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Family Reunification Among Women in Recovery From Substance Abuse and Complex Trauma

Cesha Tiffany Reese
Walden University

Walden University

College of Social and Behavioral Sciences

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Cesha T. Reese

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Review Committee
Dr. Barbara Benoliel, Committee Chairperson, Human Services Faculty
Dr. Tracey Phillips, Committee Member, Human Services Faculty
Dr. Mary Bold, University Reviewer, Human Services Faculty

Chief Academic Officer
Eric Riedel, Ph.D.

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Abstract

Family Reunification Among Women in Recovery

From Substance Abuse and Complex Trauma

by

Cesha T. Reese

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Human Services Administration—Family Crisis and Intervention

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Abstract

For women in recovery from complex trauma and substance abuse, the lack of posttreatment family reunification services such as family engagement, service delivery, and aftercare planning increase the likelihood of parental relapse and children reentering foster care. A primary caregiver's continued relapse can lead to longer out of home placement for minor children and a loss of parental rights, with a negative impact on both children and parents. The purpose of this qualitative phenomenological study was to examine the lived experiences of women in recovery, their sobriety practices, and how they reunified their families. The theoretical framework was Herman's trauma and recovery model. The research question focused on gaining a broader understanding of the complexities of substance abuse recovery among single-parenting women with trauma histories and their efforts to achieve and sustain family reunification. Data were obtained from interviews of 10 participants using an audio recording device and open-ended interview questions. Five themes emerged through analysis using open and axial coding: (a) choosing to remain sober, (b) cultivating and connecting, (c) trust and discovery, (d) trauma histories, and (e) aftercare and maintenance. Results indicated a possible connection between foster care recidivism and outdated aftercare services and practices. Improved aftercare practices could increase sustainability of reunified families and decrease the likelihood of relapse among caregivers in recovery. This study impacts social change by informing policy makers on state and federal levels of the needs of recovering parents and their families.

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Dedication

To my brother, Coen Jamason Reese, who embraced the thought that I would one day achieve more than I expected to, go further than I thought I would, and influence people I thought I could never reach. To my brother, who has been called into the fullness and presence of a loving and faithful God, I dedicate this to you. May you rest in peace knowing that I finished what I started because you believed that I could, so I did. I love you eternally.

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To my parents, whose unconditional love and support made it possible for me to surpass the stars and reach for the moon. To my son, CaCoa Chatman, who inspires me daily as he pursues with conviction the goals set before him. To my brother Cagen and his family, whom I love and appreciate. To my nephew Christopher, whose presence is a reminder of the favor of God. To my committee members, Dr. Benoliel, your patience is beyond understanding. Thank you for all the encouraging words and wisdom. To Dr. Bold for encouraging me to think critically and dig deeper. To Anna Kosoff, who leads by serving. To Toni L. Watson, thank you for being the epitome of a friend. To the Walden University staff, who have been available and supportive from beginning to end. Thank you for being a part of my journey.

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Chapter 1: Introduction to the Study

In the early 1990s, researchers identified a lack of communication regarding child welfare policies and procedures implementation and how professionals approached the issues of child neglect, parental substance abuse, and family reunification (Drabble, 2011). The disconnection or lack of understanding of how best to serve families involved with the child welfare system was evident by the increase in open Department of Children and Family Services (DCFS) cases concerning child neglect and maltreatment involving caregiver substance abuse (Baharudin et al., 2014). The Adoption and Safe Families Act (ASFA) of 1997 was created to provide prevention and intervention services to children identified in the child welfare system as at risk of abuse and neglect (Oliveros & Kaufman, 2011). The act's main provisions included family preservation, child safety, accelerated placement of children into fostering families, and effective accountability in child protection agencies (Seay & Kohl, 2013). Although these provisions led to higher accountability and increased long-term placement in foster care, the act did not adequately address post-family-reunification dynamics or improve external agency collaboration (Oliveros & Kaufman, 2011). Historically, the lack of external communication between human services agencies and professionals working with marginalized populations has not facilitated the services needed to sustain postreunification families (Rivera & Sullivan, 2015).

According to ASFA policy and child welfare guidelines, child neglect allegations can be either substantiated or unsubstantiated (U.S. Department of Health and Human Services, 2011). The general definition of abuse has three categories: physical, sexual,

and emotional. According to the Legislative Analysis Office of California (2013), general abuse is the caregiver's failure to provide satisfactory shelter, clothing, food, and adequate medical care or supervision while severe neglect is the caregiver's negative influence on the child's emotional and physical development and failure to protect the child from severe maltreatment. In most cases, reports of substantiated allegations are investigated. Substantiated allegations of maltreatment or risk of maltreatment are determined according to California statutes and polices. The upward trend of substantiated neglect cases opened in child protection agencies due to alcohol or other drug (AOD) addiction combined with ASFA policies warrants collaboration between child welfare agencies, substance abuse treatment providers, and the legal system (Traube, He, Limei, Scalise, & Richardson, 2015). These partnerships are in place to decrease long-term out-of-home placement while increasing family reunification. The ASFA's stringent requirements served as a catalyst to improve poor service delivery among support systems for families struggling with parental AOD addiction.

Case management services for AOD parents with children who are wards of the court often reflect fragmented cross-agency collaboration among child welfare agencies, family drug courts (FDCs), and AOD treatment (Grant et al., 2011). Women with open child welfare cases are at increased risk of relapsing because of their primary caregiver role. In addition, Lietz, Lacasse, and Cacciatore (2011) found that 80% of women with children in the child welfare system who seek treatment for their AOD addiction are victims of childhood trauma or sexual or physical assault. Because of the lack of gender-based services and treatment specifically targeting psychological trauma and addiction

issues, women are not being fully supported in their efforts to achieve sobriety, therefore decreasing their chances for successful and sustainable family reunification.

Problem Statement

There is little postreunification support offered to women who complete court-ordered drug rehabilitation and whose children are returned to their care (Grant et al., 2011). Many women in recovery lose their children because of issues associated with neglect and maltreatment influenced by substance abuse and addiction. Women who enter drug rehabilitation with trauma or co-occurring disorder histories are being inappropriately served and are at higher risk of relapse. Women in recovery are susceptible to relapse due to issues associated with trauma and stress, which may be triggered by reassuming the parental role (Martin & Aston, 2014; Mendoza, 2013; Zeoli, Rivera, Sullivan, & Kubiak, 2014). Women with trauma histories who are sober parenting may require additional support to decrease triggers associated with relapse.

Additional research is needed to further the understanding of how single mothers exposed to trauma adjust to receiving their children back from foster care and how they manage and maintain their sobriety while resuming their role as a primary caregiver while sober. Most researchers have focused on the process and factors contributing to or impeding family reunification rather than the reunification experience. Many women who leave their children to complete mandated drug rehabilitation programs do not receive adequate postreunification support and find it difficult to maintain sobriety while parenting. The experiences of women who had been reunited with their families for at least 2 years were examined in the present study to gain insights into this phenomenon.

Purpose of the Study

The purpose of this qualitative phenomenological study was to explore post-substance-abuse recovery challenges among women with trauma histories and their experiences with family reunification and sober parenting. The sample for this study was 10 women who completed a court-ordered 30-day drug rehabilitation program due to child maltreatment and neglect influenced by substance abuse. Women participating in this study were single parents and were selected for having achieved 2 or more years of sobriety and for their experiences of family reunification and sober parenting.

Research Question

The research question for this study was as follows: How do single-parenting women with 2 or more years of sobriety and with trauma histories describe their experience of family reunification and sober parenting?

Theoretical Framework

The theoretical foundation for this study was Najavits's (2002) seeking safety evidence-based model of recovery. The seeking safety theory identifies a safe process and transition from addiction to recovery while recognizing the risk factor of substance abuse and the possibility of adverse outcomes associated with the reconciliation of relationships of individuals with psychological trauma histories of psychological trauma. This explanatory framework uses various approaches and measures to address trauma in the lives of survivors. Other trauma and recovery models such as Herman's (1992) model of recovery frame the phenomenon of past abuse and its consequences of disempowerment and disconnection to provide insights into the structural and relational

cycle of rehabilitation and sustainability through the lens of safety. The seeking safety theory offers human service professionals and policy makers insights into drug addiction and complex trauma through the integrated treatment of trauma and substance abuse. Results from studies on complex trauma and drug abuse have suggested that co-occurring disorders act as barriers to resources, safety, and restoration of parent and child relationships, thus limiting the likelihood for successful long-term family reunification (Messina, Calhoun, & Braithwaite, 2014).

Key findings in a 2015 report by the Children's Bureau suggested that parental substance abuse and neglect are significant factors in open Child Protective Services (CPS) cases (Child Welfare Information Gateway, 2017). The U.S. Department of Health and Human Services' Administration for Children and Families division reported that of an estimated 402,378 children in foster care, 51% were reunited with a primary caregiver or parent within 11 months of being in provisional care (as cited in Seay & Kohl, 2013). About 53% of CPS cases opened in 2013 involved neglect due to AOD by a primary caregiver or parent (Baharudin et al., 2014). Cases opened in the state of California due to neglect brought on by parents' substance abuse disorders are presided over by FDCs in collaboration with CPS. These courts address substance abuse, trauma, and mental health issues. FDCs are governed by the juvenile court system and are responsible for providing linkages and services to vulnerable and marginalized populations (C. M. Brown, 2016; Drabble, 2011) with the goal of reducing the time children spend in temporary care.

Before reunification, parents must comply with the court's orders and must show evidence of self-sustainability such as housing, employment, and completing a 30-, 60-,

or 90-day substance abuse rehabilitation program, or their children become wards of the court (Balsells et al., 2013). The 12-month period for complying with FDC mandates may not provide adequate time to address unmet needs and unresolved psychological trauma (Balsells et al., 2013), leading to neglect and out-of-home placement of children. Other studies have shown that women with substance abuse and trauma histories are more likely to have psychological symptoms impacting their ability to sustain the parent–child relationship upon reunification (Lynch, Heath, Mathews, & Cepeda, 2012). Once reunification occurs, parents may have difficulty establishing emotional attachments, affecting their capacity to reconnect with and parent their children (Flora, 2012). The seeking safety theory was used in the present study to frame knowledge learned about the symptoms of psychological trauma associated with women who are in recovery from drugs and alcohol.

Nature of the Study

My intention was to explore the lived experiences of women with similar situations, contexts, and conditions. Using the flexibility of hermeneutic phenomenology to examine and frame data allowed me to bracket any preconceived conceptions of the phenomena under investigation and to aim for fresh, real perspectives and experiences of the participants, as described by Crowther, Ironside, Spence, and Smythe (2016). Hermeneutic phenomenology is used to study common experiences in health care and social science education settings in which researchers want to understand situations, context, and conditions (Moustakas, 1994). As such, it was an appropriate approach for

gaining a better understanding of women's experiences of family reunification, access to resources, and sober parenting

My focus in this study was on women in recovery who were clean and sober for 2 years or more and their experiences of being reunited with their children. Using the seeking safety explanatory framework allowed me to focus on descriptions and experiences of the identified population and articulate the need for greater accessibility to viable resources while providing a narrative of the phenomena.

Assumptions

During this study's investigative phases, assumptions regarding the sustainability of the reunified family and the caregiver's ability to provide adequate parenting were examined. These assumptions were based on the traditional ideas of substance abuse treatment for women and the need for more postreunification services. A key assumption was that these women would be able to report what they have experienced regarding these issues. Additional assumptions were that (a) study participants would be open and honest in reporting their experiences, (b) they would talk about sobriety, (c) they had achieved 2 or more years of sobriety, and (d) they would find it difficult to attend sobriety meetings due to lack of childcare and supportive family systems. Furthermore, I suspected that high-risk factors associated with relapse such as interpersonal trauma, depression, and stress would likely interfere with proper parenting, thus triggering substance use and increasing the likelihood of their children reentering the foster care system.

Limitations and Scope

This was a qualitative study with a sample size of 10 women who were reunited with their children for 2 or more years and who were active in their recovery process. These women lived in a southwestern U.S. city at the time of the study. Findings reflected experiences specific to this group of women and may not be representative of all single-parenting women in recovery in the southwestern United States or nationwide. However, there may be similarities, patterns, and behaviors common to individuals who are practicing recovery. I managed logistical limitations by discussing scheduling with participants and confirming with facilities managers that a safe place would be provided for interviews. The scope of delimitation for this study was based on its geographical location and that its results cannot be generalized because of its qualitative nature. Only individuals living in one southwestern U.S. city were chosen for this study due to their location and my availability as the researcher.

Significance of the Study

This study is significant as its findings further the body of knowledge on family reunification and issues concerning challenges of women in recovery who have been reunited with their children placed in foster care. Another important consideration was the high number of trauma-exposed women working toward reunification with children in out-of-home placement. S. Brown, Jun, Oh Min, and Tracy (2013) found that 80% of women identified as AOD reported having high levels of trauma that involved physical and sexual assault. Of these women, some will have their parental rights terminated (S. Brown et al., 2013). Caregiver neglect and failure to consistently provide adequate food,

housing, and clothing can result in children reentering and remaining in foster care (Flora, 2012; Staton-Tindall, Sprang, & Clark, 2012). There are more cases of neglect influenced by parents' substance abuse and addiction than by physical or sexual abuse (Einbinder, 2010; Lewis, 2011). Therefore, examining the experiences of women in recovery may help to inform social and human service systems of the issues associated with substance abuse, family reunification, and continuity of care for reunified families and strengthen current service delivery systems.

Maternal Substance Abuse and Treatment

Substance abuse can have a devastating effect on women and their ability to parent. S. Brown et al. (2013) indicated that women who parent while under the influence of alcohol or drugs have poor supervision and impaired judgment that compromises their decision-making abilities. Other researchers have suggested that 80% of children involved in the child welfare system are there because of neglectful parenting and maltreatment influenced by a primary caregiver's substance abuse (S. Brown et al., 2013). During the 1990s, most research on substance abuse treatment was not gender specific or trauma focused (Balsells et al., 2013). Gender-specific substance abuse treatment and recovery programs for women are now considered important to the sustainability of reunited families.

Researchers such as Twomey, Miller-Loncar, Hinckley, and Lester (2010) and Zeoli et al. (2014) identified the importance of service delivery to recovery and reunification outcomes of women with AOD addictions. Other researchers have confirmed the benefit of comprehensive multidisciplinary case management services that

are customized for women who are parenting while practicing recovery (S. Brown et al., 2013). In many cases, women who are attempting AOD recovery do not have healthy family systems supporting their recovery efforts. It is important to understand the internal causes of maternal substance abuse while examining risk factors and barriers to substance abuse treatment and aftercare services. Most substance abuse and child welfare researchers have focused on a few main areas: the family, the children, foster care, and drug treatment (Einbinder, 2010). However, few researchers have focused on what happens to these families after reunification.

This study was an exploration of women's experiences after reunification had occurred and their commitment to recovery as sober parents. I gained insights using hermeneutic phenomenology to understand similar experiences shared by women addicted to drugs or alcohol in context of their substance abuse recovery and reunification with their children. I examined interconnected relationships of support systems and postrecovery services such as child welfare, FDCs, and substance abuse treatment that focus on risk factors that can trigger relapse such as trauma, stress, unemployment, and lack of resources, including mental health services.

Definitions and Terms

The following definitions are provided for clarity of the content and language in this study:

Addiction recovery: Also known as substance abuse recovery, this is the rehabilitation process and treatment necessary to achieve and maintain sobriety over a lifetime (Panchanadeswaran & Jayasundara, 2012).

Alcohol and other drugs (*AOD*): A term used to explain or describe substance use or addiction (Substance Abuse and Mental Health Services Administration [SAMHSA], 2009). In the present study, AOD was often used to describe both substance use and addiction and to simplify wording discussing these issues.

Complex trauma: As defined by S. Brown et al. (2013), complex trauma refers to a history of interpersonal violence, mental health disorders, and substance abuse and addiction contributing to and triggering distress and trauma-related symptoms.

Family reunification: A term used to describe the process in which children return to the custody of a biological parent from foster or provisional placement (Harwin, Alrouh, Ryan, & Tunnard, 2013).

Foster care: Temporary settings or provisional care such as nonrelative homes, group homes, residential facilities, and biological family homes used for the temporary care of children who are or are in the process of becoming wards of the court (Child Welfare Information Gateway, 2017).

Postreunification: After family reunification has been achieved (Child Welfare Information Gateway, 2017).

Postreunification support: Resources and aftercare services that address the needs of the reunified family and the recovery needs of the parent (Child Welfare Information Gateway, 2017).

Posttraumatic stress disorder (*PTSD*): An anxiety disorder in which symptoms develop following an extreme psychologically distressing event (Messina et al., 2014).

Sober: Also referred to as sobriety, this is the state of abstaining from alcohol and other drugs to maintain a drug-free lifestyle (SAMHSA, 2009).

Sober parenting: This term refers to parents who are practicing recovery while parenting their children.

Summary

Women who are seeking to reunify with their children in foster care are expected to complete mandatory substance abuse recovery programs for reunification to occur. These programs are often not gender specific or equipped to deal with co-occurring mental health disorders and AOD. Women with domestic violence and or sexual abuse histories are more likely to develop psychological symptoms associated with trauma and turn to drugs or alcohol as a coping mechanism. Single mothers who abuse or are addicted to substances and lack social support are at a greater risk of their children entering foster care due to maltreatment and neglect.

Information presented in Chapter 1 addressed family reunification among women in recovery from drug abuse or addiction. Herman's (1992) three-stage trauma and recovery model, which is used to examine the psychological symptoms of trauma in women with abuse histories and the negative effects that complex trauma has on their quality of life, was discussed. Through the seeking safety theory, women with trauma and substance abuse histories reduce the effects of PTSD and possible relapse, therefore strengthening sustainability within their reunified families. In Chapter 2, I discuss the literature on family reunification and substance abuse recovery among women with trauma histories. of trauma. In Chapter 3, I discuss the study's methodology and

phenomenological case study design as well as the in-depth interviews created to obtain information about the experiences and understanding of the participants and the meanings given to those experiences. Chapter 4 is a presentation and discussion of the study results. Chapter 5 provides an overview of the study findings and recommendations.

Chapter 2: Literature Review

Women who complete court-ordered drug rehabilitation and receive their children back into their care lack postreunification support (Lietz et al. 2016). Women in recovery are susceptible to relapse due to issues associated with trauma and stress, which may be triggered by reassuming the parental role (Martin & Aston, 2014; Mendoza, 2013; Zeoli et al., 2014). Women with trauma histories who are sober parenting may require additional support to decrease triggers associated with relapse. There is a gap in the research regarding the understanding of how single-parenting women with trauma histories adjust to receiving their children back from foster care and manage and maintain their sobriety while being reintroduced to their role as a primary caregiver and as a sober parent. To fill this gap, my purpose in this qualitative phenomenological study was to explore post-substance-abuse recovery challenges among women with trauma histories and their family reunification and sober-parenting experiences.

The following is a review of the literature regarding post-substance-abuse recovery challenges among women with trauma histories and how they experience family reunification and sober parenting. I first present the literature search strategy, followed by discussions of the theoretical framework and the literature reviewed on the related issues of trauma and AOD use in women, family reunification among women with 2 or more years of sobriety, trauma among women in treatment, and challenges of substance abuse and recovery among women. A summary and conclusions end the chapter.

Literature Search Strategy

The literature review for this study was conducted online and included the domains of post-substance-abuse recovery challenges among women, trauma history, family reunification, and sober parenting. Libraries in local institutes and the electronic databases ProQuest, PsycINFO, PsycARTICLES, and SocINDEX were the primary sources for the search. The keywords used for the search included *post-substance-abuse recovery*, *women*, *trauma history*, *family reunification*, *sober parenting*, *trauma and AOD use*, *sobriety background*, *trauma among women in treatment*, and s*ubstance abuse and recovery*.

Theoretical Foundation

Seeking safety is an integrated recovery model designed to address trauma and substance abuse (Najavits, 2015). In practice, the goal of seeking safety is to acknowledge the triggering effect of both disorders, how they overlap, and why they are connected. In addition, seeking safety explores the order in which each disorder occurred, the effects of healing on both trauma and substance abuse, and the beginning of other problem areas. The seeking safety evidence-based model uses Stage 1 of Herman's (1992) trauma and recovery model safety. Safety is the priority of treatment and is used as a lens to view the healing process that individuals go through while recovering from unwanted abuse or traumatic experiences of their past. Stage 1 is not about discussing or processing memoires of unwanted abuse or experiences. Rather, its focus is on exploring how individuals overcome their past in terms of keeping themselves safe. The seeking

safety model addresses phenomena and experiences of substance use disorder and trauma without asking participants to discuss their trauma narratives.

Seeking safety is used to help survivors with co-occurring trauma and substance use disorders learn specific ways of coping. There are five main seeking safety principles:

1. Safety as the overarching goal (helping clients attain safety in their relationships, thinking, behavior, and emotions).
2. Integrated treatment (working on both trauma and substance abuse at the same time).
3. A focus on ideals to counteract the loss of ideals in both trauma and substance abuse.
4. Four content areas: cognitive, behavioral, interpersonal, case management.
5. Attention to clinician processes (clinicians' emotional responses, self-care, etc.; Treatment Innovations, 2016, para. 6).

Examples of these principles include helping clients stop all self-harm, gain control over symptoms, eliminate dangerous relationships, and develop self-care (Morelli, n.a.).

V. B. Brown et al. (2007) studied the implementation of seeking safety groups for women with physical and sexual abuse histories. Results from 157 clients and 32 clinicians indicated that all were satisfied with the treatment. Clinicians found the treatment to be relevant, and clients found it to touch on needs that were not addressed with other treatment approaches such as safety (V. B. Brown et al., 2007).

The seeking safety theory helps to explain how issues that result from trauma and substance abuse complicate the reunification experience while exploring how parents

face difficulties such as establishing emotional attachments and discovering their lack of capacity to reconnect with or care for their children (Lenz, Henesy, & Callender, 2016). The seeking safety theory helped me to frame knowledge learned about the symptoms of psychological trauma associated with women who are in recovery from drugs and alcohol.

Trauma and Addiction in Women

Women who are addicted to alcohol or other drugs have a 30% to 59% chance of developing a co-occurrence of AOD addiction and PTSD (Martin & Aston, 2014). S. Brown et al. (2013) found that 30% to 80% of individuals with drug addiction histories reported traumatic events in their lifetime. Women who have been traumatized are at a greater risk of abusing alcohol or other substances and developing psychological disorders, thus creating internal barriers to accessing supportive services (Martin & Aston, 2014; Mendoza, 2013). While prior researchers have indicated a need for trauma-informed supportive services, pre- and post-family-reunification researchers have reported that substance abuse, recovery, and family reunification for women with children in the welfare system are significant social problems (C. M. Brown, 2016).

S. Brown et al. (2013) noted the value in determining how maternal trauma influences substance abuse and how trauma-focused recovery programs impact pre- and post-family-reunification efforts. More specifically, it is important to consider how sober-parenting women manage to maintain sustainability of their families after the women complete mandatory drug treatment. S. Brown et al. explored the experiences of women who were trauma exposed and their efforts to maintain sobriety while parenting sober

after reunification had occurred. The researchers also studied cross-agency collaboration and case management services between child welfare, AOD treatment, and FDCs to understand participants' experiences of possible institutional barriers, available resources, and issues of bonding and attachment.

Factors Affecting Family Reunification Among Women With 2 or More Years of Sobriety

Substance abuse reportedly affects 50% to 80% of families involved with CPS and is further complicated by environmental risk factors, internal and external trauma, and other psychological and social dynamics (Salter & Breckenridge, 2014). Women in treatment for AOD addictions have a 50% chance of relapse within 2 years (SAMHSA, 2009). Caregivers who have children in the system because of an AOD addiction are given an opportunity to complete a 30-, 60-, or 90-day drug rehabilitation program. Those who successfully complete their programs are eligible to be reunited with their children according to ASFA guidelines (U.S. Department of Health and Human Services, 2015). Failure to comply with ASFA recommendations could terminate parental rights when a child is removed from the home for 15 of 22 months (U.S. Department of Health and Human Services, 2011).

Main causes of noncompliance that lead to termination of parental rights are gender-specific issues of complex trauma and a lack of services and support for women entering treatment for AOD addiction who have children (Akin et al., 2016). In a study of women whose parental rights were removed for issues involving neglect, Escobar-Chew, Carolan, and Burns-Jager (2015) discussed the concept of complex trauma, or

reoccurring and long-term distress. Complex trauma is the result of ongoing revictimization over a lifetime (Blakey & Bowers, 2014; Blakey & Hatcher, 2013). Women who are trauma exposed have a higher risk of having their children removed from their custody because of neglect influenced by AOD behaviors. CPS professionals working with women with AOD addictions have described mothers as noncompliant, detached, depressed, and emotionally distant; characteristics unique to women impaired by complex trauma (Akin et al., 2016). Mendoza (2013) reported that single mothers often have little or no secondary support (i.e., extended family or childcare services) after recovery from drug and alcohol abuse. As a result, these women find it difficult to comply with mandates such as housing, mental health treatment, and employment set by organizations such as child welfare agencies, FDCs, and the ASFA.

When a child is placed in temporary custody for abuse or neglect due to a parent's AOD addiction, the case is supervised by an FDC officer who works in conjunction with child welfare workers. It is through this collaborative effort between FDC officers and child welfare workers that temporary and permanent placements are discussed and reunification or termination of parental rights is decided (Drabble, 2011). In addition, FDC officers are responsible for linking parents to AOD treatment facilities and providing support to parents who are willing to comply. A comprehensive study of various FDC models showed that 90% of AOD cases were identified as needing a wide range of supportive services addressing trauma, mental health, housing, employment, and childcare issues (Hunter, Jason, & Keys, 2013). Although enhanced efforts for collaboration between the courts, child welfare agencies, and treatment providers have

been implemented to increase positive outcomes for families, researchers have noted a lack of awareness or concern regarding institutionalized barriers and long-established practices that impede access to services (Blakey & Hatcher, 2014). Kearney (2012) found that a lack of support for coexisting psychological problems interfered with pre- and postsupportive services and negatively impacted reunification rates. For mothers attempting recovery without dependable postreunification support systems in place, the odds of remaining drug free significantly decrease to 30% (U.S. Department of Health and Human Services, 2011). This decrease is primarily due to the absence of case management and secondary supportive services (Mendoza, 2013).

I found little about the experience of family reunification among women in recovery in existing research. Further research is needed to contribute to the understanding of how single-parenting women with trauma histories handle issues associated with family reunification and manage and maintain their sobriety while being reintroduced to their role as a primary caregiver and as a sober parent. As such, I examined the experiences of women who had been reunified with their children for 1 to 2 years to gain insight into this phenomenon.

The federal government describes child neglect and maltreatment as intentional or unintentional acts of neglect of physical, emotional, or sexual abuse or harm caused or overlooked by a primary caregiver, parent, or extended family member (U.S. Department of Health and Human Services, 2010). According to the U.S. Department of Health and Human Services (2014), 75% of all reported child abuse cases are due to neglect. According to the National Council on Child Abuse and Family Violence, 40% to 60% of

neglect cases involve substance abuse by a primary caregiver (U.S. Department of Health and Human Services, 2015). Historically, 80% of all child neglect and maltreatment cases received by child welfare services involve children from substance-abusing households. Most neglect cases in the child welfare system are influenced by neglectful behaviors by parents with a substance abuse history (Brook, McDonald, Gregoire, Press, & Hindman, 2010). Children from drug-addicted households are more likely to enter the child welfare system and become wards of the court or oscillate in and out of foster care (Child & McIntyre, 2015). Researchers have found that children entering the child welfare system from households where substance abuse is present are at increased risk of being detained and placed in foster care and for longer than average periods of time (Carnochan, Rizik-Baer, & Austin, 2013). D'Andrade and Huong (2014) found that children from substance-abusing families are more likely than children from non-substance-abusing families to enter into the foster care system and become permanently involved with CPS. Substance-abusing parents whose children are involved with CPS due to neglect are at an increased risk of losing their parental rights (Ben-David, 2016).

When children are removed from their homes and placed in out-of-home settings, reunifying the family is the court's primary goal. Family reunification with children placed in foster care depends on system-related factors and the parents' abilities to follow through with court-mandated services (Oliveros & Kaufman, 2011). Research regarding casework practices has shown that reunification rates are lowest among children from drug-addicted families whose parents fail to comply with goals and objectives of the case

plan determined by CPS. However, Harwin et al. (2013) found that parents who enter and complete a drug treatment program are more likely to achieve family reunification.

The child welfare system's goal is to promote safety and well-being among children and families and to work toward reconnecting children with their families of origin (Kearney, 2012). This is accomplished through collaboration between a group of services and programs that are responsible for preventing child abuse and neglect, children and family services departments, and FDCs. For women with a history of substance abuse and mental illness, losing their children to the system often results in losing their parental rights (Mullins, Cheung, & Lietz, 2012). Martin and Aston (2014) and Subica and Claypoole (2014) found that issues associated with substance abuse, trauma, and domestic violence affect parental ability to successfully navigate or complete court-required parenting classes or substance abuse treatment programs necessary to regain custody of their children.

The 1997 ASFA gives parents a 12-month period during which they must meet the compliance demands stated in their CPS plans. However, for most women with trauma histories, compliance and navigating the court systems prove difficult due to the current internal processes in the systems of care (Whitt-Woosley & Sprang, 2014). Other researchers have suggested that the 12-month time frame is insufficient for targeting and addressing parenting and substance abuse challenges in a meaningful way (Traube et al., 2015). Most researchers have focused on obstacles parents face prior to reunification and the challenges of navigating the system as a parent participating in substance abuse treatment and recovery (Brook, 2015). Other studies have focused on current polices,

practices, and child welfare system and FDC trends. More specifically, these researchers have highlighted efforts among child welfare services, FDCs, and interagency collaborations and services providing targeted substance abuse treatment for the purposes of returning children to their primary caregivers (Sharma & Bennett, 2015). Researchers have found correlations between substance abuse, child neglect, and time spent in foster care. In the child welfare system context, family reunification is the act of providing comprehensive and targeted services aimed at reconnecting children with their families. While family reunification is the primary goal when children are placed in temporary custody (Harwin et al., 2013), the needs of parents with substance abuse and mental illness histories are frequently overlooked in research, policy, and practice (Martin & Aston, 2014).

Researchers have suggested that trauma's psychological effects impact parenting and substance abuse recovery (S. Brown et al., 2013). Previous research has largely overlooked the idea of gender-specific services that are relevant to mothers with psychosocial trauma histories who are attempting recovery while their children are in the child welfare system. Several researchers have emphasized the need for trauma-informed services during and after the recovery process (Lesperance et al., 2011). Thompson, Roper, and Peveto (2013) found that knowing more about parenting patterns and resources to support trauma-exposed women in recovery from AOD addiction who reunite with their children is important in addressing long-term sustainability for reunified families.

While parental substance abuse is a major influence in many child welfare cases, maternal substance abuse is one of the leading causes of child maltreatment and neglect cases that are reported in the child welfare system (Lloyd, 2015). More than half of children involved with the child welfare system due to neglect have a parent with a co-occurring disorder (Panchanadeswaran & Jayasundara, 2012). Equally important to the outcome of pre- and postreunification cases are concerns about co-occurring disorders associated with substance abuse and addiction such as mental illness and complex trauma (Sharma & Bennett, 2015). Such concerns contributed to the number of child neglect cases reported by SAMHSA in its 2009 report on substance abuse and mental illness. Thompson et al. (2013) stated that families with open cases due to neglect or maltreatment are at greater risk of breakdowns in the family system and returning children to out-of-home placement. Flora (2012) said that in child neglect cases involving parents who are attempting substance abuse treatment, the parents are often unsuccessful and lack critical resources and support.

According to Harwin et al. (2013), a better understanding of the risks associated with returning children to homes with parental substance abuse is needed when making the decision to reunify families. FDCs, in collaboration with departments of child and family services, bear the responsibility for reuniting families. FDCs are specialized substance abuse dependency courts that oversee and monitor substance abuse treatment for parents whose children are in custody (Lesperance et al., 2011). Parents seeking reunification must comply with orders issued by the FDC within a 12-month time frame or risk losing their parental rights. The FDC model is designed to facilitate early

reunification and promote better outcomes for parents by offering substance abuse treatment assistance (Child & McIntyre, 2015).

Lewis (2012) concluded that parents who participate in FDC programs have better outcomes before family reunification and are more likely to meet court-mandated timelines within 6 to 12 months. Researchers have found that 77% of families participating in FDC programs regained custody of their children, suggesting that time spent in treatment was an indicator of parent-child reunification (Mullins et al., 2012). Although Madden et al. (2012) found that participation in FDC programs significantly improved the likelihood of parent-child reunification, the study authors noted many family-level functioning issues that are not being addressed. Blakey and Bowers (2014) reported that gender-specific treatment barriers and disparities of mental health and other psychological disorders specific to women and how these issues are treated affect program compliance and completion. These disparities are thought to act as deterrents to case management and drug rehabilitative services required by the courts. Child and McIntyre (2015) found that women attempting to meet FDC program requirements who have trauma histories are less likely to follow through with reunification prerequisites as established by the court. Lloyd (2015) stated that trauma is thought to hinder participation and program compliance among women.

Trauma Among Women in Treatment

Interpersonal trauma is common for women with addiction histories. As many as 85% of women have experienced interpersonal trauma in their lifetime (Salter & Breckenridge, 2014; Sharma & Bennett, 2015). Women with addiction histories can

experience multiple traumatic events; some have reported more than 10 occasions of interpersonal violence over a given period (S. Brown et al., 2013). Addressing trauma and addiction issues among women during the recovery process can be difficult. Drabble (2011) and Subica and Claypoole (2014) indicated that the complexities and unique needs women face while in treatment and the approaches taken by court-mandated substance abuse services are not effective in treating women who have co-occurring disorders. Issues associated with substance abuse, trauma, and domestic violence can impact parental ability to successfully navigate or complete court-required parenting classes or substance abuse treatment programs in order to regain custody of their children (Martin & Aston, 2014; Subica & Claypoole, 2014).

There is some disagreement about gender-specific substance abuse interventions being more effective at targeting traumatic personal histories. Stevens, Andrade, and Ruiz (2009) argued that there is a lack of attention to women's sobriety. Baharudin et al. (2014) and S. Brown et al. (2013) demonstrated a historic disconnect between substance abuse and mental health services in addiction treatment, especially in addressing the needs of women with co-occurring disorders and complex trauma. Martin and Ashton (2014) expounded on the idea that substance abuse treatment should take a more integrated and gendered approach to substance abuse by specifically targeting trauma. Research on integrated approaches for addressing substance abuse and mental health has shown that women are more responsive to treatment specifically targeting the complexities of family relationships but that women are more likely to have symptoms that are more persistent, severe, and resistant to treatment (Lesperance, 2011).

Many barriers exist to integrating substance abuse treatment approaches in FDCs (Powell, Stevens, Dolce, Sinclair, & Swenson-Smith, 2012). Barriers attributable to lack of participation because of program delivery are considered a mismatch of needs between participants and service delivery rather than noncompliance (Sharma & Bennett, 2015). Little attention has been given to how trauma adversely affects the ability to navigate systems of care such as child protection and child welfare (Oliveros & Kaufman, 2011) and impacts participants' abilities to follow through with their plan of care as outlined by child protection and welfare workers.

Women who are mandated to treatment by a FDC must complete the program within 30 days (Smith, 2003). For most women with trauma histories, this time frame addresses only the addiction and neglects the challenges associated with mental health (Martin & Ashton, 2014). While women may pursue substance abuse recovery, most treatment options are limited to treating the addiction only. Co-occurring disorders are not often addressed in treatment or in court-mandated programs (Salter & Breckenridge, 2014). Furthermore, staff providing mental health services are often limited in their treatment approaches toward individuals with co-occurring disorders and may not understand how to target interpersonal challenges or traumatic experiences often misconceived as barriers to treatment (Sharma & Bennett, 2015).

Women with trauma histories can encounter many challenges when attempting to reunite with their children in the foster care system (Salter & Breckenridge, 2014; Sharma & Bennett, 2015; Stevens et al., 2009). Some researchers (Panchanadeswaran & Jayasundara, 2012; Taylor, 2010) have suggested that compliance issues resulting from a

lack of desire or unwillingness to participate as one of the reasons for long-term placement of children in the system while others (Thompson et al., 2013) have suggested that family-sensitive mental health services and interventions are neglected and that therapeutic environments can be insensitive toward family life and relationships. Regarding treatment of women with substance addiction and trauma histories, Subica and Claypoole (2014) stated that poor treatment outcomes reflect the system's inability or failure to acknowledge the needs and challenges associated with women in recovery.

Challenges of Substance Abuse and Recovery Among Women

More women than men are likely to assume the primary caregiver role. Therefore, it is important to understand the external and internal obstacles that may interfere with female parenting during and after substance abuse recovery (Harwin et al., 2013). Several researchers (Fullilove et al., 1993; Grant et al., 2011; Hunter et al., 2013) have identified trauma, poverty, and domestic violence as psychological and environmental risk factors associated with maternal substance abuse. Adverse experiences in childhood, including issues resulting from parental rejection and abandonment and physical and sexual abuse, can cause long-term relational challenges in adults (Escobar-Chew et al., 2015). Although these stressors have been linked to pathways to substance abuse and parenting challenges, researchers have not adequately addressed how maternal stressors can upset or pose formidable threats to substance abuse recovery and family reunification (Martin & Ashton, 2014).

Past researchers have paid little attention to the unique challenges and needs of women seeking sobriety. For example, study findings have shown that women may be

hesitant to enter into treatment if they lack financial independence or childcare resources (Rivera & Sullivan, 2015). Women with children in the system due to neglect influenced by an AOD addiction often encounter negative social attitudes and are expected to overcome systematic obstacles (Lewis, 2011). For most women with children in the foster care system, the decision to enter treatment is often a response to a court-mandated order as a condition to reunite with their children. While some researchers have agreed that substance abuse influences child neglect and maltreatment, many have not fully considered the maternal stressors or co-occurring disorders that predispose these women to child welfare system involvement (S. Brown et al., 2013; Twomey et al., 2010).

Studies have shown that women who abuse substances and have children in the welfare system have common maternal stressors and personal histories (Kearney, 2012). For example, several researchers (Balsells et al., 2014; Priester et al., 2016) have highlighted a lack of social support as a commonality among mothers whose children enter the foster care system. These women often lack family support and were in the child welfare system themselves as children. Prior research has indicated the importance of social support such as strong family relationships and resources availability during and after the recovery process to help participants complete mandatory drug treatment and remain drug free (Brooks & Rice, 1997). Although the idea and purpose of mandatory substance abuse treatment is to promote and encourage sobriety, many psychological and environmental factors influencing substance abuse and addiction are not addressed and continue to exist during and after recovery (Priester et al., 2016).

Addressing physical and sexual trauma presents unique challenges in treating women with substance abuse or addiction (Salter & Breckenridge, 2014). Some substance abuse treatment facilities have turned away women seeking treatment because the complexity of these women's issues could not be adequately treated or the treatment they would receive would focus on the primary addiction and ignore trauma and co-occurring disorders. Women who are seeking to reunify with their children may find it difficult or impossible to successfully complete a recovery program due to treatment limitations, thus decreasing their chances of successful reunification.

Child Reunification Issues

Staudt and Cherry (2015) noted that child welfare workers involved in family reunification work may have difficulty determining how soon to return a child to a parent who has been through addiction treatment and has stopped abusing substances. Workers need baselines for determining if parents are practicing recovery and how these baselines are measured. Addiction treatment providers have argued that providing clients enough time to solidify their treatment goals can help to decrease premature reunification (Sharma & Bennett, 2015). Premature reunification can increase the possibility of recidivism. Findings from Oliveros and Kaufman (2011), Rittner and Dozier (2000) and the U.S. General Accounting Office (1998) showed that not all mothers are successful in reunification after substance abuse treatment. In a 2001 study, Hohman and Butt presented details on a case study of a 32-year-old single mother who was a drug user. She was homeless, and her child was declared a ward of the court. A reunification plan was developed for her that included a parenting and drug rehabilitation program, random drug

testing, and Narcotics Anonymous meeting attendance as well as housing and drug treatment. This mother barely participated in the group sessions and reported that she had no problems. She left the recovery home after several weeks and did not return. Her drug tests were positive, and she was discharged from the recovery home. She continued to test positive and failed to enroll in a drug rehabilitation program, thus she was not reunited with her child.

Murphy, Ponterotto, Cancelli, and Chinitz (2010) presented daughters' perspectives on their mother's substance abuse. These authors investigated the experiences of racially and culturally diverse young mothers whose mothers were substance abusers. Semistructured interviews were used to gather data from 10 drug-free mothers who were raised by mothers addicted to drugs, primarily crack cocaine. These women reported that their mothers were unavailable to them and that they wanted to be there for their children. They also wanted to protect their daughters from sexual abuse and raise sons who would not abuse women. These women provided insights regarding the negative experiences of being raised by mothers who were unable to recover and parent.

Much change is needed to help ensure successful child reunification. Martin (2011) reported that it may be difficult for mothers to disengage from injecting drugs. Martin conducted an ethnographic study of young mothers and pregnant women who tried to disengage from injecting drugs and found that many women had difficulty establishing new ties to the non-drug-using world as they faced social isolation and ongoing stigmatization. While these women wanted to be good mothers, many were

ambivalent about giving up their drug use activities and their relationships with others that were an important part of their identities.

Baker (2000) explored the efficacy of gender-sensitive substance abuse treatment programs and gathered perceptions of these programs from female addicts. Interviews and treatment group observations provided data for analyzing the women's stories about their lives. Results showed that these women underwent an identity transformation. They had to come to understand that they were addicts and were not always able to parent well in order to change their identity and become better mothers.

Carlson, Matto, Smith, and Eversman (2006) investigated the experiences of women in recovery from drug abuse regarding their mothering role. These women resumed this role after being reunited with their children, who were in foster care. The study included six mothers and 11 service providers from substance abuse treatment facilities and child welfare agencies. All were interviewed about their experiences of mothers being reunited with their children after the mothers completed substance abuse treatment. The mothers had very intense emotional reactions to their children having been placed, which motivated their recovery. However, reunification was also a source of stress. The mothers needed additional counseling, parenting education, and childcare and financial support to resume their mothering role. This role was described as overwhelming and filled with challenges such as needing to provide limits with their children. Other challenges and barriers to successful reunification included stigmatization experienced in the child welfare system (Carlson et al., 2006).

Einbinder (2010) studied 21 long-term poly-substance-abusing mothers who graduated from a family-focused residential substance abuse treatment program. These mothers described how they successfully completed the program and how completion helped them retain or regain custody of their children. They reported missing their children and feeling horrified at how they had treated their children in the past. They needed parenting classes, individual therapy, and informal guidance from peers and staff about parenting to become better mothers.

Gruber, Fleetwood, and Herring (2001) reported on the need for in-home continuing care services for women in substance-affected families. The Bridges Program provides this care. Continuing care services is an important issue for the social work field since social workers need to understand the need for a program that addresses substance abuse recovery and family preservation. Services are needed to help substance-abusing parents recover their roles with their families. Such services should offer education on effective parenting skills and support avoidance of drugs and alcohol (Gruber et al 2001). Relapse prevention must also be addressed through continuing care services. The Bridges program establishes a supportive home environment for grief and substance abuse recovery, maintaining sobriety, and reuniting with children. Support services include a relapse prevention plan, addiction counseling, education on problem-solving skills and emotional management, and weekly Alcoholics Anonymous meetings. Again, this support was needed to help ensure successful parenting and child reunification (Gruber et al., 2001).

Thompson et al. (2013) reported that approximately 80% of children who are served by child welfare agencies have parents who either abuse or are dependent on alcohol or drugs. Since CPS workers are limited in their options to help these families, the Parenting in Recovery program was developed. Participants in this program reported that family therapeutic services, parenting education, and financial support are needed before reunification occurs. They reported the need for long-term aftercare support to become self-sufficient and good parents.

Zweben et al. (2015) described family protective factors needed in residential treatment for substance use disorders. While these programs tend to focus on attitudes and actions related to substance dependence, protective factors needed to sustain recovery may not be provided. These programs must have supportive treatment components that build support systems. Protective factors include "(1) concrete support in time of need; (2) knowledge of parenting and child development; (3) social and emotional competence of children; (4) parental resilience; and, (5) social connection" (Zweben et al., 2015, p. 145). These factors help reduce mental health symptoms and risk behaviors and increase program retention.

Summary

Key findings from this literature review showed that women with AOD addictions have a 30% to 59% chance of developing a co-occurrence of AOD addiction and PTSD (Martin & Aston, 2014), and 30% to 80% may have had a traumatic event in their lifetime (S. Brown et al., 2013). Maternal trauma influences substance abuse impedes recovery and impacts family reunification (S. Brown et al., 2013). As noted by Mendoza

(2012), single-parenting women have little or no secondary support after recovery from drugs and alcohol, which can make reunification problematic.

Interpersonal trauma is common for women with addiction histories (Salter & Breckenridge, 2014; Sharma & Bennett, 2015), and most substance abuse programs do not effectively address trauma and addiction issues among women during the recovery process (Drabble, 2011). Martin and Aston (2014) and Subica and Claypoole (2014) reported that issues associated with substance abuse, trauma, and domestic violence can impact parents' ability to complete court-required parenting classes or substance abuse treatment programs and regain custody of their children. Moreover, these women face challenges that must be better understood in order to help them. Successful family reunification may depend on the type of treatment women receive while participating in a drug and alcohol program, their length of their sobriety before reuniting with their children, and their ability to follow through with court-mandated services (Brook, Akin, Lloyd, & Yan, 2015). While it is understood that these challenges include the need to treat substance abuse addictions as well as physical and sexual trauma (Salter & Breckenridge, 2015), there is a lack of information about other issues these women face. In Chapter 3, I describe the methodology I used to investigate these issues.

Chapter 3: Research Method

In this qualitative phenomenological study, I explored post-substance-abuse recovery challenges among women with trauma histories and their experiences of family reunification and sober parenting. In this chapter, I describe the study methodology, including research design and rationale, role of the researcher, participant selection logic, instrumentation, recruitment procedures, data collection, and data analysis. I also discuss issues of trustworthiness and ethical concerns. A summary concludes the chapter.

Research Design and Rationale

The research question for this study was as follows: How do female single parents with 2 or more years of sobriety and with trauma histories describe their experience of family reunification and sober parenting? The nature of this study was qualitative with a hermeneutic phenomenological focus. My focus was on exploring the experiences of single-parenting women with 2 or more years of sobriety and with trauma histories who have gone through family reunification and are now sober parenting. This focus was consistent with qualitative research goals as participants were asked to share their lived experiences of addiction, trauma, and sobriety. A hermeneutic phenomenological approach was used for this study. This approach allows for gathering and analyzing narrative data (Moustakas, 1994). The rationale for choosing a phenomenological approach is that using this approach results in data relevant to study participants' lived reality (Moustakas, 1994). Hermeneutic phenomenology facilitates the understanding of lived experiences (Van Manen, 1997), which is consistent with my intentions in this study.

My focus was women in recovery and their experiences of being reunited with their children while being clean and sober for 2 years or more. I chose a phenomenological approach because it allowed a greater understanding of the lived experiences of women with similar situations, context, and conditions. Hermeneutic phenomenology provided the flexibility for examining and framing the data and allowed me to bracket any preconceived conceptions of the phenomena under investigation and to gain fresh, real perspectives from the participants.

The phenomenological approach begins with formulating the phenomenological question: What is the lived experience that the researcher is attempting to explore (Moustakas, 1994)? The phenomenological question for this study was how female single parents with 2 or more years of sobriety and with trauma histories describe their experience of family reunification and sober parenting. The second stage of the phenomenological process is the investigatory stage. During this stage, I gathered data regarding the lived experience of participants using one-on-one interviews.

Role of the Researcher

There was no relationship between myself and the study participants. I contacted the participants, conducted all interviews, and transcribed and analyzed the data. I took notes during the interviews regarding body language and attitudes. Following data analysis, I met with participants to review and address any issues of researcher bias and to check for verification and accuracy.

Methodology

Nonprobability convenience sampling was used to obtain a sample of 10 women who completed a court-ordered 30-day drug rehabilitation program due to child maltreatment and neglect influenced by substance abuse or addiction. The inclusion criteria were women who (a) completed a court-ordered 30-day drug rehabilitation program due to maltreatment and neglect influenced by a substance abuse addiction, (b) are single parents and who have achieved 2 or more years of sobriety, and (c) were reunited with and live with their children. Participants were chosen from a southwestern U.S. city due to convenience and location.

According to Moustakas (1994), phenomenological studies view participants as the experiential experts. These studies typically engage a small number of participants over a longer period of time. Mason (2010) suggested that a sample size needed for a phenomenological study ranges from five to 25 participants. Exact numbers needed are not empirically supported, but researchers have reported using different numbers of participants. Most, however, use a minimum of 10 participants in order to reach saturation (Flick, 2007; Patton, 2002). Thus, a sample size of 10 was used for this study. This sample size was deemed sufficient to capture the breadth and depth of the demographics of the study sample.

Instrumentation

The phenomenological approach includes open-ended questions. For this study, the research question and the seeking safety theoretical framework were used to guide the questions asked of study participants (see Appendix A for examples of questions asked).

To validate the interview protocol, I conducted a field test with a panel of experts that included my dissertation committee members. As suggested by Miles, Huberman, and Saldana (2014), validation was addressed by receiving feedback from this panel. The purpose of the field test was to assess the understandability of the questions, not to test for the kind of data that would be collected.

Demographics for the participants were gathered, including age, gender, race/ethnicity, number of children reunified with, completion of a court ordered 30-day drug rehabilitation program due to maltreatment and neglect influenced by a substance abuse addiction, single parent status, and years of sobriety. See Appendix B for the demographic questions that were asked. The following prompts were used to elicit further information: “Can you please tell me more about that?” and “Please explain what you mean by that.” Participants were given a link to a free counseling service upon completion of their interview.

Procedures for Recruitment, Participation, and Data Collection

Following institutional review board approval, I recruited participants at places they frequented or had transitioned to after completing their drug rehabilitation programs and being reunited with their children such as local transitional and affordable housing communities. These transitional and affordable housing communities were available to participants who had completed a trauma-based 30-day mandatory drug treatment program. I posted signup sheets with explanations about the study in public places such as laundry room areas, local coffee shops, and nail salons. I placed recruitment flyers on public information boards and other locations designated to share information. In

addition, I contacted local social service agencies that provide substance abuse treatment and trauma support.

The first 10 women who agreed to participate and met the inclusion criteria were selected for this study. I emailed all potential participants and provided them a cover letter explaining the study. All interested participants were instructed to contact me via email or phone. I sent participants demographic and consent forms (see Appendix B for the demographic questions) via email or provided copies in person. It took approximately 2 weeks to gather a minimum sample of 10 participants and to schedule interviews.

I emailed or called participants and arranged times for one-on-one interviews in their homes or in a private community room in the facilities where they lived. I used unstructured, open-ended questioning to encourage participant participation. The interviews took between 40 to 60 min and were audio recorded using an iPad. Before and during the study, I checked in with participants to assess their comfort and informed them that they could withdraw from the study at any time with no consequences. I took field notes during the interviews to review at a later time. I spoke with each participant at the end of the interview to clarify questions regarding confidentiality. Following completion of all interviews, I transcribed the data from the iPad. I analyzed the content for themes related to the research question and theoretical framework. After analyzing the data, I contacted the participants and arranged 30-minute follow-ups for member checking. I met with each participant at a scheduled time to review and read over their answers to the research questions, comment on accuracy, and report missing details. I informed each participant that identification numbers were used instead of names.

Data Analysis Plan

I used content analysis to determine themes related to the research questions. Open, axial, and selective coding were used to analyze the narrative data (see Strauss & Corbin, 1998). I analyzed the transcribed interview data by hand. I used open coding, read through the data several times, and summarized data to be coded, based on meanings that emerged. I used axial coding to identify relationships among the findings. Selective coding was used to determine core themes that related to the research question.

Data Analysis Procedures

I transcribed the audio-recorded interview data. I read all transcribed data and identified all themes, relationships among themes, and basic themes related to the research question. I examined themes and coded them according to terms reflecting content obtained from the transcribed data, as related to the research question. I examined the coded data and identified themes and patterns supportive of the content and related to the research question. I drew conclusions based on my findings. I returned all conclusions to the participants and asked for their feedback regarding the accuracy and validity of results. I made appropriate adjustments to conclusions based on participant feedback, which helped establish the validity of findings. I related all findings to preexisting research from the literature review. Themes and concepts are reported in Chapter 4.

Issues of Trustworthiness

Trustworthiness of a study is the ability to present unfiltered data of the phenomena being explored. Trustworthiness involves the credibility of the study and its findings (Trochim & Donnelly, 2008). Issues of trustworthiness in a qualitative study

reflect the ability to show reliability and validity. This is achieved through establishing credibility, transferability, dependability, and confirmability.

Credibility (Internal Validity)

Congruency of a study is established thorough reviewing data with participants and triangulation of discourse, narratives, and content analysis. Truth and accuracy are what make the research creditable. To establish credibility for the present study, all findings were returned to participants for verification.

Transferability (External Validity)

Transferability refers to how data can be generalized to other situations and contexts. Although transferability is not perceived to be a workable research method (Glasser & Strauss, 1967), the present study's results were specific to the study participants' lived experiences and may be transferable to similar individuals (Trochim & Donnelly, 2008). Participants' experiences are considered baseline to which subsequent studies can be compared.

Dependability

In this study, dependability was established through my efforts to achieve credibility through using overlapping methods of open-ended interviewing and participant narratives. This process is reported in detail in Chapter 4 where data collection and analysis are discussed. To ensure dependability, reliability, and validity of data and findings, I conducted a content analysis of the data from the participant interviews and then returned conclusions to the participant for verification of findings.

Confirmability

Reflexivity is used to establish confirmability (Trochim, 2008). In the present study, I enhanced confirmability by carefully documenting data collection procedures of checking and rechecking throughout the study. Returning conclusions to participants for verification and credibility of results helped to prevent any researcher bias or effects.

Ethical Procedures

Following institutional review board approval (IRB # 060617-0265419), I began data collection. I placed flyers with information about the research project, the procedures, the interview method, and the intended use of interview data in community rooms and on dash boards within sober living facilities. I provided full information to the potential participants and obtained signed letters of consent from participants prior to data collection. The letter of consent ensured that participants were fully informed about the research project and had provided voluntary consent to participate. Participants were debriefed and informed that anonymity, confidentiality, and privacy would be maintained by using identification numbers instead of names on all documents and data.

I received informed consent from the study participants. I informed the participants that they may withdraw from the study at any time with no consequence. Only I had access to the data, which I uploaded from my iPad to iCloud, a secure online storage site. Participants could ask questions at any time to avoid any confusion, risk, or harm. Minimal risk was possible due to the topic and subject matter; therefore, I provided links to online mental health information and confirmed that participants had access to counseling services.

Summary

This chapter was a detailed description of the methodology and procedures used for this study. I discussed my role as the researcher, the methodology employed, participant selection logic, recruitment procedures, data collection, and data analysis. I also reviewed issues of trustworthiness and ethical procedures. In summary, I used convenience sampling to obtain a sample of 10 participants to meet saturation and capture commonalities in the participant demographic. The first 10 volunteers who met eligibility criteria were selected. I used open-ended questions during the interview process, which allowed participants to use their words to convey information about their thoughts, feelings, attitudes, and understanding of the research topic. I used axial coding to link categories and concepts and used open coding to identify, name, and describe themes. I followed up with participants once coding was complete to member check and review the analysis for accuracy. Chapter 4 is a discussion of the findings and data analysis results.

Chapter 4: Results

In this qualitative study, I focused on family reunification among women who were sober parenting and who had drug abuse and complex trauma histories. The purpose of this study was to explore the lived experiences of sober parenting women with 2 or more years of sobriety with trauma histories who were reunited with their children. The children had been placed into foster care due to maltreatment and neglect influenced by their mother's alcohol or drug addiction. The participants' responses facilitated a greater understanding of family reunification, substance abuse rehabilitation, trauma, and the challenges of sober parenting. I used a hermeneutic phenomenological approach to collect data from 10 study participants. I conducted 10 in-depth interviews during which I asked open-ended questions about the participants' recovery, reunification, and sober-parenting experiences. The following research question guided this study: How do female single parents with 2 or more years of sobriety and with trauma histories describe their experience of family reunification and sober parenting? In this chapter, I discuss how the data were collected and analyzed. Chapter results are presented in participant narratives.

Study Setting

Participants were contacted via phone to determine availability and to schedule interview locations and times. Interviews were conducted in the participant's home or in a private community room on the grounds of the participant's residential or transitional housing facility to ensure confidentiality. Many of the original interview dates were rescheduled multiple times due to participant availability. The interviews were 30 to 50 min in length.

Demographics

The study participants ranged in age from 33 to 45 years. Seven participants reported having 3 to 5 years of sobriety. Three reported having over 5 years of sobriety. One participant reported having 1.5 years of sobriety due to a relapse. Seven participants reported being in long-term relationships. All participants identified as a single parent, had completed a 30-day to 18-month mandatory drug rehabilitation program, and lived in a southwestern U.S. city. All were reunited and living with their children, who were previously in the foster care system. Table 1 shows the number of children removed, the number of children returned, and years of sobriety for each participant.

I used nonprobability convenience sampling to recruit participants for this study. I used inclusionary and exclusionary criteria for quality assurance. Women who were court ordered to attend a drug rehabilitation program were selected to add to the study's credibility. I conducted interviews to explore participant experiences and meanings of sober parenting and reconnection after being reunified with their children. Each participant reported receiving some form of programming (e.g., mental health, life skills, anger management) while in treatment. However, most reported not continuing with aftercare services once treatment was complete.

Table 1

Participant Demographics

Participant	# of children removed	# of children reunified	Years of sobriety
1	1	1	3
2	1	1	6
3	1	1	5
4	4	4	8
5	4	4	5
6	6	4	2
7	1	1	8
8	2	2	1.5
9	2	2	3
10	2	2	4

Data Collection

I conducted in-depth interviews with the 10 study participants. Interviews were scheduled to accommodate participant availability and location. Eight interviews took place in the participants' homes; two were conducted in a private community room on the grounds of the participant's residential or transitional housing facility to ensure confidentiality. I recorded the interviews using an iPad. To ensure confidentiality and anonymity, I assigned a code to each participant, which I used when taking field notes and when transcribing the interviews.

The participant interviews varied in length, with none lasting more than 60 min. Prior to beginning the interviews, I informed the participants that I would use an iPad to record their interviews. I explained the informed consent process and asked the participants to sign an informed consent form to acknowledge their understanding of the study. I informed the participants they had the right to stop the interview and withdraw from the study at any time during the process. All participants were eager to share their experiences and willingly talked about their substance abuse histories, their sober parenting experiences, and the challenges of sobriety.

Data Analysis

I began each interview by recording the participant's demographic information. Once completed, I transitioned into the interview questions. I kept field notes during the interviews to capture context and perspective. After each interview, I referred to my field notes to clarify any thoughts I had regarding participant responses. After the data were transcribed, I reviewed them and scheduled a time to speak with each participant for member checking. Once I received participant verification and approval of the data, I coded the transcripts according to the participants' response words and themes.

I approached the data using open and axial coding. Open coding allowed me to review the data on two levels. The first level of coding was applied to identify and examine distinct concepts and categories, following the model outlined by Strauss and Corbin (1998). Once I identified emerging themes, I proceeded to break down the content into concepts and categories. I then color coded and highlighted distinguishing concepts

and subcategories. Using axial coding, I revisited and studied the emerging themes to confirm that the concepts and categories represented participant responses.

I next explored how concepts and categories were interconnected or related. Emergent themes were (a) choosing to remain safe and sober (minimizing exposure, discontinuing substances, letting go of unhealthy relationships, gaining control), (b) cultivating and connecting (asking for help, sharing experience, community), (c) trust and discovery (communicating, learned behavior, risk taking, assumptions), (d) types of trauma (domestic violence, rape, molestation, death, incarceration, environmental), and (e) aftercare and maintenance (attended 12-step meetings, received individual therapy, linked to supportive services, followed sober living tenets, attended groups). I revisited the transcripts several times to familiarize myself with the content and context of each interview. I took 2 days to think about how the data and themes were connected to the research question and to go over field notes I took during the interviews.

Evidence of Trustworthiness

Transferability was achieved by capturing patterns of social and relational phenomenon participants experienced and described. To ensure dependability and confirmability, participants were provided copies of their transcribed interviews. Transcribed interviews were also provided for member checking and clarification of participant viewpoints, thinking, and meaning. I scheduled a time to meet with each participant 1 week after each interview session. I then reviewed and evaluated the accuracy of meaning and to confirm whether or not the findings, interpretations, and conclusions were supported by their narratives. Participants were asked to correct errors

or challenge any wrong interpretations. All 10 participants affirmed my thematic interpretations. All 10 participants also reviewed acknowledged and confirmed the accuracy of their individual transcripts.

Study Results

The results section begins with brief biographies on study participants. The biographies are followed by details on individual participant experiences, organized by theme. Tables showing the subthemes and the number of participants who mentioned each theme are presented in each theme discussion. The biographies offer insights into the participants' experiences of completing a mandatory drug and alcohol program and maintaining sobriety while reuniting with their children after the children returned from foster care. Participants' names and other identifying information were not collected or included to ensure confidentiality and to protect the privacy of the women who participated in this study.

Participant 1

Participant 1 was a 33-year-old African American woman whose child was placed in foster care due to neglect. She thinks of herself as a good and attentive parent. She reported that her drug of choice was marijuana. She said she did what she was told and knew what was expected. She reported that she smoked marijuana but was still a good parent before her children were placed. Participant 1 said that completing an 18-month drug program was hard work.

> Yes. Every day. It's like your personal life is over. You've just got to stay for them. I got tired of being on the bus. You have to get on the bus, then on the train, and get here on time. Yeah, it was just having to be here every single day.

Participant 1 received her child back when he was 18 months old. He was in foster care for 1 year.

Participant 2

Participant 2 was a 32-year-old African American woman who had one child placed in foster care due to maltreatment and neglect. She reported having a difficult time completing the drug program due to lack of desire and unwillingness to follow the rules.

> Nobody can tell me nothing. I'm not going to class when I don't want to. I was hard headed. I was, and so yeah, I was hard headed, and so once I stopped doing that, the only thing I needed to fix was my attitude. I was bad with people trying to tell me anything. Like, "You know you need to do this." The truth always hurt, and I don't know how to take that. Eventually, I just got . . . I don't know. I just got it together. I don't know how it happened. It just happened like, they helped me.

Participant 2's son was returned to her after 5 years in foster care.

Participant 3

Participant 3 was a 43-year-old African American woman who had one child placed in foster care. She reported being in a drug program when she found out her son was placed in foster care by his biological father. She reported allowing her children to live with their father due to her drug addiction and criminal activity. She stated that she

was determined to do whatever it took to get her son out of foster care and back living with her.

> The only way that my child could come with me is if I completed a drug program, because of my background, I had violence, and they didn't want my child in a violent environment. They want the child to be with a parent, but the parent will have to prove that they're capable of taking care of them. So, I wanted to prove that I was capable.

Participant 3's son was returned to her after 1 year in foster care.

Participant 4

Participant 4 was a 45-year-old African American woman with 8 years of sobriety. Participant 4 voluntarily surrendered guardianship of her four children to a family member by request of the Department of Children and Family Services. Participant 4 reflected on being out of control, homeless, and suffering from a co-occurring disorder. She described her thoughts about entering a drug rehabilitation program.

> I was homeless at the time I went into the program, so it helped me have stability in me and my children's lives. Mental health, I was suffering from mental health all my life, that helped me to deal with some of my issues that I was going through to stay clean and sober. The drug treatment program itself. My children, any issues that they were dealing with, far as one of my children having a sexual

> abuse case, so that helped her. Our relationship as a family unit, so those are ways that those things helped.

Participant 4's children were returned to her after 1 year in foster care.

Participant 5

Participant 5 was a 44-year-old Mexican American woman whose four children were placed in foster care due to neglect caused by her substance abuse addiction. Participant 5 talked about her breaking point prior to entering a drug program for treatment.

> Then it came a time where I wasn't functioning. I wouldn't get up from my bed. I wouldn't get up get out of the room. I didn't send the kids to school. It was a mess in my house, you know? And there was no order. So then it was my breaking point.

Participant 5's children were returned to her after 2 years in foster care.

Participant 6

Participant 6 was a 45-year-old African American woman with 2 years of sobriety. She has six children. All six were removed from her care due to drug abuse and neglect. Two children were removed by children and family services and adopted. The four remaining children were placed in a family member's care, where they stayed for 5 years. These children were placed back into her care after she completed a mandatory drug rehabilitation program. All 6 children were removed from her care due to drug abuse and neglect. She described her attempts at recovery and having her kids taken away multiple times.

> This wasn't my first time though. See, because I done been in a whole lot of programs, you know. I'd of got my kids took, got 'em back, got 'em took, you know, so it was not the first time. But, I knew what I had to do, I had to get myself together and appear in court every time that they tell me I had to go.

Participant 6's four children were returned to her after 5 years in foster care.

Participant 7

Participant 7 was a 45-year-old African American woman with 8 years of sobriety. She had one child removed from her care due to substance abuse and neglect. She talked about participating in treatment, dealing with a drug addiction, and not being able to handle life. She described her understanding of coping and what influenced her addiction.

> You talk about your problems, what's going on with you at that time, basically how to handle like life problems, 'cause sometimes people, they believe that since we utilize drugs then there's a reason we utilize drugs, because we couldn't handle life. And you really try to figure out why is it that you utilize drugs. What made you become an addict? How did you become an addict?

Participant 7's child was returned to her after 8 months in foster care.

Participant 8

Participant 8 was a 36-year-old Mexican American woman with 1.5 years of sobriety after a relapse that happened when she was 3 years sober. She had two children removed from her care and place into foster care. She reported that she was a victim of

domestic violence, which perpetuated her addiction. She described her efforts to achieve and sustain sobriety by distancing herself from toxic relationships and bad environments.

> I got away from the people that were using. I keep myself away from family members that I know that they're using. I keep myself away from places that I know where I used to get high, loaded. I keep myself away from being afraid.

Participant 8's children were returned to her after 2 years in foster care.

Participant 9

Participant 9 was a 34-year-old African American woman with 3 years of sobriety. She had two children removed from her care due to substance abuse and neglect. Participant described her feelings of hopelessness after her children were removed.

> I would cry because it was my fault my kids were taken, and I didn't want them to be separated. I know my kids were going to be back with me, but the point was the time frames. I told myself I was going to do everything I can. I'm going to class every day, I'm doing this, I'm testing clean. I'm doing everything. It's just it's a process. It's a waiting game. You just have to wait.

Participant 9's children were returned to her after 3 years in foster care.

Participant 10

Participant 10 was a 34-year-old African American woman with 4 years of sobriety. She had two children removed from her care and placed into foster care due to substance abuse and neglect. She talked about her experience of being under the influence and wanting instant gratification.

> When you in your addiction your moment is smoking. But then when you smoke it takes you on. You know it's not a moment when you smoke, its days that turn into weeks that turn into months that turns into years. I know . . . For me, I wanted instant gratification.

Participant 10's children were returned to her after 5 years in foster care.

Theme 1: Facilitating and Maintaining Sobriety

The first theme identified steps participants took to facilitate and maintain a sober lifestyle. The identified subthemes are minimizing exposure, discontinuing substances, letting go of unhealthy relationships, and gaining control. The participants who identified each subtheme are shown in Table 2.

A component of the seeking safety therapeutic model of recovery is crisis intervention through stabilization. Stabilization often occurs after 30 to 60 days of sobriety while in a drug treatment program. Participants in the present study reported feelings of being out of control and a sense of hopelessness. All 10 participants reported discontinuing substance use; however, some did not acknowledge the steps they took to minimize exposure or end toxic relationships. Most participants acknowledged the need for help with their addiction and were willing to complete a court-ordered program.

Table 2

Choosing to Remain Sober Subthemes and Participant Counts

	Subtheme			
Participant	Minimizing exposure	Discontinuing substances	Letting go of unhealthy relationships	Gaining control
1	x	x		x
2		x		x
3	x	x	x	x
4	x	x	x	x
5	x	x		x
6	x	x		
7	x	x	x	x
8	x	x	x	x
9	x	x	x	
10		x	x	x

Study participants understood that a condition of being reunited with their children was completing a mandatory inpatient drug treatment program of 30 days or longer. Some participants reported feeling forced into treatment while others went voluntarily. The participants said that stabilization is not always achieved during the first time in treatment. However, for those who continue, minimizing exposure to their drug of choice and letting go of unhealthy relationships are priorities. Participant 4 said,

> I said, I can't do that no more. The people I used to get high with, smoke joints with, now I can't do that with them. I can't go hang out with them 'cause I know what they're doing already. Especially if they haven't gotten any help for it. Then if they're not, you know, when then God bless them, but still it's not best if we get back around each other 'cause it'll go through our head, we'll get to talking about it, and then next thing you know I'm back out there.

Like Participant 4, many of the other study participants mentioned distancing themselves from toxic relationships and environments in order to stop using drugs and work on achieving sobriety. Participant 7 said,

> You have to make up your mind, and know in your mind, that you don't ever want to use again. You have to. And a lot of people go through the motions just to get their kids back, and then do the same thing.

Participant 3 said that some treatment program participants feel as though they are being forced to get into a program just to get their children out of foster care.

> A lot of people had problems completing the program because they were only doing it because they were forced by a court mandate. It wasn't something that they wanted to do. So, a lot of them either used again or they disappeared.

While some study participants decided not to seek help on their own, other participants shared their experiences of gaining control over their addiction by entering a court-mandated drug treatment program. Participant 2 said,

> Well, the first time I had to go to court, when I first went, automatically, they told me like you have to go to a program, which I never knew what it was, so I'm

> crying like I don't want to live with roommates. I don't want to do that. At first, it was kind of, it was bad because I had just started going to the program. I was court ordered to go so I went, you know what I'm saying? It was hell. Within the first 2 years, I was messing up, you know what I'm saying? They were telling me like, "Look. You know what you need to do. While you're in the program, we cannot receive any bad reports for your," you know, like the, and the case managers from the program wrote reports to the court updating the court and the DCFS worker about the progress I was making. If you're in good standing or not or whatever. They're going to write it down on paper and give it to the worker. So the worker's like, "I can't help you." That goes back to what I was saying earlier. We can't help you if you don't help yourself. You got to help yourself by going through this program. If you really want to win this case and really get your son back. you know what I'm saying? So they were really trying to . . . They're trying to reunite the family.

Participant 2 described her experience with letting go of an unhealthy relationship to comply with court orders and regain custody of her son.

> My son's dad. He used to beat me or whatever. They noticed that I was still staying with him. So I had to show the courts that I was serious about leaving him. I got a restraining order. I went into the program. I just was like I'm done with everything. I give up. I want my son back. That's what I was like I'm going, you know what I'm saying? I haven't been talking to his dad ever since.

Study participants said that minimizing exposure, discontinuing substances, and gaining control over their addiction increased the likelihood of their being reunited with their children. They expressed concerns about putting other children in the home at risk of being removed from their care due to poor choices and were therefore determined to do what it takes to get them back. Participant 3 said,

> Like when I look at my kids, I don't want to have to do anything wrong to where I know it might jeopardize the daughter I have now, you know what I'm saying? Because at first, I went through the situation already with DCFS with my son. I don't want to allow that to happen again and have my daughter experience that, you know what I'm saying? So I'm not going through that again. I'm determined not to, so I think that my kids, like I look at them and I feel like they deserve better. They don't deserve to be taken away just based on my foolishness. I refuse. I just don't want to go down that road no more. I really love my kids that much. I love my kids. I do.

Study participants described choosing to remain sober as a lifestyle, a different way of living and handling life's problems. Participant 10 described her experience of sober parenting.

> They were teaching me how to be a mom, because at that time my feelings going up and down, mixed feelings and all that stuff. So, one time I was feeling angry and the other time I was crying because my system was clean. So that whole thing was crazy for me, so they were teaching me how to control it, how to lead a different type of life. They saw that I was doing everything that I was supposed to

> do to become a better parent. I was doing my classes, I was testing clean, I was doing my therapy.

Participant 9 shared about being positive and her experience of wanting to complete the program for herself and for her children.

> Just stay positive, stay focused. If this is what you really want, not just for your kids, you want it for yourself, if it's something that you really want, you focus. Don't let anyone or anybody distract you of getting what you trying to do. I tell that to everyone. It's going to be okay. Stay positive. If you think things are going to be too hard for you, start praying. Start praying to God, talk to somebody. Don't just let this disease defeat you.

Theme 2: Cultivating and Connecting

The second theme identified was cultivating and connecting. Subcategories of cultivating and connecting were asking for help, sharing experiences, reconnecting, and coping. The participants who identified each subtheme are shown in Table 3.

The theme and subthemes present views of how participants progressed through treatment and their ability to connect with peers and staff. Participants shared their experiences of reconnecting with their children, attending Alcohol Anonymous and Narcotic Anonymous meetings, coping with their addictions, and asking for help.

Table 3

Cultivating and Connecting Subthemes and Participant Counts

	Subtheme			
Participant	Asking for help	Sharing experiences	Reconnecting	Coping
1		x	x	
2		x	x	
3		x	x	x
4		x	x	x
5	x	x	x	x
6		x		
7		x		x
8	x	x	x	x
9		x	x	
10		x	x	

The seeking safety model of recovery focuses on participants' willingness to connect and cultivate healthy relationships while practicing recovery. While in the program, participants are encouraged to break though the silence and taught to articulate their experiences into words describing what they endured before and after seeking help for AOD addiction. Although the seeking safety model does not encourage revisiting past trauma, it does support exploring why participants used drugs to cope and how they can ask for help.

Participant 2 shared her experiences of getting to know staff and feeling respected.

> I think that all the case managers there, they were nice. They respected all of us. Like I said, they were just trying to help too, but at the same time, it goes both ways. If I'm not trying to do my part, then they can't help you. But I liked all the case managers, but sometimes, I would get upset when things didn't go my way. Now, I'm fussing and I'm cussing. I feel bad when I think about it.

Some study participants stated that valuing relationships with case managers and taking the required parenting classes prepared them the most for reuniting with their children while others said they were not interested in parenting classes or recovery. Participant 7 said, "I don't want no more classes, I don't want no more recovery, I'm recovered, that's what I thought of myself. That's what I said. I felt like I was done. I didn't need any more recovery." Other participants described how they had to learn how to cultivate better parenting skills. Participant 3 said,

> I had to have parenting classes to get my kid back, but I did learn some things while taking those courses as far as how to talk to your kid when he is acting up. How to discipline him when he does something wrong. I just learned how to use those tools I probably would have never used before, I probably would have did a spanking. I would have probably been mad and yelled at him and said some foul things. With an active child like mine, you know him, it was other ways that I was able to reverse his discipline.

Participant 5 shared her apprehension about reconnecting and being reunited with her children in her comments on her relationship with her case manager.

> She provided any kind of help like a referral or if I needed just to call her to talk. I told her I didn't feel that I was completely ready, like mentally to get my kids back. I knew to get them back so fast, it was going to be overwhelming because I had nothing. I had no apartment, no car, no job, nothing. So I felt like I had nothing so why would I want them back. The classes that they had especially for kids, like the Mommy, Daddy, and Me, child development classes that I took, I really, really like. I wanted to make sure I understood, and they gave me the tools I needed to cope.

Study participants also described learning how to share their experiences and receive support from each other when they were in their court-mandated programs. Participant 8 reflected on reaching out and asking for help.

> I kept busy. I volunteered and started talking to other women who had their kids taken away. We would listen to each other, some of our stories sounded the same. You felt like other people have been through what you have and that are clean and sober. I wanted to know how they did it, how they got sober. And just that, I started asking for help. Asking for help and keeping busy and being around people who wanted better.

While some participants were willing to share their experiences with one another, some were not willing to engage in or attend Alcoholics Anonymous or Narcotics Anonymous meetings during and after they completed their programs. Their reasons for

not wanting to connect with others and ask for help were associated with trust issues. Participant 7 said,

> I don't like meetings. I didn't like to go to a program in the first place, 'cause it's not for me. I felt like it wasn't for me. But I don't like meetings. I don't think meetings is what I need. I don't trust very many people, and I don't put my faith in anyone. I just think I just need God, and to continue, you know, make the right choices. I don't like meetings. Their meetings don't help me.

Many participants reported being uncomfortable with talking about and sharing their experiences in a group. They reported negative thoughts about themselves and others prior to treatment. However, most said that the process of talking and connecting with other women taught them how to openly express feelings of loss, rejection, and abandonment as well as hope, determination, and future goals. Participant 9 discussed her experience of loss.

> The teacher ask us each one of us how we're feeling today. She could tell how you were feeling, especially me. She'll know if something's wrong with me. She'll like, "You're not yourself today." I said, "I just miss my kids. I'm just going through one of those days that I don't want to be here right now. I just want to cry. I want to be with my children."

Participant 10 shared how connecting with her children and setting personal goals increased her desire to remain sober.

> When you first get them back, it's not easy. They have trust issues. I had to learn how to be a responsible parent. I had to learn how to make sure their needs were

met. I set personal goals. I kept my personal goals in front of me to make a better life for my kids. Looking at them every day makes me want to stay clean.

Theme 3: Trust and Discovery

The third theme identified from participant interviews was trust and discovery. Subcategories of trust and discovery were honesty with others, not ready for reunification, adapting to sobriety, and sober parenting. The participants who identified each subtheme are shown in Table 4.

The theme of trust and discovery represents the study participants' personal views on how they experienced recovery. They described what they discovered about themselves and how being honest permitted healing and trustworthy relationships. Honesty with self and others is said to be the foundation upon which recovery is built. Honesty is viewed here as the quintessential characteristic of achieving sobriety.

Table 4

Trust and Discovery Subthemes and Participant Counts

	Subtheme			
Participant	Honesty with self and others	Not ready for reunification	Adapting to sobriety	Sober parenting
1			x	x
2	x	x	x	
3	x	x	x	x
4	x		x	x
5	x		x	x
6	x	x		
7	x		x	x
8	x	x	x	
9	x		x	
10	x	x		

Study participants identified honesty as the catalyst to reunification, sobriety, and sober parenting. While honesty is thought to be an important characteristic in achieving and maintaining sobriety, self-deception and denial are most damaging, putting individuals in recovery at risk for relapse. The study participants spoke in terms of their truth and discovering how honesty can either destroy or repair relationships. Participant 3 communicated her experience of sober parenting and setting boundaries.

> When you're a sober parent, there's boundaries. There's a respect. There's borderlines on what you say and how you say it. And when you're high, you don't care. You, like, you know, you say some really disrespectful things and, you know, instead of telling your child they're disobedient you tell them how bad and awful they are. You just, you don't care. I had to trust in the skills I learned while in the program. I had to trust that I would remember how to use them once I got my kids back.

Participant 4 explained how she was honest with her children about her addiction.

> My kids already know what we went through and our story. So I let my kids know I'm choosing my sobriety for me. I'm choosing this life for you. I can always go back out there and use, I say, and I like to smoke, I like to drink. You see me drinking? No. I think that it also helps them understand that my struggle is real. I don't try to hide what I went through from them. I believe the fact that I can talk about it, it's the reason why we're together now.

When asked about sober parenting and adapting to sobriety, Participant 5 said,

> I had to work on it. I had to work on it. It was hard for me when I discovered how my addiction affected my life and my children. When you're in your addiction you don't think about the consequences. You only think about yourself, and I struggled being honest about that. Now that I have my daughter back I feel like I have to earn her trust; she don't trust that I am clean.

All study participants completed a 30-day or longer mandated substance abuse program. Many of them were able to reunite with their children once they complied with

their court orders. Some of the participants said they rushed through treatment to get their children out of the foster care system. Participant 6 recalled,

> I just was not ready. The fear of not being ready would mess me. I would be like, well I already finished this or whatever, I just want my kids back. And then I got the kids back and didn't how to deal with them. I was not in the program to get sober; I was in the program just to get my kids back. I knew I had a drug problem and would end up in the situation again.

While Participant 6 reported not being ready for reunification, several other participants described their experiences of adapting to sobriety and sober parenting. Participant 7 said,

> I know better. Because of all of the classes I took. I know what's right and how to do it. And what's right and how to fix a problem or deal with it. It's not to a point where I could get frustrated and think, man, I wish I could drink. I wish I could get high. Now it's like, you know what? Let me try to calm myself down and even if I have to remove myself and then come back and deal with it. It doesn't enrage me at that moment like it used to. Now I can kind of take to respond instead of react.

Participant 5 said,

> When you're a sober parent you have to give your child a lot more attention, and you have to pay more attention. And a lot of times when you're on drugs you abandon your child. You're like, you can have that, go ahead, do it, I don't care, instead of correcting what they're doing wrong. Now you have to be like stop it, don't do that, don't run around the house. Sit down and just watch TV. It's a lot

> different, because when you're doing drugs you don't really care. I learned that life shows up when you get sober.

Participant 7 shared her experience of talking about drug addiction with her son.

> Everything was different because this time I was doing it, I was not loaded, I was not numb, I was able to sit down with my son at the table and talk about things that had happened. I was able to be honest with him about what drugs did to me. He knows I have patience now. I have patience, and I had to learn how to talk to him in a way he would understand. He's not afraid of me anymore.

Most of the participants reported feeling stigmatized by society for being mothers and having a drug addiction. Some reflected on the reality of being a neglectful parent resulting in abandonment of their children. Participant 10 said,

> I was doing me. Doing me is doing a lot of drugs, hanging around the wrong people, stuff like that. In the back of my head I said, "I'm not a good mother and everybody is going to know that I have a cocaine problem." People say all the time, you should want to keep your baby with you. You should want to have her with you. That's your baby. But I had to give her to my mom because I wasn't . . . I wasn't a good mother at the time.

Theme 4: History of Trauma

The fourth theme identified was history of trauma. The types of trauma participants identified were domestic violence, death, molestation, rape, incarceration, and environmental (reoccurring exposure). The participants who identified each subtheme are shown in Table 5.

Table 5

History of Trauma Subthemes and Participant Counts

	Subtheme					
Participant	Domestic violence	Death	Molestation	Rape	Incarceration	Environmental
1		x			x	x
2	x		x	x		x
3					x	x
4		x				x
5						x
6	x	x		x		x
7		x				x
8	x					x
9		x			x	x
10		x				x

The majority of women who are drug and alcohol dependent have been trauma exposed. In some cases, study participants identified childhood and early adolescent relational trauma accompanied by feelings of guilt and shame. All participants reported experiences of interpersonal and environmental trauma. Other stressors participants identified were shame, fear of children being placed back into foster care, inadequate resources, barriers to employment, sustainable housing, and relapse. Participants identified types of trauma and coping mechanisms they used to deal with the stress and

negative emotional effects of trauma. While some identified their trauma experiences, others discussed how trauma challenged their ability to sober parent. Participant 1 identified death as a traumatic experience.

> I tend to still grieve on my mom. It seemed like it really hit me then. I think because my 15-year-old I had my mama with me. She was helping me do everything with him. Then when I had my other baby I'm just like, "Wow, my mom's not here. I've got to do all this stuff by myself." Yeah, it's been a couple times that I could have relapsed.

Participant 2 shared her experience of being molested as a child and why she thinks it caused deep-seated trust issues.

> I went through a lot of things too in my younger years. I've been molested. I've been in foster care too when I was a kid. I remember like a lot of bad stuff. Me and my sister and my brother were left at a park. My mom gave us to her boyfriend's mom, who was homeless and pushing a basket. I really don't want to get into all that emotional stuff, but it's deep. The things that I went through, and I really needed that therapy because just based on what I'm telling you right now, it was bad. I don't talk about it because I kind of feel a lot of resentment, I think that's why I ended up in bad relationships.

In treatment, participants are taught to identify and safely cope with their reactions to trauma. Participant 5 explained how repressed feelings led up to her addictive behaviors.

> A lot of this stuff is that I used because I had so many secrets and so many burdens that turned into resentments. Holding on to abuse, holding on to rape, holding on to your mamma don't love me, my daddy doesn't love me, my boyfriend left me. Drinking and smoking troubles away. You . . . you're hurting people, you're losing people. And you don't care, because all you're worried about right now is that high.

Participant 7 elaborated on her treatment experience and what she did in treatment to work through feelings associated with trauma to prevent unwanted behaviors and emotions in the future.

> They hit all those points. They hit all the baggage you were carrying, to the trauma you were holding onto, to everybody that you resented. I had to write it down, burn it, release the secrets. I wrote and shared about it. I told my truth. I told mine 'cause I wanted it out. I wanted to get better so that I could be a better parent.

After treatment, participants reported flashbacks of traumatic experiences. Some reported feelings of shame and guilt, others reported difficulty managing emotions affecting daily tasks associated with parenting. Participant 7 stated,

> I couldn't function because I was depressed. I started attending therapy. Just taking the kids to school and picking them up was too much. They were young so, they were more on me. I couldn't be drunk or high or go get my stuff even though sometimes I would want to. Before I could leave and do my thing. Now since I'm sober I don't do that anymore. I have to make sure they have what they need.

Study participants admitted to using substances to numb feelings of anger, anxiety, stress, and sadness. Once sober, they described learning how to deal with past traumatic experiences without the crutch of substance abuse. While some participants learned how to deal with reactions to trauma, others are still prone to relapse. Participant 6 said,

> A lot of stuff happened to me out there, and I just really got tired. I've been raped and beat. I kept losing my kids to the system because I couldn't stay sober, you know. I went through a lot of programs. It took me a couple of times. But, I knew what I had to do, I had to get myself together and appear in court every time that they tell me I had to go.

Participant 8 described her difficulty with attachment due negative life experiences.

> There's a detachment. When a child is at a certain age, there just becomes a detachment if you're not around the child, you just generally don't have that love for your child. For me it was hard to feel. For many years I was empty and used drugs because I did not want to feel pain. I felt like what I experienced in my life would not allow me to love like I wanted.

Participant 4 made a connection between addiction and trauma.

> I had therapy to deal with depression and anxiety issues. The case workers at the program suggested that I receive therapy because my mom passed away in a car accident. They probably felt as though that I was not doing a good job coping which was part of my problem. I did drugs to cope.

All participants reported some form of environmental and interpersonal trauma. Participant 9 identified death and environmental stressors as traumatic experiences.

> It's a lot to deal with, because living in the ghetto, and dealing with the police, and dealing with the stuff that goes around is traumatic. And for you to even have other tragedies happen to you, I saw my boyfriend get shot in the head. That's a lot to deal with. And if you can't cope with it, you're gonna stuff it or pick up the pipe again.

Participant 9 shared about her mother passing and reestablishing a relationship with her father after resolving underlying emotions from the traumatic experiences of being without a mother at 20 years of age.

> My mom died when I was 20 years old. Me and my mom were close. My mom never done any drugs or anything. She was a single mom. My dad, he's still around. I just recently started talking back to my dad. I was able to let him know he hurt me. I finally told him that I felt like he abandoned me. It felt good to be communicate instead of keeping all the hurt inside. I learned a healthier way of coping with life problems and disappointments.

Theme 5: Aftercare and Maintenance

The fifth theme identified was aftercare and maintenance. Aftercare and maintenance subthemes identified were attending 12-step meetings, individual therapy, linking to supportive services, sober-living environments, and attending group therapy The participants who identified each aftercare support are shown in Table 6.

Table 6

Aftercare and Maintenance Subthemes and Participant Counts

	Subtheme				
Participant	12-step meetings	Individual therapy	Linking to supportive services	Sober-living environment	Attending group therapy
1			x	x	x
2	x			x	
3			x	x	
4		x	x	x	
5				x	x
6				x	
7		x	x	x	
8				x	
9				x	
10			x	x	

Aftercare plans focus on relapse prevention and monitoring triggers, cravings, and addictive behaviors such as dishonesty, toxic relationships/environments, and negative responses to reoccurring trauma. Aftercare is a supportive environment that participants have access to once they have completed a drug treatment program. Aftercare is not mandatory although participants are encouraged to attend. Treatment by itself is not enough; aftercare increases the probability of long-term recovery success.

All participants reported completing their rehabilitation programs and relocating into sober-living environments; however, most stated that they did not seek aftercare support. Participants were asked to identify posttreatment aftercare options available to them. Their responses indicated which aftercare options they sought to continue when they concluded treatment. Participant 1 reported being linked to supportive services, attending groups, and living in a sober environment: "Yeah, well, they assisted me with further treatment if I did need it. They assisted me with housing. They assisted me with childcare for my kids, if I needed it. And that's about it, basically." Participants 2, 6, 8, and 9 identified nothing other than living in a sober environment. Participant 2 reported attending 12-step meetings and living in a sober environment. She noted the importance of attending meetings.

> When you go to the meeting you get to actually sit down and hear about other people that has a disease like you, and also let you know that you're not the only one going through it, and it just helps you understand that it happens. And it's up to you to believe and achieve what you can strive to stay focused in. I feel like I gotta go be around other people like me. I have to. 'Cause it's a disease, it sucks. 'Cause it calls me, it calls me all the time. I ain't going to lie.

Participant 4 identified living in a sober environment and being linked to supportive services.

> They will eventually help you once you've completed the program. Then yes, they do help you go to school, work, you know, they help you get your bank account, library card, all this stuff that's required of you. And then housing, stable

> housing, especially if you were reunified with your kids. Or if not, you can stay to help continue trying to be reunified with your kids.

Participant 5 reported living in a sober environment. She shared her thoughts on being cut off from services one treatment has been completed. She also provided her opinion on what aftercare is lacking and how it could improve.

> Once you graduated, that's it. You're cut off. I need someone to come here once a month to ask "Is there anything you need? How are you doing? Do you guys have any issues?" And then from there, if you had an aftercare worker like that for families after the program, that's like the best idea, you know. It's after the program. A person might say, "Oh, you know what? I need some therapy for myself" or "I'm feeling this way." Then they kind of get an idea of "Okay. Well after these families are transitioned out of a program, we still got problems. You have some people who have been out there and on drugs for 10 years, 15 years, so if a program is timing you out, letting you graduate when they have no business to, which happens in a lot cases after a year and a half or two years, it's hard to think you're fixed from 15 years of use, 10 years of use, in 2 years through a program."

Participant 6 reported living in a sober environment and did not seek aftercare services. Participant 7 reported living in a sober environment and being linked to supportive services. She described the benefits of attending treatment and the types of supportive services she was given.

> The drug program was extremely beneficial because of the fact that they pretty much give you a lot of different assessments in trying to figure out where you are in your life. They try to help you get some type of computer experience under your belt and help you go back to school.

Participant 8 reported living in a sober environment and did not seek aftercare services. Participant 9 reported living in a sober environment. She admitted wanting to attend a 12-step meeting once a week but cannot seem to commit.

> I should attend 12-step once a week, but I don't. I have a new baby. It's not an excuse, but I told myself I would work on that, do it a little bit more. Not just do the same thing at home. I told myself I need to work on that.

Participant 10 reported living in a sober environment and being linked to supportive services. She explained her positive experiences with supportive services:

> They help you with transportation if you need to take a baby to the hospital, or you need a taxi to go take care of your business, or even if you need to sit and talk in that moment. They were good. They helped me a lot. It was really cool.

Summary

I presented findings from the present study in this chapter. The themes that emerged from the face-to-face interviews reflected women's experiences with substance abuse addiction, their abuse and trauma histories, and the challenges of abstaining and maintaining sobriety in their sober-parenting efforts. Significant deficits in the area of accessing aftercare and maintenance were identified and could be linked to and consistent with higher rates of relapse and short-term recovery noted in studies reviewed in Chapter

2. These results are critical for macrolevel administrators and policy makers due to the high rate of relapse among mothers and likelihood of recidivism in the child welfare system. In Chapter 5, I present a discussion of these findings. I discuss the significance of themes noted in Chapter 4, and I compare similarities and differences between these findings and the literature view findings.

Chapter 5: Discussion, Conclusions, and Recommendations

In this study, I provided family reunification experiences of 10 sober-parenting women with 2 or more years of sobriety. Each participant met the study criteria and was in various stages of recovery. The participants identified several stages or themes associated with substance abuse or addiction recovery: (a) choosing to remain sober, (b) cultivating and connecting, (c) trust and discovery, (d) trauma history, and (e) aftercare and maintenance. While there is a substantive amount of gender-specific research about substance abuse disorders among men (Baird, Campanaro, Eisele, Hall, & Wright, 2014; C. A. Green, Yarborough, Polen, Janoff, & Yarborough, 2006), challenges of trauma and drug addiction among women needed to be explored.

The purpose of this qualitative phenomenological study was to explore post-substance-abuse recovery challenges among women with trauma histories and their experiences of family reunification and sober parenting. My intention in this study was to inform the systems of care and add to the body of research regarding the stages of recovery leading to family reunification of sober parenting women with similar situations, context, and conditions. Studies about substance abuse and trauma confirm the likelihood of relapse is greater for single-parenting women and is often the cause for foster care recidivism (Carnochan et al., 2013; Martin & Aston, 2014; Mendoza, 2013; Zeoli et al., 2014). Sobriety is more likely to be maintained long term among sober-parenting women through integrated treatment models and reunification-specific services.

The seeking safety model frames the stages of achieving sobriety and recovery in the context of cognitive, behavioral, interpersonal, and case management practices. Topic areas are key features emphasizing participant contribution toward their recovery and treatment. Table 7 shows the themes found in the data and how they align with the four seeking safety content areas.

Table 7

Study Themes and Seeking Safety Content Areas

	Content area			
Theme	Cognitive	Behavioral	Interpersonal	Case management
Choosing sobriety	x			
Cultivating and connecting	x			
Trust and discovery			x	
Trauma history	x	x	x	
Aftercare and maintenance	x	x	x	x

All study participants identified all four seeking safety content areas (cognitive, behavioral, interpersonal, and case management) positioned in the context of choosing to remain sober, cultivating and connecting, trust and discovery, trauma history, and aftercare and maintenance. All 10 participants shared their experiences of choosing a sober lifestyle while simultaneously practicing recovery and attaining reunification with their children. Each participant provided an in-depth look into her addiction and the

process of recovery and family reunification. Participants identified challenges with family, trust, unhealthy attachment, setting boundaries, self-respect, forgiveness, gaining control, and minimizing exposure to substances. Findings in this study indicated that participants were willing to share experiences to help encourage each other and were transparent about their recovery, coping, and readiness for reunification. Participants were often traumatized by their environments, and most did not seek aftercare recovery supports. Participants used safety as a coping mechanism to deal with triggers of their co-occurring disorders. Participants who were ready for reunification reported that sober parenting was an adjustment, and it took time to reestablish trust with their children. Participants who were not ready for reunification reported complying to treatment just to get their children back often resulting in their children being taken away multiple times for issues of neglect. Other participants reported surrendering their children to relatives because of overwhelming feelings of being an unfit parent

Interpretation of Findings

These interpretations are based on my analysis of the data by applying open and axial coding. I used horizontalization to better define the identified themes for analysis. I highlighted noteworthy statements, sentences, and quotes that would provide an understanding of how participants experienced the phenomenon. This allowed me to look for and examine distinct concepts and categories. Once I was satisfied with the emerging themes, I then proceeded to break down the content into master themes and subcategories of what the participants experienced and the setting that influenced the phenomenon.

Next, I revisited emerging themes to confirm that the concepts and categories were representative of common experiences as described by participants.

The aim of this study was to explore post-substance-abuse recovery challenges among women with a history of trauma and their experiences of family reunification. Herman's (1992) theory of trauma and recovery maintains that those affected by trauma are often disempowered, disconnected, and struggle to form healthy relational attachments. A review of the literature indicated that individuals with drug addiction histories experience multiple traumatic events in their lifetime and often find it difficult to establish boundaries or engage healthy interpersonal relationships (S. Brown et al., 2013; Ungar, Liebenberg, Landry, & Ikeda, 2012) and are unlikely to maintain a sober-parenting lifestyle (Martin & Aston, 2014; Mendoza, 2013; Taylor, 2010). Some participants in this study reported multiple traumatic experiences leading to addiction while others reported abusing substances to cope with past trauma.

The seeking safety theory is grounded in the trauma and recovery approach and combines concepts of substance abuse and complex trauma. Principles of seeking safety include helping clients stop all self-harm, gaining control over symptoms, eliminating dangerous relationships, and developing self-care (Morelli, n.a.). The seeking safety model frames the stages of achieving sobriety and recovery in the context of cognitive, behavioral, interpersonal, and case management practices. Through participation in this model of recovery, people can learn how to free themselves of negative emotions and behaviors influenced by trauma and addiction. The following sections are the findings reflective of the themes and subthemes found in the study.

History of Trauma

Six subthemes of trauma history were identified that reflected various types of trauma participants were exposed to: death, domestic violence, molestation, rape, incarceration, and environmental trauma. All study participants reported trauma experiences either prior to or during their substance abuse. They were not asked to describe their trauma experiences, merely to identify the types of trauma they were exposed to. However, in providing these identifications, some descriptions were offered. Some of the trauma experiences resulted in these women participating in high-risk behaviors. Others experienced depression and stress due to the loss of a parent. All stated that they have suffered from and encountered environmental trauma such as reexposure, poverty, and flashbacks. Participants stated that their ability to sober parent depended on their capacity to cope and free themselves from negative behaviors resulting from substance abuse and complex trauma, therefore allowing a stronger connection and attachment with their children. Environmental trauma was identified as a subtheme of trauma histories. All participants were exposed to trauma when returning to their environment. Participants reported that although they were living a sober lifestyle, they would often come in contact with people or situations that would remind them of the life they used to live. Environmental trauma has been identified as a high risk factor that can challenge recovery and may interfere with seeking safety practices and sober parenting (Harwin et al., 2013). Participant 7's description of her experience of walking her son home from school is an example of the environmental trauma study participants have experienced.

> The neighborhood where we lived was bad. I would walk to go get my son because I didn't have no money to catch the bus. When I walked down the street I would see needles and broken pipes in trash cans and in the street. I would become sick to my stomach.

Aftercare and Maintenance

Five subthemes of aftercare and maintenance were identified that describe the types of services participants had access to after completing substance abuse treatment: 12-step meetings, individual therapy, linking to supportive services, sober-living environment, and group therapy. All participants reported living in a sober environment. Their meaning of living in a sober environment is not connected to sober housing; it represents living a sober lifestyle in their homes and relationships. Study participants also noted differences between supportive services and aftercare services. Participants 1, 3, 4, 7, and 10 reported being linked to supportive services such as childcare, transportation, and employment during the transition from their drug treatment facilities into their sober-living environments. Findings also indicated that study participants had minimal interest in continuing individual therapy or attending 12-step meetings or group therapy. While some participants stated that these supports were not helpful, the following comments from Participant 6 reflect barriers to participating more than issues with the supports themselves.

> We are encouraged to attend meetings once we complete treatment but that don't work. It's hard to get to meetings when I don't have a car or baby sitter. All my kids done been through I can't leave them with anyone. Their meetings don't help

> me because I can't get there. It would be better if they had someone come over to talk with me about how I can be a better parent and stay sober for me and my kids.

The lack of interest in aftercare services is significant. It illustrates the relevance of recovery-specific aftercare services and could be considered a risk factor to relapse and sustainability (D. Brown, 2016). Participant 5 reported that supportive services do not continue beyond treatment as she was cut off from services. She expressed the need for long-term services to assist with adjusting to sober parenting.

Choosing Sobriety

Four subthemes of the theme choosing sobriety were identified: minimizing exposure, discontinuing substances, letting go of unhealthy relationships, and gaining control. All participants reported discontinuing substances and completing treatment. Participants viewed discontinuing substances as a priority and understood it as a condition of being reunified with their children. While all participants reported discontinuing substances and complying to mandated treatment, Participant 6 noted that reuniting with her children was her sole intention for complying with and completing treatment. Participants' efforts in minimizing exposure were limited to their sober-living environments and letting go of unhealthy relationships. Participants' meanings of gaining control were illustrated by their ability to complete treatment. Choosing sobriety is a cognitive response to a commitment to action. Participants identified meaning, value, and beliefs as catalysts for a recovery lifestyle. They reported gaining control over their addiction only after learning how to cope with uncomfortable feelings of anxiety and

depression. The act of choosing to remain sober is an acknowledgment and acceptance of actions that cause positive or negative consequences. It is about learning self-control strategies leading to functional behavior, identifying beliefs, and restructuring of ideas. Participants learned how to cope without using substances.

Cultivating and Connecting

Four subthemes of the theme cultivating and connecting were identified: asking for help, sharing experiences, reconnecting, and coping. All participants reported that sharing their experience with others and the ability to reconnect with their children as meaningful. Participants found it difficult to ask for help once reunification occurred. Their ability to ask for help was likely hindered by a need to be seen as strong or independent. Other reasons participants may not have asked for help may reflect trust violations in their past such as childhood molestation or learning that asking for help led to punishment, isolation, or withdrawal of love by a parent, family member, or friend. When participants shared stories about successful reunification, they commonly spoke about the challenges of cultivating and connecting. However, they also reported cultivating and connecting as beneficial coping mechanisms and necessary for recovery and reunification. Substance abuse recovery is both individual and community oriented. Healing takes place in the context of relationships (Herman, 1992). Therefore, individuals practicing recovery are encouraged to ask for help while seeking and maintaining healthy friendships and boundaries.

Trust and Discovery

The theme of trust and discovery describes participant vulnerabilities regarding reunification and sober parenting. Four subthemes of the theme trust and discovery were identified: honesty with self and others, not ready for reunification, adapting to sobriety, and sober parenting. Most participants reported honesty with themselves and others as the beginning of recovery. Achieving sobriety can be intimidating. Participants 2, 3, 6, 8, and 10 said they were not ready for reunification. Expectations of sober parenting while maintaining a recovery lifestyle can feel overwhelming and unattainable (Barrow, Alexander, McKinney, Lawinski, & Pratt, 2014).

When looking at their role of sober parenting and being reunified with their children, some participants reflected on their prior substance abuse or addiction and expressed feelings of uncertainty about their roles. In reflecting on her past, Participant 10 said,

> Doing me is doing a lot of drugs, hanging around the wrong people, stuff like that. In the back of my head I said, "I'm not a good mother and everybody is going to know that I have a cocaine problem."

Participant 6 talked about being uncertain about being reunified with her children.

> I just was not ready. The fear of not being ready would mess me. I would be like, well I already finished this or whatever, I just want my kids back. And then I got the kids back and didn't how to deal with them.

Study participants discussed interpersonal issues such as supportive people versus destructive people and getting people to support their recovery efforts. Substance abuse is

often courted and perpetuated by relationships (Herman, 1992). Because of past traumas, participants reported interpersonal violence often invoking feelings of distrust and confusion in relationships. These feelings tend to make it look like participants find it difficult to bond with and form healthy attachments with their children when in reality they are protecting themselves from extreme relationship dynamics of overcompensation and enmeshment. Prior research suggests that women entering court-mandated substance abuse treatment programs are not being treated for both trauma and substance abuse (S. Brown et al., 2013), which may complicate the reunification process. Addiction and trauma-related issues can also impede the ability to complete treatment (Martin & Aston, 2014; Subica & Claypool 2014). However, findings in the present study suggested that participants with co-occurring disorders and domestic violence histories who lived in high-risk environments and who went through court-ordered treatment were more likely to complete treatment.

Limitations of the Study

I used nonprobability convenience sampling to identify women with 2 or more years of sobriety who reunited with their children, who had been placed in foster care. Nonprobability convenience sampling, by design, is subject to biases and errors. Because of participants' self-reports, reliability could not be determined, but data quality can be addressed by comparing results with available information about the targeted population. Participant selection from social service agencies was not easily achieved, so I placed recruitment flyers in public spaces frequented by the target population.

Because of the nature of this study, I was cautious about directly addressing trauma issues. To eliminate substantial risk, I used open-ended questioning that was sensitive to the topic and research question. During the interview process, I clarified participants' understanding of the questions and their points of view. To further clarify data interpretation, I scheduled times with participants for member checking. Reliability and validity of research questions were determined and approved by my dissertation committee before any data collection had occurred. Only women from one city in the southwestern United States who met participant criteria were interviewed.

Recommendations

All participants discussed reentering environments where they were reexposed to trauma. In addition, participants stated that supportive services such as child care, transportation, or vocational support were discontinued once they completed treatment and were living on their own. The discontinuation of supportive services, minimal participation in aftercare services, and reexposure to trauma are unique challenges associated with reunification and sober parenting. Akin et al. (2016) found that a lack of aftercare services was a main risk factor in compliance and sustainability, therefore indicating a need for continuing supportive services and trauma-informed, community-based case management practices addressing needs related to both trauma and addiction recovery.

Other researchers have found that participants who go through FDCs experience better outcomes than with traditional family reunification services (Carey, Mackin, & Finigan, 2012). While Casey et al.'s (2012) findings support better outcomes of

participants who complied with FDC requirements and who completed substance abuse treatment, most researchers have not considered or addressed the specific needs of sober parents and the types of supportive and aftercare services they need.

Results from the present study indicate that better aftercare practices are needed to support both reunification and sober parenting. While treatment can be effective, women in recovery who have trauma histories often experience multiple crises and relapse to substance use (Choi, MacMaster, Adams, & Morse, 2015; Gil-Rivas, Fiorentine, & Anglin, 1996). However, findings from the present study indicated that nine participants maintained their sobriety past 2 years with no new substantiated cases of maltreatment or neglect. One participant reported that she achieved 2 years of recovery; however, she relapsed and now has 1.5 years of recovery. These promising findings clearly justify the benefit of treating both the addiction and the trauma experienced by women who are sober parenting. A recommendation for further research is to explore the benefits of offering evidence-based treatment, outreach, and trauma-informed case management services in high-risk communities and participant homes.

Another recommendation is to conduct a program evaluation of substance abuse treatment facilities that receive FDC-mandated clients to further evaluate program delivery, continuity of care, and aftercare practices. A final recommendation is to provide resources and referrals addressing postreunification and recovery needs in the form of recovery support networking and that includes natural support systems. Recovery support networking identifies emotional, companionship, informational, and instrumental resources (Huebner, Young, Hall, Posze, & Willauer, 2017).

Implications

Findings from this study may further facilitate research in the area of family reunification and sober parenting. By examining sobriety and postreunification support challenges, social support providers may be better equipped to handle the needs of the parent and the needs of the addict. This study's findings helped to fill the gap in research regarding how women with histories of complex trauma experienced family reunification and sober parenting. Sober parenting depended on participant capacity to cope and free themselves from negative behaviors resulting from trauma to allow stronger connections and attachment with their children.

The study participants expressed that recovery does not end after they complete a substance abuse program, therefore suggesting continuation of services that address mental health and social support needs. Suitable aftercare services targeting after-treatment needs such as community mental health services, childcare, expungements, vocational opportunities, and transportation would promote long-term recovery and strengthen after care practices.

The study participants communicated that aftercare practices should focus on conjoint influences of sober parenting and family reunification. Positive social change is possible through addressing issues associated with recovery such as relapse, stressors, and coping and by targeting reunification issues such as housing, childcare, and transportation through providing services for strengthening aftercare and recovery support.

Extending supportive services to women in recovery is critical to the process and stabilization of family reunification. Lack of attention to the needs of reunified families and caregivers with trauma and addiction histories would likely result in continuing increases in foster care recidivism and long-term placements in the foster care system. Further research is needed to improve the FDCs' current approach to aftercare practices and the treatment facilities they contract with to deliver services. In addition, funding for strategically targeted aftercare services may increase aftercare participation and possibly reduce foster care recidivism.

Conclusion

The study participants believed that their postreunification needs were not met and that their primary needs were being inadequately served. Participants reported primary needs of postreunification support to be expungement, child care, community mental health services, recovery support networking, affordable housing, transportation, and creating family reunification facilities. The study results supported those of Akin et al. (2016) and Mendoza (2012), who noted that single sober-parenting women in recovery from substance abuse or addiction require gender-specific postrelease services and linkages. Once reunited with their children, participants in the present study expressed concerns about their abilities to ask for help, reconnect, and cope, confirming that sober parenting combined with a co-occurring disorder may predispose foster care recidivism (S. Brown et al., 2013; Twomey et al., 2010).

Other researchers have found that FDCs are improving retention rates in the child welfare system (B. L. Green, Furrer, Worcel, Burrus, & Finigan, 2009; Oliveros &

Kaufman, 2011). Retention rates are based on the number of women who complete mandated treatment through the FDC whose children remain in their custody once reunification occurs. The women in the present study attributed positive reunification and sober parenting experiences to a better understanding about themselves and their drug addiction.

The results of this study support the seeking safety recovery model and Herman's trauma and recovery theory, which suggest that individuals with trauma and substance abuse histories are vulnerable to repeated traumas, are dealing with unmanaged stress, and are hypersensitive to stressors (Herman, 1992; Najavits, 2015). The seeking safety model's primary goal is safety. The model identifies key stages of substance abuse addiction, mental health, case management and recovery. Herman's trauma and recovery theory addresses issues where addiction and trauma interconnect through unhealthy relationships, toxic environments, lack of natural supports, negative thoughts and actions, and higher stress perceptions.

Some participants in the present study stated that family reunification came too soon, and they were not prepared for it. Other participants reported that they were ready to be reunified with their children but needed more assistance with resources. Further research is needed to build on this study's findings and others to further understanding about the culture of recovery reunification and treatment outcomes for women with complex trauma and substance abuse or addiction histories. Furthermore, the findings identified the unique challenges specific to sober parenting and family reunification populations.

Implications for social change are grounded in a strength-based approach to improving family-level functioning beyond substance abuse treatment and family reunification. Within the framework of seeking safety and Herman's theory of trauma and recovery exists an awareness of the multifaceted treatment needs of sober-parenting women. Improvements to how FDCs identify and manage families being reunified combined with identifying recovery-based ideas and interventions may increase family reunification, support its sustainability, and decrease the likelihood of children being placed back into the foster care system.

Substance abuse addiction is not a construct, it is a variable. Changes in programing offered to women who are court ordered to attend a substance abuse treatment facility as a condition to have their children returned to them may need to be revised and replaced with evidence-based intervention models that target specific trauma-based issues and aftercare practices. Funding at the state and federal levels is needed to increase treatment attendance and retention rates through better programing, outreach, and engagement. The present study's results have the potential to influence how family reunification and sober parenting is being managed, leading to sustainable positive outcomes in the culture of gender-specific substance abuse recovery.

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Appendix A: Interview Questions

1.How many children were placed into foster care?

2.What linkages or referrals were you given that assisted you with receiving your children back into your care?

3. Can you talk about the process of family court and your relationship with your case worker?

4.Did you understand the process of family court and being mandated to attend a 30-day drug rehabilitation program?

5. What were the requirements set by the court that you had to meet prior to being reunited?

6. How is the relationship with your children since being reunified?

7. What if any obstacles did you encounter while seeking to reunify with your children?

8. Can you talk about the process of reunifying with your children?

9. How have you managed to maintain living a sober lifestyle since being reunified?

10. How often do you attend Alcohol Anonymous meetings?

11. Can you describe how sobriety influences or fits into you parenting lifestyle?

12. Since being reunified have you expressed any stressors that may trigger a relapse?

13. What kind of resources were you linked with after receiving your children back into your care?

14. What resources were most useful and how did you access them?

15. In your opinion did the 30-day rehabilitation program address issues of trauma that you associate with influencing the removal of your children?

16. What kind of support system do you have?

Appendix B: Demographic Questions

1.How many children do you have?

2.Do you or did you have children in the foster care system?

4.Is that child or children currently in your care?

5.Did you complete a 30-day drug and alcohol rehabilitation program?

6.What city do you live in?

7.What is your marital status?

8. What is your age?