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Experiences of Postpartum Women in One Residential Treatment Facility for Substance Use Disorders: A Qualitative Case Study

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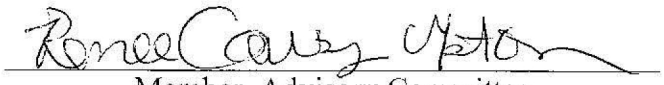

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DEDICATION

This thesis is dedicated to Brett.

May you rest in the peace that escaped you in life.

ACKNOWLEDGMENTS

I would like to thank my thesis advisor, Dr. Christine Privott, for her guidance and support. I would also like to thank my committee members, Dr. Renee Causey-Upton and Dr. Robert Mullaney for their feedback. I would also like to express thanks to the participants of my study for sharing their stories with me.

ABSTRACT

A growing opioid crisis in the United States has sparked a need for gender-specific research and treatment to address unmet needs and promote positive health outcomes for both women and children. The primary purpose of this research is to provide insight into the experiences and perceptions of postpartum women with substance use disorders receiving care at one residential treatment facility. Two women, aged 22 and 27 years old, participated in semi-structured interviews designed to elicit perceptions about barriers to treatment, the value of various programs, the role of physical, social, and temporal contexts in treatment, and beliefs about the effect of treatment on quality of life. Interview transcripts were analyzed using a-priori coding with codes derived from the Social Stress Model of Substance Abuse. The pilot findings suggest that for these women separation from children during treatment is experienced as a major stressor, communication, counseling, and program staff and peer resources helps to offset this stress. The descriptive - level findings could provide insight to occupational therapy practitioners and other providers about women in substance abuse recovery and their perceptions of the value of programmatic interventions, meaning of their occupational deficits, and significance of occupational therapy as treatment to address these deficits.

Key words: Substance use disorders, Substance Abuse, Postpartum, Parenting

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Chapter I

Introduction

The United States is in the midst of what many consider to be an opioid epidemic (Nelson, Juurlink, & Perrone, 2015; Burke, 2016; Murthy, 2016). In addition to increased frequency of opioid use, emergency room visits related to nonmedical use of prescription opioids have doubled, and death rates have nearly tripled (Nelson, Juurlink, & Perrone, 2015). There has also been increased incidence of infants being born with neonatal abstinence syndrome (NAS), a postnatal condition characterized by symptoms of withdrawal related to the mother's drug use during pregnancy (Patrick et al., 2012). It is estimated that from the years 2000 to 2009 hospitalizations for infants born with NAS rose 330% nationally (Patrick et al., 2012). Appalachian areas have especially been affected by the opioid crisis, as demonstrated by NAS related hospitalizations increasing by 1400% in the same time frame in the state of Kentucky (Kentucky Injury Prevention & Research Center, 2014).

The objective of this qualitative case study was to explore the perceptions of postpartum women receiving treatment for substance use disorders in one residential treatment facility located in Lexington, Kentucky. The research setting utilizes an integrated care delivery model which provides clients with services such as case management, psychoeducational courses, job readiness training, housing assistance, domestic violence counseling, and childcare assistance in addition to substance abuse treatment. Postpartum participants contributed data through semi-structured interviews and were observed in their treatment environment to provide insight into how they experienced treatment; specifically in regards to stress, social supports, gained social

competencies, and access to resources. Knowledge of their experiences and perceptions contributes to understanding the occupational deficits experienced by participants, the possible role that occupational therapists could play in providing care, and the value of integrated care in remedying this health crisis.

Literature Review

Available literature related to this topic illustrates the complex nature of substance use disorders in pregnant and parenting women. To highlight the severity of this issue, data related to poor health outcomes and increased hospital expenditures is presented. The historical context for female specific substance abuse literature is described, and findings from research which emphasize the gender specific needs and challenges experienced by women. Additional data from both quantitative and qualitative research is used to describe what best practices may entail for pregnant and parenting women with substance use disorders.

Impact of perinatal substance abuse

Perinatal drug abuse, meaning drug abuse between the 20th week of gestation and up to four weeks after delivery (World Health Organization, 2016), is a critical issue not only due to the health consequences for both the mother and child, but also because of the resulting substantial societal burden. It is estimated that between one and two thirds of child welfare cases are related to parental substance abuse, though it is difficult to provide accurate statistics as there is no ongoing, standardized, national data collection on the topic (Children's Bureau, 2014). Children born to women with substance use disorders are more likely to experience increased incidence of health problems, impaired

growth and development, emotional and behavioral problems, psychiatric disorders, and poor cognitive functioning (Viteri et al., 2015).

The health and financial costs associated with perinatal drug abuse are also significant. Whiteman et al. (2014) conducted a cross-sectional analysis of the largest publicly available inpatient database in the United States. They found that women who use opioids during pregnancy have higher rates of depression, anxiety, and chronic medical conditions and there is also an increased likelihood of preterm labor, poor fetal growth, and stillbirth. Associated healthcare costs are also increased as the expenditures per-hospitalization for women who used opioids during pregnancy were $5,616 compared to $4,084 for nonusers. (Whiteman et al., 2014).

A retrospective analysis of a nationally representative sample of infants born with NAS in the United States sought to describe the national incidence of NAS and determine the trends in health care expenditures (Patrick et al., 2012). They found that infants born with NAS were more likely than any other hospital birth group to have low birthweight, respiratory complications, feeding complications, and incidence of seizures. Newborns with NAS were also more likely to be insured under Medicaid. In 2009, Medicaid was the primary payer of 77.6% of aggregate hospital charges associated with NAS hospitalizations (Patrick et al., 2012). The data describes overall total hospital expenditures related to NAS that have increased from $190 million in 2000, to $720 million in 2009 (Patrick et al., 2012). The substantial increase in incidence of NAS and related costs has produced a considerable financial burden on the current U.S. health care system.

Gender and substance use disorders

Historically, substance abuse research and treatment has focused primarily on the male experience (Sun, 2006). Public funding for women-specific substance abuse research and treatment began in 1976, faded out by 1981, and recurred in 1988 when the majority of states were ill-equipped to manage the "crack baby" epidemic of the mid 1980s (Finklestein, 1994). In the late 1980s the federal government mandated that 10% of block grants be used for substance abuse programs serving pregnant and postpartum women and their children (Ashley, Marsden, & Brady, 2003). Increased funding into these programs fueled interest into services which treat women with substance use disorders and the amount of available evidence regarding this population has increased substantially over the past few decades (Uziel-Miller, & Lyons, 2000).

From a gender perspective, the literature indicates that women experience substance use disorders differently than men, thus resulting in gender specific treatment needs. For example, women with substance use disorders are more likely than men to experience low self-esteem, guilt, depression, anxiety, suicidal ideation, psychosexual disorders, eating disorders, and posttraumatic stress disorder (Ashley, Marsden, & Brady, 2003). Women may also experience barriers to accessing treatment related to low attainment levels of education and employment, custody obligations of children and a lack of access to childcare, as well as societal stigma towards substance abuse by childbearing women (Center for Substance Abuse Treatment, 2009).

One study looked at barriers to accessing substance abuse treatment experienced by pregnant women living in rural Kentucky (Jackson & Shannon, 2011). Researchers analyzed data from 85 participants exploring perceived barriers to accessing treatment.

Data was coded into four overarching categories including perceived barriers related to acceptability, availability, affordability, and accessibility. Results indicated that the majority of participants experienced barriers related to acceptability (the stigma surrounding accessing treatment) and accessibility (pragmatic complications such as a lack of childcare or transportation).

Women are also more likely to experience traumatic life events including physical and sexual violence as a precursor to substance abuse (Covington, 2008). Ouimette (2000) distributed a survey to 24,959 patients with substance use disorders who were being treated through the Department of Veteran Affairs and measured histories of trauma in both men and women. Results of this study indicated that women with substance use disorders had significantly higher rates of histories of physical and sexual abuse than their male counterparts, with two thirds of all female participants having experienced abuse as compared to one quarter of male participants (Ouimette, Kimerling, Shaw, & Moos, 2000).

Covington (2008) asserts that there is a correlation between a history of abuse and violence and increased probability that a woman will abuse alcohol or substances. A study conducted with 500 female participants in a California prison population receiving substance abuse treatment confirms this connection (Messina & Grella, 2006). Data indicated a strong and aggregate impact of childhood traumatic events on health outcomes. Between 62%-76% of women who reported five or more traumatic childhood events also indicated increased incidence of homelessness, co-occurring mental health disorders, and previous substance abuse treatment as compared to 30% of participants who had no traumatic childhood experiences (Messina & Grella, 2006). Participants with

five or more traumatic childhood experiences also experienced the earliest involvement in drug use and criminal activity (Messina & Grella, 2006).

A qualitative study sought to draw connections between the indicators of substance use disorders and partner violence by analyzing data from in-depth interviews with fifteen women in substance abuse treatment (Macy, Renz, & Pelino, 2013). Participants were recruited from a trauma-informed substance abuse treatment facility. Analysis of data revealed that the connections between substance abuse and partner violence presented in varying ways, but a common factor was that each problem exacerbated the other (Macy et al., 2013). Participants described severe psychological, physical, and sexual abuse from their partners and explained that substance use became a coping mechanism. The majority of participants also described steady access to substances as a major factor causing them to remain in the abusive relationship. The participants universally described concern for their children as the motivation behind leaving their partners and seeking safety in treatment (Macy et al., 2013). Using a trauma-informed approach, accounting for histories of violence and avoiding practices that may trigger painful memories, is an essential element to the treatment of women with substance use disorders.

Substance use disorders and treatment of women in programs

Adams et al. (2011) sought to identify factors that were related to program retention for women in substance abuse treatment facilities. Using a prospective design, 105 female participants at one integrated, residential substance abuse treatment facility were clinically assessed using various measures. Length of stay was measured for all

participants (Adams et al., 2011). Results indicated that women who were older, were not currently taking prescription pain medicine, and had identified a higher personal commitment to recovery were all indicators of greater program retention (Adams et al., 2011). The authors implied that younger women who may lack the maturity to recognize the severity of their substance use disorder could benefit from additional program supports. Also, women managing chronic pain conditions with prescription pain medicine may benefit from alternative pain management techniques.

To better understand the needs of women in treatment for substance use disorder, one study aimed to evaluate the correlation between expressed and clinically assessed client needs (Hohman, & Loughran, 2013). A secondary analysis was conducted of data collected during the evaluation process for 237 women receiving treatment at a residential, integrated substance abuse treatment facility. Results indicated there was not a significant relationship between clients' expressed needs and the severity of their addiction, except when related to housing/employment factors and medical needs (Hohman & Loughran, 2013). This study's findings suggest that a holistic approach may be valuable when evaluating the treatment needs of women in substance abuse treatment programs, considering both clinically assessed and expressed needs. This approach can promote client-centeredness in treatment planning.

Analysis of data from 353 participants diagnosed with co-occurring substance use disorders and post-traumatic stress disorders, including women who had received integrated, trauma-informed care was conducted by Lopez-Castro, Hu, Papini, Ruglass, & Hien, (2015). Findings emphasized the understanding of addiction as a chronic disorder, and recovery as a dynamic process in which positive outcomes may serve as

motivation to continue to seek treatment, which may then lead to more positive outcomes (Lopez-Castro et al., 2015). It may also indicate a need for integrated programs to follow up with clients post-treatment and offer access to outpatient services.

Substance use disorders and treatment of pregnant women in programs

Substance abuse treatment of pregnant women is more effective than legal action and incarceration to improve long-term outcomes including maternal and infant physical and psychological health (American Society of Addiction Medicine, 2011). Improved outcomes related to birth, treatment, and behaviors have been measured when pregnant and postpartum women have access to comprehensive, gender specific substance abuse treatment. Although evidence indicates that exposure to integrated, residential substance abuse treatment results in positive outcomes; there is still a lack of clear definition as to what constitutes best practice for treatment.

Clark (2001) conducted a cross-site analysis of 24 sites receiving federal grant money to provide comprehensive, residential substance abuse treatment to pregnant and postpartum women and their children. In addition to traditional counseling, relapse prevention, and self-help services, these sites also provided women with prenatal and postpartum medical care, psychotherapy, parenting classes, domestic violence counseling, adult education, employment preparation, legal assistance, and supportive aftercare. Analysis of data from the 1,874 participants indicated decreased incidence of infant mortality and infant morbidity. Data indicated positive treatment outcomes including increased treatment retention and completion for women whose children resided with them during treatment. Positive behavioral outcomes included decreased

substance use, decreased criminal activity, and increased employment following treatment (Clark, 2001).

Sun (2006), in a systematic review of 35 empirical studies which included female subjects, identified five elements related to effective substance abuse treatment for women: 1) a single-sex program model, 2) residential treatment, 3) provisions for childcare, 4) case management, and 5) supportive staff . These elements have demonstrated positive outcomes, including increased program retention/completion, decreased substance use, and increases in employment post-treatment.

Milligan et al. (2011) conducted a meta-analysis to identify the effect of integrated programs on birth outcomes. Results indicated that infants born to women in integrated programs (as compared to infants born to women with substance use disorders not in treatment) had higher birth weights, and larger head circumferences. There were also fewer birth complications and fewer positive toxicology screens. Women in integrated programs attended more prenatal visits and had fewer pre-term births than women receiving treatment in non-integrated programs.

Niccols et al. (2012) conducted a systematic review to measure the effectiveness of integrated substance abuse programs on parenting outcomes. Results indicated a small advantage for improvement in parenting skills in the integrated programs, and larger positive effects in programs that offered residential treatment, maternal mental health services, and space for children to reside in the treatment facility.

Although the quantitative literature provides evidence in support of the use of integrated, residential programs (Clark, 2001; Sun, 2006) a growing body of qualitative and mixed-methods studies explore the lived experiences of women who participate in

integrated treatment programs. Wong, (2006) conducted an exploratory-descriptive study with 10 mothers residing in residential substance abuse treatment facilities in New York City, and found that the social support offered in integrated programs was a significant factor in helping mothers to build a foundation in their lives and enhance their self-development.

Sword et al. (2009) conducted a qualitative meta synthesis identifying additional perceptions of integrated substance abuse programs and spoke to the importance of a supportive staff, opportunities to learn coping mechanisms for stress, development of self and personal agency, and the motivating presence of children. It may be valuable to consider these elements when planning for substance abuse programming.

Kuo et al. (2013) conducted focus groups with 18 pregnant and postpartum women receiving substance abuse treatment as outpatients. Focus group discussions centered on the treatment needs of pregnant and postpartum women with co-occurring substance use disorders and depression, particularly social and program supports participants perceived to be central to their recovery. Participants reported that social relationships with family, friends, and romantic partners both aided and challenged their recovery. They also noted that treatments which focused on mental health, family issues, and gender-specific issues were helpful to their recovery. Pragmatic challenges, such as a lack of transportation and limited time with specialists, were also noted (Kuo et al., 2013

While it is essential to understand how recovery programs inform policy and treatment decisions related to integrated care for pregnant and postpartum women, it is equally important to gain an understanding of how women experience these programs. By doing this, we can explore treatment options and how treatment might improve

women's health, perceptions of well-being and quality of life – including their role of mother.

Chapter II

Introduction

Perinatal drug abuse, meaning drug abuse between the 20th week of gestation and up to four weeks after delivery (World Health Organization, 2016), is a critical issue not only due to the health consequences for both the mother and child, but also the substantial societal burden. National estimates indicate that hospitalizations for infants born with neonatal abstinence syndrome (NAS), a postnatal condition characterized by symptoms of withdrawals, have increased by 330% from the year 2000 to 2009 (Patrick et al., 2012). Children born to women with substance use disorders are more likely to experience increased incidence of health problems, impaired growth and development, emotional and behavioral problems, psychiatric disorders, and poor cognitive functioning (Viteri et al., 2015).

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Literature indicates that women are also more likely to experience traumatic life events including physical and sexual violence which are a precursor to substance abuse. A survey distributed to 24,959 patients with substance use disorders who were being treated through the Department of Veteran Affairs and measured histories of trauma in both men and women. Results of this study indicated that women with substance use disorders had significantly higher rates of histories of physical and sexual abuse than their male counterparts, with two thirds of all female participants having experienced abuse as compared to one quarter of male participants (Ouimette et al., 2000).

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positive effects in programs that offered residential treatment, maternal mental health services, and space for children to reside in the treatment facility.

Although the quantitative literature provides evidence in support of the use of integrated, residential programs, a growing body of qualitative and mixed-methods studies increase understanding of the lived experiences and perceptions of women who participate in integrated treatment programs. Wong, (2006) conducted an exploratory-descriptive study with 10 mothers residing in residential substance abuse treatment facilities in New York City. The author found that the social support offered in integrated programs was a significant factor in helping mothers to build a foundation in their lives and enhance their self-development.

Sword et al. (2009) conducted a qualitative meta synthesis to identify perceptions of integrated programs by mothers with substance use disorders. Derived from the studies analyzed, authors noted the importance of a supportive staff, opportunities to learn coping mechanisms for stress, development of self and personal agency, and the motivating presence of their children.

One qualitative study used data collected from focus groups with 18 pregnant and postpartum women receiving substance abuse treatment at an intensive outpatient clinic (Kuo et al., 2013). Focus group discussions centered around the treatment needs of pregnant and postpartum women who had co-occurring substance use disorders and depression; particularly the various social and program supports that participants perceived to be central to their recovery. Participants reported that social relationships with family, friends, and romantic partners both aided and challenged their recovery. They also noted that treatments which focused on mental health, family issues, and

gender-specific issues were helpful to their recovery. Pragmatic challenges, such as a lack of transportation and limited time with specialists, were also noted (Kuo et al., 2013). Knowledge of perceived needs may be helpful when planning for treatment.

While it is essential to understand how recovery programs inform policy and treatment decisions related to integrated care for pregnant and postpartum women, it is equally important to gain an understanding of how women experience these programs. By doing this, we can explore treatment options and how treatment might improve women's health, perceptions of well-being and quality of life – including their role of mother.

Methods

Research design

A qualitative case study approach, over the course of two months in 2016, was used to explore the experiences of two postpartum women in one integrated, residential treatment facility. This approach has been identified as a useful methodology when exploring a system that is confined by time and place (Creswell, 2013). A case study design is intended to develop in-depth description and analysis of a particular case (Creswell, 2013). Multiple sources of data were utilized to create an in-depth description of participants' experiences including a brief interview with the clinical director, semi-structured interviews with the two participants, and three non-participant observations in the treatment setting.

Sampling and research setting

Purposeful sampling was used for this study and participants were recruited from one integrated, residential substance abuse treatment facility located in Lexington, Kentucky. The research setting was a comprehensive agency which includes three residential facilities. In addition to substance abuse treatment, women have access to individual and group counseling, parenting classes, psychoeducational courses, domestic violence counseling, medical and psychiatric care, job readiness training, GED tutoring, childcare, and housing assistance. Services are tailored to meet the needs of pregnant and parenting women and admissions are prioritized for pregnant clients. Infants and children up to the age of two are allowed to live onsite with their mothers. Older children are not allowed to live onsite, but can attend preschool and afterschool programs at the onsite childcare facility.

Participants were recruited if they were between 18 and 38 years of age, no more than 12 months postpartum, and currently receiving residential treatment at the facility. Recruitment took place in consultation with the clinical director of the program to help plan the logistics and determine an appropriate time and setting. No directors were present during the recruitment process to reduce the risk of coercion. Prospective participants were approached by the primary investigator prior to their group meal time and presented with a short flyer describing the study. Ultimately five participants were recruited and three participants dropped out of the study due to a change in admission status; two participants were actually interviewed during the study time frame. The two participants were interviewed in a common space at the treatment facility though the

space was unoccupied at the time. Each participant was interviewed once with the process lasting approximately 30 minutes.

Procedure

The study was approved by the Eastern Kentucky University (EKU), Institutional Review Board (IRB). Prior to recruiting and meeting with participants, the primary investigator (PI) conducted a brief interview with the clinical director to gain insight about the programs offered at the facility in order to frame questions for the interview protocol. Field notes were used to document this interview.

The PI gained both verbal and written informed consent to participate in the study from the initial five participants. Although five participants were initially recruited, three participants dropped out of the study prior to being interviewed: One found employment and was not able to participate due to scheduling conflicts, and two were removed from the facility for reasons unknown to the PI. Each of the two participants was interviewed in person, one time, in an unoccupied common living space in the treatment facility, for approximately thirty minutes.

The PI also conducted three non-participant observations at the treatment facility during a typical recovery program day. The individuals observed were informed of the PIs purpose and study and verbal consent to observe was obtained. The PI selected the specific observations based on data obtained from the participant interviews. The PI attempted to triangulate data by using multiple forms of data as both a key element to case study methodology and a way to support evidence and increase validity (Creswell, 2013). The PI observed one general group session, one Job Club meeting, and a parenting

class. Each observation lasted 30 minutes to one hour and was documented via field notes.

Data analysis

All data was secured through use of pseudonyms on documents and data was stored on a password protected computer. Audio-recorded data from participant interviews was transcribed verbatim (omitting any identifying information), and the original audio recordings were destroyed. Data was analyzed using an a priori approach with codes derived from Rhodes and Jason (1990) Social Stress Model of Substance Abuse. This model is based upon multiple psychosocial models and theories and asserts that a person's likelihood to abuse substances is correlated with the amount of stress they experience, and their ability to offset that stress through social supports, social competencies, and access to resources. The PI sought to analyze participant data using the Social Stress Model of Substance Abuse to more fully understand the stressors, social supports, social competencies, and resources available during the women's recovery. Data was coded and emergent themes discovered within a framework of the Social Stress Model of Substance Abuse. For this study, validation and reliability strategies included triangulation of data (participants and director interviews, observations), debriefing with a peer, and the use of detailed description throughout the research process

Results

Heather

Stressors

Heather is a 27 year old woman who had been in residential substance abuse treatment for four months. Heather was two months postpartum and is a mother to three children; a two month old, a five year old, and a nine year old. Heather lost custody of her three children, and being apart from them was experienced as a major stressor while she was in treatment. When asked if it was difficult to be separated from her children, Heather became tearful and said:

> *"Yeah it really is. I'm apart from my kids. I get to visit them down at DCBS office but that's it right now."*

Supervised visits with her children took place at the local Department for Community Based Services and she felt this limited her ability to bond with her infant son. Heather stated:

> *"I feed him and burp him and change his diaper and then it's pretty much over. It's not very long."*

Although being separated from her children was experienced as a stressor for Heather, it also served as a motivating factor to continue treatment and maintain her sobriety. Heather explained:

> *"But I'm supposed to go back to* [family] *court in October so I'm hopeful about that. I went to court Monday and they want 30 more days of clean screens so I'm gonna give it to them."*

Social supports

To offset the stress of being separated from her three children, Heather described social supports from both staff and her peers in recovery as being meaningful to her. Support from the staff was especially important to Heather within the context of her journey to reclaim custody of her children. Having support from the staff in navigating the custody process was identified as important as well as being able to confide in them. Heather explained:

> *"It don't matter when it is, if I need to talk to one of 'em it don't matter if they're over there or here, I can and I know I always can. They've wrote letters of recommendations for me, and they've called my attorney, they've called DCBS and invited them out for a visit; they really have gone above and beyond."*

Heather also identified social support from her peers in recovery as being important. She described their relationship as somewhat familial. She was unbothered by living in close quarters with her two roommates and roommate's child and described their living space as comfortable. Even when managing conflict, Heather found community with her "sisters" in recovery. She stated:

> *"Yeah we are really like sisters. I mean we argue sometimes, but we've all been through it. We are all there for each other."*

Social competencies

Heather also spoke to the social competencies she had gained in treatment and how she felt they might influence her future sobriety and role as a mother. She described having gained social competencies related to communication skills, employment skills,

and parenting skills. Heather spoke specifically to the value of learning to use "I statements" when managing conflicts. Heather explained:

> *"Like instead of being smart alec, making it sound the right way. Like using 'I statements'. Sometimes when I talk to people my mouth can cause problems. I think it's gonna help me to think before I say something."*

Social competencies related to employment skills were also deemed valuable by Heather. In particular, it was important to Heather to learn how to navigate the job-seeking process without oversharing information about her substance use disorder and past criminal history. Learning how to fill out a job application and speak to future employers was described as important. Heather described gaining these social competencies while participating in Job Club. She said:

> *"I've always lied on applications about my charges and she has learned me that I cannot do that. And told me how to go into an interview without being like, 'okay I'm in treatment I've got these charges,' because that's usually what I do."*

Heather also valued the social competencies she gained related to parenting skills. Heather participated in a parenting class, which takes place in a group format. Clients use a workbook which provides them with different strategies for effective parenting. Heather described the strategies she had learned:

> *"Well like how to discipline a kid and the different age groups how you should discipline them for their age. How you should have routines with them. . . It's very practical."*

Gaining social competencies related to parenting was important to her and she felt it would have a direct impact on her future role as a mother, stating:

> *"Well luckily I have this place and my young son will never have to know the addict side of his mother because of this place. And I'm gonna be able to try to make up to my older children what I've done to them the past two years. I can be a good mom."*

Resources

In addition to social supports, and social competencies, Heather also felt that resources available to her in treatment would aid her recovery and future sobriety. One resource that was especially meaningful to Heather was access to domestic violence counseling. Heather had witnessed domestic violence as a child between her parents, and had also experienced violent trauma in a partner relationship. She indicated that she did not believe that she would have gained access to domestic violence counseling had she not entered this program. Heather felt that domestic violence counseling would help her to identify patterns, and help her avoid engaging in abusive relationships. She spoke to her perceived value of domestic violence counseling in the following statement:

> *"I think it learned me all the warning signs of domestic violence and making sure I'm not gonna repeat, like how everything was with my mom and dad. Making sure I can watch for stuff like that in another relationship."*

Overall, Heather indicated that treatment at this residential facility was a valuable experience for her. She spoke to the importance of gaining practical skills that would help

her to gain employment, improve interpersonal relationships, and aid her in regaining custody of her children.

Lisa

Stressors

Lisa is a 22 year old woman who had been in residential treatment for six months. Lisa was four months postpartum and has four children; a four month old, a one year old, a three year old, and a five year old. Lisa had also lost custody of her children and experienced this as a stressor. When asked if she found it stressful to be separated from her children, Lisa responded:

"Oh yeah definitely. It's really bad. I guess I am learning to cope with it."

This was especially stressful for Lisa because she maintained that she was sober in the months prior to her infant child's birth and believed the hospital had turned the case over to child protective services because of her history of drug use. Lisa stated:

"They said he was having withdrawals. So they had to go back and do the umbilical cord testing, to see if I had anything in his system. And it came back negative. I was supposed to get him back which was like 2 weeks later. And he's still not here with me. I'm still fighting it."

Lisa was also only allowed supervised visits with her children, and these visits were described as stressful to her. She stated:

"I had all four of my kids one day here. They were all excited to see me. I was trying to hold the baby, trying to hold my one year old, trying to get on the floor and play with my other two. It's pretty hard to divide my time with four kids."

She felt the visits were too short to bond with her infant child and give attention to her other children. She explained that the visits helped her realize she was not yet ready to parent independently as the stress was overwhelming. Being separated from her infant child in the first months of life was described as difficult. Lisa described her son's foster mother being the one to experience all of the first moments with him in the following statement:

> *"He's with this woman every day, she's changing him and bathing him, she's seen his first smile, she's seen his first laugh. I haven't got to experience any of that."*

She felt that they had not bonded, and wondered if her infant child knew who she was during visits. Lisa said:

> *"I feel like a part of my motherhood is lost."*

In addition to being separated from her children, Lisa also described the social anxiety she felt in treatment as being stressful. There are few private spaces in the residential facility, clients share living spaces, and the majority of treatments happen in group settings. Daily group interaction and a lack of alone time was experienced as stressful to Lisa. She explained:

> *"I don't like to deal with a lot of people on a daily basis, I can only handle people without having my 'me time' in small doses."*

Social supports

Despite feeling social anxiety, Lisa also experienced social supports from her peers in recovery and the staff. Lisa noted that there was a strong sense of solidarity in

their recovery community. She explained that even if they didn't always get along, she knew they could relate to and understand one another. Lisa spoke to the solidarity of their recovery community in the following statement:

> *"Everyone that's in this program, staff and everything, they are all recovering from something. Whether it's a substance, alcohol, or dealing with family using. No matter what we're going through, they can always relate and they can always approach it in the right way."*

Social support from the staff was also identified as meaningful by Lisa. She described feeling cared for and supported by staff members. This type of support was not something that Lisa was used to. When discussing her relationship with staff members, Lisa said:

> *"I really think every single one of the staff here has a genuine love and care and concern for us. And I think that's awesome because I've never been around anybody who really cared or wasn't using too. So, it's new to me."*

Social competencies

One of the social competencies gained which was most important to Lisa was the ability to effectively communicate, especially within the context of family court. Lisa explained that previously, she had a tendency to engage in what she described as "aggressive" lines of questioning with the judge. One of the staff members worked with Lisa on how she could effectively communicate her concerns in court in a more appropriate manner. This gained competency was valuable to Lisa and she believed that it would help the court to recognize how she was changing in treatment. Lisa stated:

"She helped me with my communication, because when I talk, when I want something and I try to ask questions, people feel like I'm being aggressive with them, like attacking them. So she kind of helped me with that. So she just said to, just take it in, don't say much, because I will talk, talk, talk, talk because I want to know what's going on. She said, 'Don't do that.' It lets them see I'm changing."

Another social competency Lisa gained in treatment was related to parenting skills. Lisa talked about the value of the parenting class and learning new skills for disciplining her children.

"The parenting class I've taken here really helped me like you know about how to discipline your children and you know don't make a big deal if they do something bad."

She also spoke to the value of practicing skills through helping her peers whose children were living with them in treatment. Lisa stated that she was proud of the fact that her peers came to her for advice about caring for their infants, and that through helping her peers she became more confident in her own parenting skills. She stated:

"I feel like it's really helped to see all the other mothers here and how they mother. . . They all call me the baby whisperer. Because I take pride in how well I am with kids. I'm a nurturer."

Resources

Lisa also gained access to what she perceived to be valuable resources in residential treatment. One of those was access to a home-like space. Prior to entering treatment, Lisa was having difficulty paying her rent and her boyfriend had recently been incarcerated. Lisa was unsure about where she was going to live and had spent time

staying with various friends. Upon entering treatment, she valued having a space of her own where she could put her clothes away and hang pictures on the wall. Although Lisa stated that this place was not her home, it felt home-like. She said:

> *"I feel at home here. I don't call it my home, because home is where my heart is and it's not here. It's with my family, and my children, and my boyfriend. But this is a house I can start my foundation on."*

Another important resource Lisa gained access to through treatment was psychiatric care. Lisa had never been to a psychiatrist before and the program helped to facilitate her first appointment. Lisa learned that she had a diagnosis of ADHD and was prescribed medication to help her manage her condition. When asked about what accessing medical services was like now that she was in treatment, Lisa responded:

> *"I mean it's easy now. Anytime I need something I can get it taken care of."*

Overall, Lisa felt that treatment was helping her to gain the coping skills she would need to manage the stress of parenting her four children. She had gained access to needed resources and improved social competencies related to communication and employment skills. She felt supported in her recovery community, and she was hopeful about the future.

Discussion

The study findings are not generalizable, due to its design and small sample size; however, the data reveals some meaning that can inform the reader in new ways about women's substance abuse recovery. Overall, both women experienced separation from their children as a major stressor while in treatment. This is consistent with scholarly

literature which indicates that the presence of one's children in substance abuse treatment is preferred by women (Sword et al., 2004). Both women felt that the bonding experience with their infant children while in recovery was limited by short visits and limited opportunities to develop meaningful relationships with them. For one participant, visits with her children were described as overwhelming - she felt incapable of managing the stress of parenting four children while in treatment but was hopeful about gaining the coping skills she would need when discharged.

These women may benefit from participating in parenting interventions designed to practice stress management and promote bonding within the context of their visits with children at the Department for Community Based Services. Although both women noted that the parenting class was a valuable tool for learning new parenting skills, the class was structured using a workbook. Evidence suggests that occupation-based interventions, understood as performance interventions in which a person is engaging in everyday life activities, may be beneficial for helping people with substance use disorders to master new skills (Wasmuth, Outcalt, Buck, Leonhardt, & Vohs, 2015). Occupation-based interventions such as new stress management skills for these women in recovery could help promote greater bonding between mother and child.

One participant felt that the constant social interactions required as part of the treatment program were a major stressor. Although building a recovery community is a central goal and therapeutic tool for treatment in this residential facility, increased use of one-one, client-centered, and personalized intervention may be beneficial. For example, the participant may benefit from frequent breaks during the day (to have time alone), or participate in specific strategies to manage social anxiety.

Both women generally experienced social supports from staff and peers in the recovery program. The importance of building relationships with supportive staff members is consistent with the literature in what is considered best practice (Sun, 2006). It was especially important to both participants to feel supported in their journey to reclaim custody of their children. Staff support specifically for this purpose of aiding in parenting, could be a beneficial element, through pragmatic elements such as support navigating court procedures and interpersonal elements such as feeling cared for and personally invested in.

Solidarity with peers in the recovery program was also social support. The literature explores single-sex program models for women in substance abuse treatment and positive outcomes (Sun, 2006). Both Heather and Lisa spoke to the importance of being part of a community of women recovering from substance use disorders and also being a part of a community of mothers. This is support for the use of integrated substance abuse treatment programs which prioritize care for pregnant and postpartum women.

Both participants discussed communication skills, employment skills, and parenting skills as major social competencies gained in treatment. The Job Club and parenting class were also identified by both participants as valuable treatment programs. The Job Club and parenting class at this setting, as well as other opportunities to practice communication, employment, and parenting skills, could be supported the study's findings.

Additional analysis reveals that the clinical director advocates for the skill of mindfulness for the women; neither participant felt fully informed about mindfulness and

how mastery of this skill could promote their recovery. The use of occupation-based interventions to teach mindfulness skills could be warranted. This is supported by Wasmuth et al. (2015), who emphasize the usefulness of teaching metacognition techniques (such as mindfulness) to populations with substance use disorders through occupation- based interventions.

For the women, access to resources was also identified as a beneficial outcome to recovery at this facility. Both participants identified individual counseling as a useful resource to help them manage stress. One participant cited that access to domestic violence counseling was especially meaningful and believed she would not have gained access to this resource had she not entered treatment. Both participants cited easier access to medical services as an important resource gained through this facility. This finding may be especially important for pregnant women with substance use disorders seeking access to prenatal care and could support the prioritization of their admission to treatment facilities.

Overall, the findings from this research are bound to this case study and not generalizable. Understanding the experiences of *these* women may help to elucidate the unique challenges and needs of this population. Furthermore, giving pregnant and post-partum women at one facility a platform to share their experiences could be a useful tool to increase understanding and destigmatize views of these women in addiction recovery.

Implications for Practice

Stoffel (2013) asserts that as our health care system shifts to recovery-oriented systems of care, opportunities for occupational therapy clinicians in mental health

settings may expand. Additionally, Wasmuth et al (2015) notes that occupational deficits are a significant characteristic to substance use disorders and therefore the expertise of occupational therapists may be beneficial to address these dysfunctions. Based on the study findings and supported literature, possible ways occupational therapists could work with women recovering from substance use disorders in integrated recovery programs could include job readiness training, performance deficits in occupation-based and instrumental activities of daily living (IADLs) such as home management skills, and adapting recovery environments, routines, and activities to promote client-centeredness. The two women in this study help to illustrate the significance of gaining communication, employment, and parenting skills to aid positive recovery program outcomes and the health and well-being for their own family.

Limitations and Future Research

The major limitation of this study is the small sample size, even for a qualitative approach. Two participant interviews and three participant study drop-outs, mean that additional rich data was likely missed. Additionally, interviews could not be conducted privately at the setting: Participants may have withheld information due to fear that a peer or staff member could hear the interview. Participants may have also been distrustful of the interviewer, as an outsider, and withheld information. Finally, the PIs graduate school timeline to complete the study may have resulted in decreased study rigor. More participants could have been recruited, the PI could have spent more time in the research setting, and a more thorough description and interview protocol could have been achieved.

A future similar case study utilizing more than one interview with each participant and/or greater number of participants, and using emergent coding, rather than a priori, to ground the data for a different level of analysis would be beneficial. With an emergent theme approach perhaps a more rich description of participant perceptions could be obtained. An ethnographic approach could also be valuable for eliciting thorough descriptions and increasing cultural understanding of the recovery community as a whole. Using an ethnography design would also help to integrate the researcher into the setting and reduce feelings of distrust. Finally, continuing with pilot studies looking at the use of occupation- based interventions to promote parenting outcomes could help identify new methods in occupational therapy intervention in the areas of communication management, health management and maintenance, employment seeking and acquisition, and role competence for women in addiction recovery – an identified vulnerable population in occupational therapy practice.

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APPENDICES

APPENDIX A:

Informed Consent

Consent to Participate in a Research Study

Experiences of Postpartum Women in One Residential Treatment Facility for Substance Use Disorders: A Qualitative Case Study

Why am I being asked to participate in this research?

You are being invited to take part in a research study about the experiences of pregnant and/or postpartum women receiving substance abuse treatment at this residential treatment facility. You are being invited to participate in this research study because you have met the inclusion criteria. If you take part in this study, you will be one of about five people to do so.

Who is doing the study?

The person in charge of this study is Rebecca Williams at Eastern Kentucky University. She is being guided in this research by Dr. Christine Privott. There may be other people on the research team assisting at different times during the study.

What is the purpose of the study?

By doing this study, we hope to learn about the experiences of pregnant and/or postpartum women in the program model of substance abuse recovery delivered here. By providing a thorough description of experiences in treatment here, the researcher hopes to identify strengths and/or weaknesses of this program model of substance abuse recovery.

Where is the study going to take place and how long will it last?

The research procedures will be conducted onsite at your treatment facility. You will meet with the researcher 1 time during the study. Each of those visits will take about 1 hour. The total amount of time you will be asked to volunteer for this study is 1 hour over the next 45 days.

What will I be asked to do?

You will be asked to complete a series of interviews with the researcher to describe your experiences during substance abuse treatment here. Questions will be open-ended in nature and interviews will be audio recorded. You will participate in at least 2 interviews over a 45 day period.

Are there reasons why I should not take part in this study?

You should not take part in this study if you are under the age of 18, or plan to discontinue treatment here during the course of this study.

What are the possible risks and discomforts?

Although we have made every effort to minimize this, you may find some questions we ask you to be upsetting or stressful. If so, we can tell you about some people who may be able to help you with these feelings.

You may, however, experience a previously unknown risk or side effect.

Will I benefit from taking part in this study?

You will not get any personal benefit from taking part in this study.

Do I have to take part in this study?
If you decide to take part in the study, it should be because you really want to volunteer. You will not lose any benefits or rights you would normally have if you choose not to volunteer. You can stop at any time during the study and still keep the benefits and rights you had before volunteering.

If I don't take part in this study, are there other choices?

If you do not want to be in the study, there are no other choices except to not take part in the study.

What will it cost me to participate?
There are no costs associated with taking part in this study.

Will I receive any payment or rewards for taking part in the study?

You will not receive any payment or reward for taking part in this study.

Who will see the information I give?
Your information will be combined with information from other people taking part in the study. When we write up the study to share it with other researchers, we will write about this combined information. You will not be identified in these written materials.

We will make every effort to prevent anyone who is not on the research team from knowing that you gave us information, or what that information is. For example, your name will be kept separate from the information you give, and these two things will be stored in different places under lock and key.

However, there are some circumstances in which we may have to show your information to other people. For example, the law may require us to show your information to a court or to tell authorities if we believe you have abused a child or are a danger to yourself or someone else. Also, we may be required to show information that identifies you to people who need to be sure we have done the research correctly; these would be people from such organizations as Eastern Kentucky University.

Can my taking part in the study end early?
If you decide to take part in the study, you still have the right to decide at any time that you no longer want to participate. You will not be treated differently if you decide to stop taking part in the study.

The individuals conducting the study may need to end your participation in the study. They may do this if you are not able to follow the directions they give you, if they find that your being in the study is more risk than benefit to you, or if the agency funding the study decides to stop the study early for a variety of scientific reasons.

What happens if I get hurt or sick during the study?
If you believe you are hurt or if you get sick because of something that is done during the study, you should call Rebecca Williams at (859)684-7871 immediately. It is important for you to understand that Eastern Kentucky University will not pay for the cost of any care or treatment that might be necessary because you get hurt or sick while taking part in this study. That cost will be your responsibility. Also, Eastern Kentucky University will not pay for any wages you may lose if you are harmed by this study.

Usually, medical costs that result from research-related harm cannot be included as regular medical costs. Therefore, the costs related to your child's care and treatment because of something that is done during the study will be your responsibility. You should ask your insurer if you have any questions about your insurer's willingness to pay under these circumstances.

What if I have questions?
Before you decide whether to accept this invitation to take part in the study, please ask any questions that might come to mind now. Later, if you have questions about the study, you can contact the investigator, Rebecca Williams at (859)684-7871. If you have any questions about your rights as a research volunteer, contact the staff in the Division of Sponsored Programs at Eastern Kentucky University at 859-622-3636. We will give you a copy of this consent form to take with you.

What else do I need to know?

You will be told if any new information is learned which may affect your condition or influence your willingness to continue taking part in this study.

I have thoroughly read this document, understand its contents, have been given an opportunity to have my questions answered, and agree to participate in this research project.

_____

_____

Signature of person agreeing to take part in the study Date

_____

Printed name of person taking part in the study

_____

Name of person providing information to subject

APPENDIX B:

Interview Protocol

Interview Guide: Experiences of Postpartum Women in One Residential Treatment Facility for Substance Use Disorders: A Qualitative Case Study

Place: Lexington, KY

Interviewer: Rebecca Williams

This interview will be used to gain insight into the experiences of postpartum women while receiving substance abuse treatment at one residential treatment facility.

Questions:

1) When did you enter treatment for substance abuse here and what made you decide to seek help?
2) Did you face any barriers to accessing treatment here? If so, what were they?
3) What is the space of your treatment setting like? What is the space where you live like?
4) What is your daily routine like?
5) In your opinion, what is the approach to treatment in this program? What is addressed and how?
6) What kind of supports do you have in this program? Is there any area that you could use more support?
7) How do you feel about your relationships with staff members? How do you feel about your relationships with other residents?
8) Which programs offered here are the most meaningful to you? Why?
9) What has been your experience with individual therapy? Do you participate in domestic violence counseling? How has this treatment affected your recovery?
10) What has been your experience with group therapy? Do you participate in peer mentoring? Has this experience been valuable to you?
11) Do you participate in GED tutoring? What has been your experience with that program?
12) Have you participated in community volunteerism while in this program? Was that experience meaningful to you?
13) Do you participate in computer skills training? Is this program valuable or meaningful to you?
14) Do you participate in the Job Club? Is this program meaningful or valuable to you?
15) Have you had access to any needed medical, dental, and/or psychiatric services while living here? What has been your experience with accessing those services?

16) Have you participated in health and wellness programs such as nutritional counseling, mindfulness courses, or yoga? Have these programs been meaningful or valuable to you? What was that experience like?
17) Do you use the childcare center on site? Do you feel supported as a new parent? What had been your experience of mothering while living here?
18) What are the strengths and/or weaknesses of this program?
19) How do you feel that your treatment here will affect your future sobriety? Your role as a mother?
20) Is there any other information you feel it is important for me to know about to understand your experience here?