Some of the younger children ran to their mother and gave her a hug, those are the ones that are clingy. Children have cried and looked fearful of mom.

Charlotte discussed the difference they have witness among older children as compared to younger children:

> Older children don't bond, they don't interact with mother and would stay in a corner. They are a little more guarded. It is almost as if they don't know what to expect most of the time. Some of the children expressed that they did not know what kind of behavior to expect from their mother or "who to expect" in the supervised visits.

It seems that as children grow older, their attachment to their mothers forms of insecure attachments and they do not react as positively to their mothers as they probably did when they were younger.

Tracy gave a detailed example of a case where she observed this age difference in the children's responses to their mothers:

> In one case the daughter was nine and the son was four. The daughter would isolate herself and the boy would climb on mom's lap to try and get her attention. So the daughter was more avoidant. Younger children are very excited, they run to mom and hug mom. In the case I'm referring to the nine year daughter did not even get out of her chair when mom walked in but the boy got up and gave her hugs. There was a very different dynamic between the children. The younger boy was climbing up on the mom's lap, holding onto her, and tugging at her. So the daughter would back off and not even try to interact with the mother while the boy was constantly trying to get the mother's attention. I picture the girl doing that when she was four too and now she learn that it's not going to matter.

It seems as if age is a great influence of children responses to their mothers who use substances. Younger children seem to response more positively and clingy to their mothers due to their lack of knowledge and understanding. While older children seem to be more avoidant of their

mothers due to their knowledge of her substance use and possibly due more years of exposure to the effects of her substance use.

From these interviews, it could be suggested that the age of the children seems to be a key variable for their attachment and responses to their mothers.

Race/Ethnicity and Socioeconomic Status

In response to a question about the possibility of any bonds having a cultural influence, both Tracy said the following:

> I had one case where the mom was Haitian and the children were placed with a foster parent and she had her visits here at the office and she was very strict her children even speaking during the visit. She would sit on the floor and wanted to pray or focus on a book she was reading and just be quiet versus interacting with the children. And the children even said that things were culturally different in the foster home that they were in, they were allowed to express themselves more. They weren't told that they are supposed to sit in silence and be quiet. And I observed that as being culturally since the children weren't with the Haitian family. That mom has an issue with the children expressing themselves and stating things that they didn't like. She didn't feel it was appropriate for the children to express themselves.

Charlotte did not observe any bonds influence by culture.

Since this observation is based only on one Haitian client and not multiple Haitian clients, it is hard to determine if all of the mother's behavior was influence by the Haitian culture or if there were another possible reasons for her behavior. Even though in some cultures it is a common belief for children to be quiet while other cultures encourage expression from children. If Tracy asked the mother if her behavior was due to her cultural values or if the mother had otherwise explicitly stated that, then her behavior could be for the most part contributed to the Haitian culture.

In response to a question about differences pertaining to maternal behavior, discipline techniques and attachment styles among women of different socioeconomic classes Tracy said the following:

> Among middle class families, the children are protected longer within the family. Like if mom is using, the grandparents would take care of children. It takes a little bit longer for services to get started and Child Youth Services (CYS) to get involved because they have people in the family to take care of children to conceal drug use. In urban areas, they are closer knit with neighbors. In rural, they are more isolated and in most cases they are hoarding and able to cover things up a little bit more than someone in an urban area. I found urban families are pretty much straight up and honest with what they did. Whereas suburban families are more guarded and blaming CYS. They may feel like they are beneath having CYS involved.

From this information it could be suggested that urban families seem to be more honest and therefore are more open to the help of FRS and Family Concern. Substance use seems to be easier to conceal in rural and suburban areas as compared with urban areas due the aspects of the geographic location and the use of family members to help mothers care for their children.

Charlotte said the following:

> I think rural, in the country, tend to do more outside things. Where a lot of the urban clients do not let the child outside of the house because of the high crime and they are afraid of them being unattended while being outside. So they [the children] are stuck inside of the house all day long.

Here is a difference of parenting based on the geographic location. In urban areas mothers keep their children protected from the violence of the environment by keeping them in the house all day. This level of protection does not seem to as necessary in rural areas that are more isolated and possibly have less crime and violence.

From these interviews, it could be suggested that race/ethnicity places a role in the mothers' interactions with their children. The cultural practices mentioned above seem to differ from the FRS expectations of parenting and discipline. Socioeconomic status and the environments of different geographic location seem to provide mothers with access to different resources (i.e. families and neighbors). Different geographic locations seem to influence interactions between the mothers and the FRS and the mothers overall view of the situation, which could be seen by how those in urban neighborhoods were more honest. Different

geographic locations also have distinct differences that interacted with their substance use, such as in rural areas it was easier to hide substance use than for those in urban areas.

Impact of Substances

When asked about the differences in the mothers' parenting from when they first entered the program as compared to while they were in the program, Tracy said the following:

> These mothers had their children during an active addiction so the children were exposed to her behavior. Most times when Family Concern get cases it's because mothers haven't been able to parent effectively because of substance use. So a lot of times mothers are completely overwhelmed with parenting. Normally if there are addiction the mothers' needs at first. Often times they will sell food stamps to get money for drugs. And their primary focus, most times, is their substance use. Putting their children at risk, when they go to buy the drugs they sometimes bring their children with them.

It could be suggested that parenting is overwhelming for mothers, especially with the battle of addiction. At this stage of the mothers' addiction, substance use seems to become a priority that is tends to be attended to before the needs of the children or in place of the priorities of the children, in which the children are neglected.

While the mothers were in the program, Tracy said the following in relation to the mothers' behavior:

> During supervised visits, I have seen mothers exhibit a wide range of emotions. Some of emotions were guilt, shame, being very passive, being verbal aggressive, sadness, fear, and happiness since mother lost custody of their children and are trying to interact with the children to the best of their ability. Some mothers would say statements like "Be quiet" and "get away from me I'm stressed out," to the children instead of using the visit as a positive time sometimes they get caught up the negativity.

Tracy observed a variety of emotions from the mothers due to their substance use, which are the same mixture of emotions mentioned in the literature review.

Charlotte focused on the emotion of guilty and promises that mothers to their children make but do not keep:

> Some mothers are not aware that some of their behaviors were harming to the child. They feel guilty then they buy the children something. Most of my clients have been neglectful in that way where they haven't done a lot to compensate for that, they just have a lot of blaming and excuses. But I think there is a lot of premises made after the fact because

> they feel guilty over drug use and not being there for their children. So they make promises to the children that they get broken. Like the one client I had promised to buy the child a bike and guitar, the child never got it. She promised a birthday party for her child and never showed up. Mothers promise to take children to the park or to special event and then the mothers don't come. The child gets let down over and over with the mom promising to be there for them. Even some of the supervised visits I have here, some mothers don't show up being of using and say that they are sick to the child.

Mothers seem to feel guilty and want to win their children over by either buying material things or by promising to buy them material things. The level of addiction causes some mothers not follow through on their promises to spend time with their children or to buy their children things.

When asked to state any more information that she felt was relevant to the project, Tracy talked about the later stages of addiction she observed and the importance of early interventions:

> Well I do work here [Family Concern] and at the detox at the local Hospital so I have seen both sides of the addiction. Most clients involved with Family Concern are at a period where there is still time for them to make changes. But the clients I see in and out of the detox already lost their children, relationships, and bonds. They have lost everything. So I have seen both sides of it and I really believe that early interventions is the best way to help families that have addiction because sometimes mothers are not offered those services or they don't have the support of their family because their parents are using and that usually run with generations. I believe it is a family disease so if you have an addicted mom most likely someone else in her family is also addicted, which is also a challenge to help the families parent effectively.

Interventions, especially early interventions, seem to be crucial for mothers with substance use disorder but access to them could be difficult. A substance-free social support system is also important but could be difficult for mothers to gain since other family members could have substance use disorder also. The lack of access to interventions and social support system were also mentioned in the literature review.

From these interviews it could be suggested that, substance use seems to have great impact on mothering. In some cases mothers are not fully aware of this impact due to being so involved in their addiction to the point that they may not take time to fully reflect on the implications of their substance use. The various emotions mentioned above and the willingness

to stay in the program show that some mothers realized the impact of their substance use and want to improve in their role as a mother. Since other mothers break promises and do not follow through with commitments, they seem invested in improving their relationship with the children for short amount of time but not in the long run. The use of agencies like Family Concern and early inventions seem to be crucial in aiding mothers with substance use disorder, since FRS observed significant improvements among mothers when they completed the program (which was also discussed more in the first section about parenting and discipline styles).

Discussion

The present study investigated the impact of race/ethnicity and socioeconomic status on mothering practices and styles of parenting among mothers with substance use disorder. The main hypothesis was that the degree of addiction can directly impact attachment styles and discipline styles of the mothers with substance use disorder while the variables of race/ethnicity and socioeconomic status also revealed distinctions among mothers. This hypothesis was supported by the data collected from the interviews. When Family Concerns start to work with mothers, the mothers have already lost custody of their children due to their substance use. The interviews were conducted based on the FRS experience with mothers who were in the further stages of addiction as compared to mothers who are in earlier stages. The FRS stated that most of the mothers did not have secure attachments to their children and some relied on inappropriate discipline styles.

The lack of attachment and use of inappropriate discipline styles could have been due to the fact these mothers were at later stages of their addiction. Maybe some of the mothers had better attachments and bonds to children when they were at earlier stages of addiction. The addiction could have been easier to manage in the earlier stages thus not impacting attachments

and bonds as much as in later stages where the addiction worsens. It was stated that mothers felt overwhelmed with parenting but it was not established whether the overwhelming feeling increased as the mothers' addictions worsen since Family Concerns is not actively involved in early interventions. Some of the mothers could have felt a little overwhelmed in the earlier stages of their addiction but as the severity increased, so did the feeling of being overwhelmed.

To a certain extent the interviews reflected the themes and trends related to parenting and discipline, attachment, and the influence of race/ethnicity and socioeconomic class, which were stated in other studies (Kumpfer 1986; Strathearn and Mayes 2010; Strathearn 2011). The interviews did not cover the use of strategies, such mothers budgeting money to pay for necessities before spending it to buy drugs, as discussed in previous studies (Baker and Carson 1999; Sterk 1999; Kearnery 1994). The use of strategies were not covered because the FRS stated that their clients did not offer that information and they did not ask it in specific details. Taken into consideration the fact that Family Concerns usually works with this population during the later stages of addiction, FRS observed more of the insecure attachments, use of inappropriate discipline, and lack of parenting abilities. Since the FRS did not observed mothers in the early stages, there is a possibility that there is lessen likelihood of the noticing the use of strategies. If the FRS had been present during earlier stages of the addiction there is a possibility that they could have noticed and discussed the use of strategies since the use of strategies, such as monitoring substance use so that it did not interfere with caring for their children, are more prevalent in the earlier stages of addiction (Kearnery 1994). If interviews could have been conducted with agencies who were involved in early interventions and/or mothers, a more in-depth picture following an overall timeline of events could have been created to better illustrate

the differences in behavior during the stages of addiction. These are things that should be pursued by researchers in the future.

The FRS views of mothering seemed to mirror some of the same characteristics, such as providing moral guidance and emotional support through empathy, mentioned in Allen, Flaherty, and Ely (2010) and Gunn and Canada (2015) research. Their construct of motherhood and discipline more or less aligned with the overall concept of motherhood in the United States. Based on their constructs, they critiqued the mothers parenting abilities and concluded that they were hinder by substance use. Similar to Jackson's (2013) research, most of the mothers seemed to adopted a laissez faire form of discipline while other were more authoritative. Forms of discipline were partially influenced by culture (i.e. Hispanic and Haitian). The attachment styles of the mothers generally seemed to be dismissive/neglectful and disorganized based on the observations of the interactions among mothers and children. Some mothers wanted to be left alone and did not want to interact with the children. While some children were avoidant, guard, and in some cases fearful which could have been to a disorganized attachment and chaotic behavior. The FRS stated that some of the children looked as if they did not know "who to expect" from the mother based on past and current fluctuations in her behavior. Even though a few major differences among socioeconomic status were discussed in the interviews, the few differences did reflect information from other studies. For example, those rural areas being more isolated and not having as much access to treated as those in urban areas (Coyer 2001). Mothers with substance use disorder in middle class areas have the resources, such as other family members, to help take care of the children.

An interesting finding gained from the interviews was the differences in children's responses to their mothers based on their age range. None of the previous studies discuss this

distinct difference among children based on their age. Some studies gave general description of how children may react to mothers but none of them went into specific detail based on the children age and the amount years of exposure children had to their mothers substance use (Allen, Flaherty, and Ely 2010; Brown 2006; Hardesty and Black; 1999). For example, some of the adult children did not want any form of contact with their mothers.

As mentioned previously in the interviews, children under the age six usually reacted to their mothers in a positive and/or clingy way. They excitedly ran up to their mother and hugged her. They would constantly try to get her attention and hold onto her. Whereas children at the age of six or older were more guarded and avoidant, they did not react to their mother at all or with much enthusiasm. Some were even fearful of their mothers. They would isolate themselves away from the mother which could be due to the years of exposure to their mother's substance use as compared with younger children. Older children have been exposed to their mothers' substance use and witness firsthand the escalation of her addiction and how it impacted her mothering ability and attachment style. Older children also have access to learn about substance use, mothering, and other related topics. Through learning about these aspects, they realize that their mother may lack certain abilities due to her substance use. Research should be conducted to further analyze the differences in reactions based on age.

Limitations and Future Directions/Implications

A limitation is the amount of interviews and the agency. Only two interviews from one agency were conducted due to multiple issues with conducting interviews at other organizations. Most of the organizations either did not call back the researcher, only allowed graduate students to conduct research, and/or only allowed employees of the organization to conduct research. Most of the agencies that were contacted were community-based agencies so they are under

staffed and overworked, so having to host a researcher and interviews may have been too much for them to take on since they have other priorities which involved attending to their clientele. Family Concerns was the only agency that agreed to the interviews but, since it is a small organization only two workers worked closely with their population.

Another limitation is the amount of exposure and interaction the FRS has with mothers on a weekly basis. The FRS usually meet with mothers and children once a week. The FRS only observe the mothers and children in a limited setting, the supervised visits and/or a few other locations (i.e. school, playground, household) after the mothers lost custody of their children. The FRS were not in household in the earlier stages of the mothers' addiction before Family Concerns became involved. So the FRS can only speak about what they currently observe in the supervised visits, not what occurred prior in the household unless mothers choose to share in depth information. The FRS were not with the mother from the beginning stages of her addiction they can only talk about the mothers current state of addiction when they first entered the program and when they completed it. If interviews could have been conducted with agencies that are involved in early interventions and/or work with mothers throughout all stages of addiction, the data could have shown more differences in the overall mothering abilities of mothers who use substances.

In addition to the limited amount of exposure the FRS had with children and mothers, another limitation is no interviews were with mothers. Mothers could have given more in-depth insight, similar to the insight gained in Hardesty and Black's (1991) study, about the impact of their substance use on their mothering abilities. Interviews with mothers would have allowed them to give their personal experience and viewpoint of being a mother with substance use disorder instead of only relying on limited observations and interactions from case managers.

Research should be conducted with a diverse population of mothers with substance use disorder to gain their unique viewpoints and experiences. Great differences could be revealed among the mothers' viewpoints and those who work closely with them.

Other future directions of research could include recreating this study but with a male population to see if there are any gender differences, especially since mothers are seen to be the more nurturing and are viewed as caregivers (Allen, Flaherty, and Ely 2010; Hardesty and Black 1991). This study was limited to one area in Pennsylvania which is not too representative. If research was conducted in an assortment of states or even various areas within Pennsylvania, more differences in trends could be revealed since geographic location plays a role in differences among people and access to resources (Coyer 2001; Hawthorne and Henderson 2002). As stated in the interviews, socioeconomic status seems to influence mothers with substance use disorder beliefs and attitudes toward their substance use. For example, the difference between those in urban areas as compared to middle class areas. Those in urban were more honest and cooperative with Family Concerns than those in middle class areas because they felt like Family Concerns was beneath them. Conducting research with mothers who receive early interventions and/or agencies who are actively involved in early inventions to compare with mothers who do not receive interventions and/or agencies who provide later interventions could display a better-rounded picture of the impact of substance use on mothering.

In addition to further research in the previously mentioned topic areas, the importance of early interventions was empathized in this paper. As seen in throughout this paper as substance use worsens, attachment styles and maternal behavior are negatively affected. Interventions performed in the earlier stages of addiction could help to save and/or prevent the loss of attachments and bonds among mother and children. As inferred from the interviews, if clients

feel that they are at a period where there is still time for them to make changes before they lose permanently their relationships to children they would be more liking commit to interventions and programs whereas if they feel like it is too late to make a change they are less likely to commit to recovery and improving their relationship with their children. Early intervention while the children are under six would be more effective than later interventions with older because as seen in the interviews by the age of six children begin to respond more negatively to their mothers and isolate themselves during supervised visits.

Appendix 1. Interview Questions.

Please answer all of the questions within the context of the mothers that you have worked who were using substances, particularly crack cocaine.

1) Did the mothers seem to have a basic understanding of parenting? Did they feel confident as parents before entering your program/facility? Of those that did have knowledge, was this a majority, half of clients, or less than half of clients? What key factors led you to believe that they had a basic understanding or did not have a basic understanding?

2) Describe what you consider to be a "good" mother. What kind of specific roles does she carry out on a regular a basis?

3) What mothering strategies did the mothers used as a way to balance out their drug use and maternal behavior so that they were still able to perform the maternal actions? For example, some women would buy their children's necessities (i.e food, clothes, bills) before spending any money on drugs.

4) How would you describe the different bonds and attachment styles the mothers had with their children? Were any of these bonds based on a cultural aspect?

5) What kind of emotions did the mothers exhibit in relation to their children while in your program?

6) What kinds of reactions/responses did mothers report they received from their children? Were they clingy to their mothers? Did they seem avoidant? Or were they excited for their mother?

7) Were there any differences pertaining to maternal behavior, mothering strategies, discipline techniques, attachment styles among women of different socioeconomic classes?

8) Did any of the mothers report disciplining their children? Of those who disciplined their children, what methods did they used? Were any of these methods commonly used in their culture and/or family?

9) How would you describe the mothers' maternal behavior and abilities when they first entered the program compared to when they completed the program?

Appendix 2. Informed Consent

Informed Consent to Participate in Research for Professional Staff

Identification of Investigators & Purpose of Study

You are being asked to participate in a research study conducted by (Nia Henry) from Albright College. The purpose of this study is to examine the impacts of substance use on parenting styles of women from various ethnic/racial and socioeconomic status backgrounds.

Research Procedures

Should you decide to participate in this research study, you will be asked to sign this consent form once all your questions have been answered to your satisfaction. This study consists of interviews of professional staff who have experience working with this population. You will be asked a series of question related to your work with mothers who are recovering from substance use disorders. Interviews will be recorded to be transcribed into a verbatim report.

Time Required

Participation in this study will require approximately 20 minutes.

Risks

There are no perceived risk in interviewing professional staff.

Benefits

Potential benefits from participation in this study include a further understanding the impact of substance use on motherhood. Greater insight could be gained about a population that is stigmatized in society. Uncovering information pertaining to this research could help understand the complexity of the impact of this disorder in relation to variables that can affect maternal behavior. This project could add to existing literature on the effects of substance use on motherhood through researching similarities and differences among previous research and qualitative analysis of personal accounts. This project could challenge misconceptions about mothers who use substances and show there is a variety of experiences. By having a better understanding of Substance Use Disorder, people negative views can change which better

treatment of this kind of population and possibly influence reexamining drug policies related to reproductive and paternal rights.

Confidentiality

The results of this project will be presented at a women's conference while maintaining confidentiality of participants. The information obtained from these interviews will be coded and analyzed to identify trends and similarities. Respondent's identity will not be attached to any part of this study. The researcher retains the right to use and publish non-identifiable data. All data will be stored in a secure location accessible only to the researcher.

Participation & Withdrawal

Your participation is entirely voluntary. You are free to choose not to participate. Should you choose to participate, you can withdraw at any time without consequences of any kind.

Questions about the Study

If you have questions or concerns during the time of your participation in this study, or after its completion or you would like to receive a copy of the final collective results of this study, please contact:

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Questions about Your Rights as a Research Subject

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Giving of Consent

I have read this consent form and I understand what is being requested of me as a participant in this study. I freely consent to participate. I have been given satisfactory answers to my questions. The investigator provided me with a copy of this form. I certify that I am at least 18 years of age.

_____
Name of Participant (Printed)

_____ _____
Name of Participant (Signed) Date

_____ _____
Name of Researcher (Signed) Date

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