ABSTRACT

SHAME, AND THE WAY IT IMPACTS THE RELATIONSHIP
BETWEEN MOTHERS WITH SUBSTANCE ABUSE
DISORDER AND CHILD WELFARE
SOCIAL WORKERS

It is estimated that between one third and two thirds of all child maltreatment cases nowadays involve substance use and studies indicate that child welfare social workers posses limited knowledge about substance abuse disorder (Child Welfare Information Gateway [CWIG], 2009). Social construction creates knowledge and determines what is considered good or bad, including substance abuse disorder and the individuals affected by it. Mothers with substance abuse disorder are stigmatized against and as a result they experience shame, which is a part of addiction cycle. The qualitative study utilizes methods of grounded theory to explore the way shame affect the relationship between mothers with substance abuse disorder and child welfare social workers. The findings indicate that child welfare social workers have the ability to either ease or contribute to women's feelings of shame, which in return affects mothers' reactions to social workers and the success of the child welfare case. Understanding the dynamics of shame and treating mothers with substance abuse accordingly is crucial for well being of children and families in the child welfare system.

Ksenija Norris
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SHAME, AND THE WAY IT IMPACTS THE RELATIONSHIP BETWEEN MOTHERS WITH SUBSTANCE ABUSE DISORDER AND CHILD WELFARE SOCIAL WORKERS

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Ksenija Norris

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We, the undersigned, certify that the thesis of the following student meets the required standards of scholarship, format, and style of the university and the student's graduate degree program for the awarding of the master's degree.

Ksenija Norris
Thesis Author

Kris Clarke (Chair)	Social Work Education
Virginia Rondero Hernandez	Social Work Education
Kathryn Forbes	Women's Studies

For the University Graduate Committee:

Dean, Division of Graduate Studies

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CHAPTER 1: INTRODUCTION

After being locked in the subconscious compartment of human psyche and human society, shame has become an intriguing and controversial subject of research (Brown, 2008). Shame is an allusive and under-examined concept. Shame's potency is in the secretiveness that surrounds it (Manion, 2003). Laymen and professionals alike often confuse shame with guilt. Though the two emotions may arise from similar situations, they have a very distinct impact on individuals (Benetti-McQuid & Bursik, 2005). Academia has a dichotomous view on shame and guilt. Some perceive them as positive emotions while others find shame to be damaging for the individual (Efthim, Kenny, & Mahalik, 2001). Most simply expressed, the differences between shame and guilt are that shame is an emotion of feeling poorly about one's self, while guilt is an emotion of feeling poorly about something that one has done (Wiechelt, 2007). Some researchers have found shame to be "the master emotion because no other emotion plays such a central role in affective, cognitive, motivational, and behavioral experiences" (Turner & Schallert, 2001, p. 320). Shame is far reaching and all-encompassing. Despite its importance in the human development, Western culture has proclaimed shame a taboo emotion, one that is better off left unexplored and unexamined (Wiechelt, 2007).

Shame and Substance Abuse Disorder

Habitual, internalized, chronic shame is linked with mental health problems, including substance misuse, mood disorders, schizophrenia, and borderline personality (Luoma, Kohlenberg, Hayes, Bunting, & Rye, 2008). Shame is a crucial part of substance abuse disorder (Wiechelt, 2007) and is

perceived as both the causal and the maintaining factor of the addiction cycle (Potter-Efron, 2002).

The importance of social work professionals understanding shame cannot be overstated since it affects and explains so much of the lived experience of the individuals with substance abuse disorder (Gray, 2009). Substance use is a deadly and devastating epidemic in the United States. Its consequences are far reaching and all encompassing. It affects more than just the individuals with substance use disorder; it also affects children, families, communities, and the society as whole. Whether aware if it or not, all the members of society pay a toll to this commonly misunderstood mental disorder. The Substance Abuse and Mental Health Services Administration (SAMSHA) reports in its national survey that

> combined data from 2002 to 2007 indicate that over 8.3 million children under the age of 18 (11.9 %) lived with at least one parent who was dependent on or abused alcohol or an illicit drug during the past year. (SAMSHA, 2009, p. 1)

According to SAMSHA, out of these children about 3.4 million lived with a mother who had a substance use issues. It is estimated that between one third and two thirds of all child maltreatment cases nowadays involve substance use (Child Welfare Information Gateway [CWIG], 2009). In addition to the immeasurable emotional cost, substance abuse disorder has a very real financial price as well. It is estimated that the United States spends more than $24 billion annually in addressing different facets of substance misuse (CWIG, 2009). According to CWIG, almost $5.3 billion of those expenses are specifically allocated toward child welfare costs related to substance abuse disorder. So, even

those members of society who are ignorant about the substance use hardships are affected by the torment of addiction.

Substance abuse disorder is often connected with physical and mental impairments, domestic violence, limited resources, troubles with the law, and estrangement from support networks (CWIG, 2009). Families in which primary caregivers have problems with substance abuse disorder face further challenges of increased stress, unemployment, and lack of nourishment, hygiene and nurturing relationships (CWIG, 2009).

Substance Abuse Disorder and Social Workers

Child welfare social workers daily interact and try to assist families and children whose lives are affected by substance abuse disorder. And yet studies indicate that social workers posses limited understanding and knowledge about substance use disorder (CWIG, 2009). In addition to the lack of comprehension about the clients with substance abuse disorder, social workers are perceived to have negative attitudes and responses toward them (Amodeo & Fassler, 2000). These negative reactions include but are not limited to stereotyping, failure to refer clients and pessimism about clients' prognosis (Amodeo & Fassler, 2000). Studies show that social workers often display negative perceptions of parents of children in child protective services by being "unsupportive of parents' efforts to be permanent resources for their children" and by "pushing adoption for children in care" (Alpert & Britner, 2005, pp. 35-36). Amodeo and Fassler found that additional training on substance abuse disorder and increased understanding of the matter help improve the attitudes of helping professionals, including social workers, toward individuals with substance-related conditions.

Social workers are not the only ones with limited knowledge and negative attitudes toward individuals with a substance use disorder. They are accompanied by other helping professionals such as nurses (Lovi & Barr, 2009) and doctoral level mental health clinicians (Kelly & Westerhoff, 2010). And these stigmatizing attitudes are not common only in the United States; various studies indicate that they are a part of an international and a global issue (Lovi & Barr, 2009).

Stigma and Substance Abuse Disorder

Stigma can be understood as a mark of an individual who is being perceived as undesirable and different from the general "normal" society (Semple, Grant, & Patterson, 2005). Simply put, stigma is a social manifestation of disgrace. It is designed to expose "something unusual and bad about the moral status of the signifier" (Goffman, 1963, p. 1). Historically, stigma used to refer to the physical mark, mainly a bodily deformity of some sort, but has over time taken a more symbolic meaning of social deviance It is shown that stigma results in "discrimination, rejection, ostracism, ridicule, prejudice, discounting and discrediting of stigmatized individuals" (Semple et al., 2005, p. 368). By definition, stigma and shame are deeply connected. While stigma largely represents social discrediting and perceived unworthiness of an individual, shame can be understood as an individual's discrediting and perceived unworthiness of herself. Social stigma can further increase the burden of shame. As mentioned, individuals with a substance use disorder are at the receiving end of social stigma. For those with addiction, stigma is not just an abstract symbol, it is a lived experience, which is marked by limited opportunities in employment, housing, health care, and social relationships, to name a few (Luoma et al., 2008).

There appears to be a conflict between the way science, popular social beliefs and institutions deal with addiction and its many aspects. Research suggests that addiction is a mental disorder and therefore, it should be treated as an illness. Addiction is defined as "a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences" (National Institute on Drug Abuse [NIDA], 2007, p. 5). According to Dr. Nora Volkow, addiction is comparable to other diseases that affect internal organs, such as heart or lung disease. As any other disease, it is preventable and treatable (NIDA, 2007). But in reality, substance use disorder is more commonly associated with crime, moral failure, sin or a simple matter of choice (Room, 2005), and is perceived and treated much differently than a heart or kidney disease. Individuals with substance use disorder are not viewed as patients who need medical attention; instead they are punished for their disease. This lack of congruity between science and everyday practice causes further disenfranchisement, alienation and discrediting of already vulnerable individuals (Goffman, 1963).

Sadly, persons with addiction are not stigmatized and shunned just by the general, misinformed public. Helping professionals from different fields of practice who are well versed in theory also subscribe to this pejorative and discriminatory outlook toward individuals with substance use disorder. While the National Association of Social Workers (NASW, 1996) upholds values of social justice, dignity and worth of the person and importance of human relationships, social work practice doesn't always meet those standards. Few years of learning theory in pursuit of advanced degrees are easily trumped by the primal values, beliefs and emotions learned in social worker's childhood. Social workers' minds are battlefields in which professional and societal values

collide. Society's norms and unattainable expectations of its members take a toll on everyone (Brown, 2008), helping professional as well as client. Social workers and the organizations they represent all exist within the social framework. All members of society are, even if unknowingly, a product of the culture and times. When professionally prescribed and socially accepted values clash, shame raises its ugly head.

Social Constructionism

Discussing stigma, or the difference between the socially normal and accepted and the abnormal and unexpected brings up the inevitable question of who, and according to what standards, defines what is normal. Words such as good, bad, and relevant are value terms (Heiner, 2006). Their meaning can be identified only within a context of culture, history and personal values and experiences. So what is bad or good is a rather subjective matter of interpretation. In order to understand stigma and the way societal values are developed, one must examine the way knowledge is constructed.

What is known is often determined and defined by science. Among sciences, one can distinguish between "hard" natural sciences and "soft" social sciences the latter of which the principles of social work are based (Heiner, 2006, p. 1). Social sciences are considered to be more subjective and prone to interpretations compared to the "hard" sciences. Both branches are created by the loudest voices in the society. Not all voices are audible; some voices of society are silent. They are not invited to contribute to the creation of knowledge; instead they are hushed and ignored. So the existing body of knowledge is censored by the simple fact that it is created by the governing group in control of resources. The experiences of the disenfranchised are generally not included in

the realm of normative knowledge. Parton and O'Byrne (2000) stress the need for the field if social work to listen to the multiple voices and to be open to the possibility of multiple understandings of the world. To be effective, social workers must share in the knowledge of their disenfranchised clients.

Research

This research explores experiences of shame of mothers with substance use disorder. The objective is to allow the unheard voices to narrate and help construct the existing realm of knowledge. The specific objective of the research is to identify sources of shame in women's lives, as well as their sources of support. The ways in which social workers may contribute to or help feelings of shame in women's lives is of special interest for the study. The interviewees' narratives are transcribed and the recurring themes are extracted while preserving as much as possible of women's original narratives.

The interviewed women were, at the time of research, residents of a California's Central Valley substance abuse treatment program. The treatment program uses a holistic approach to better meet the needs of mothers and pregnant women with substance use disorder. The program has a 90-day and a 120-day treatment track. It also provides transitional, after-care treatment. In order to better address all of the issues substance use lifestyle brings, the treatment program offers anger management, domestic violence, relapse prevention, parenting and self care classes, just to name a few.

This chapter introduced the main issues that concern the research. Shame, stigma of substance use, social constructionism and how they're all interconnected will be further examined in the upcoming chapter.

CHAPTER 2: LITERATURE REVIEW

The previous chapter established some of the main principles the study explores, such as relationship of shame and substance abuse, and how they impact the individual and the community. The literature review chapter further explores the contemporary research and the current understanding of the discussed phenomena. It further explains concepts of shame, stigma, substance abuse, and social constructionism and how they all interact. The literature review chapter lays the theoretical ground for the study.

Constructionism

In order to fully grasp the very personal impact shame has on an individual, one must widen her or his focus and examine the way all knowledge is created. The greater cultural forces are at play in a life of every member of society. The existing body of knowledge, which is often taken for granted, can be questioned and challenged. Some argue that all that is known is a subjective interpretation of reality (Parton & O'Byrne, 2000). These scholars claim that certain singular universal truth does not exist and that all versions of truths are in the eye of the beholder. This view of multifaceted reality and knowledge is coined social constructionism (Heiner, 2006). Constructionism is a part of a postmodernist school of thought, which was born in response to modernist claims that Truth, the essence of things, exists independent of the social context and the understanding of the observer. Modernists believe in order, one neutral independent Truth, and "universal categories and neutral rationality" (Parton & O'Byrne, 2000, p. 21). As modernist explanations of reality failed to describe the changing times lacking in proposed stability and security, new thoughts

emerged questioning modernist claims and providing alternative explanations (Jokinen, Juhlia, & Pösö, 1999).

Postmodernism can be understood as "modernity coming to its senses emancipated from false consciousness" (Parton & O'Byrne, 2000, p. 21). Postmodernism is characterized by "falling away of traditional values, and the loss of confidence in the grand narratives of the past-a trust that governments, economic planners, or scientists, for example, can lead us toward a better future" (Gergen, 1999, p. 195). Postmodernists rebuke the artificial claims to stability and order and instead, they embrace the plurality of things, the uncertainty of life and the lack of all guarantees (Heiner, 2006). Social constructionism stems out of this transitional state of postmodernism (Gergen, 1999).

Constructionists ask basic questions about reality. They ponder about how anything is known and if there is such thing as objectivity (Heiner, 2006). Constructionists don't believe in the inherent nature of things, instead they claim that anything can only exist within the contextual framework (Parton & O'Byrne, 2000). Constructionists further claim that knowledge is created through interactions between people and that outside social framework of knowledge ceases to be relevant. They test modernist beliefs in universality of the truth against multiple realities of non-dominant groups (Parton & O'Byrne, 2000).

One of the most important constructionist claims is that "the ways things are said are more important than the possession of truths" (Parton & O'Byrne, 2000, p. 22). Examining of language and the way things are named and explained is crucial in understanding the realities of individuals and societies alike. Parton and O'Byrne further explain that language creates phenomena, which, without the social context would not even exist. These concepts include accuracy, political correctness, racism, ableism or sexism. In a society, language determines

the value of ideas, things and people (Parton & O'Byrne, 2000). Social constructionists question the correspondence theory of language, which refers to the "words corresponding to world as it is" (Gergen, 1999, p. 20). Language also has a power of creating action. So, according to social constructionists, the tongue, and the mind behind it, can define and alter reality for the masses (Parton & O'Byrne, 2000). Constructionists stress the fact that not all voices in society are heard (Jokinen et al, 1999). It is that often the loudest, most powerful ones get to create knowledge and cause action. Lee (2001) suggests that members of non-dominant groups are customarily not allowed to represent, decipher and express their reality. In this way societal powers discriminate against certain truths, while they favor others. Oppression deepens as the stories of the oppressed and disenfranchised minority groups are stifled and the individuals are not able to name their reality (Lee, 2001). Gergen (1999) argues that social constructionists attempt to remedy this historical trend by including first-hand accounts of disenfranchised individuals, such as women and people of color. Social constructionism confronts the "scientific description" with a 'profane language of the street" (Gergen, 1999, p. 95).

Constructionist View of Social Problems

Constructionist concept that whatever is commonly considered as good, relevant or bad can be questioned, guided this research. As mentioned in the first chapter words like "good" or "bad" are charged with emotions and judgments and are not in the least objective or valueless (Heiner, 2006).

Social work practice and experiences of shame for women with substance use disorder can both be observed through social constructionist lens. Principles of constructionism compliment the field of social work as they underline

oppression and the privilege of dominant group to control the knowledge and the physical resources (Jokinen et al., 1999). Social constructionism also emphasizes the importance of acquiring knowledge through human relationships and efforts to challenge the status quo (Jokinen et al., 1999). According to constructionist thoughts, there is no ethereal essence of social work; instead there is a prescriptive subjective practice. This is evidenced by phenomena, socially defined as problems, being the focus of social work. Constructionists raise questions of what social problems are and who defines them as such. Heiner (2006) explains that social problems are considered as problems because the privileged, governing group says that they are. He explains that taken-for-granted beliefs about what is good or bad in society, have historically been defined and enforced by the governing class, which used language to influence the way different phenomena are viewed (Heiner, 2006).

Despite the natural goodness of fit, constructionist ideas are not always well represented and embodied in the practice of social work. It appears that the social work profession has abandoned the legacy and the school of thought it was built on (Reisch & Andrews, 2001). This is due to social work existing within a context of bureaucratic body governed by the dominant group. According to Galper (1980), social service agencies mimic the capitalist society they are a part of. Ironically, social work practice is driven by the laws, and values created and enforced by the power of White male privilege. Reisch and Andrews (2001) note that though the NASW Code of Ethics claims that social workers challenge injustice, the conversation about the existence of social classes has all but died in the field of social work in the United States.

Stigma

The sheer concepts of good and bad elicit the idea of stigma, introduced in the first chapter. According to Goffman (1963), stigma is a sign, or a mark that indicates moral failing and abnormality of a person. He explains that this sign is perceived to be an innate part of an individual; it is something inside of them that sets them apart from the rest of society. Stigma is not just a theoretical concept, idea or an attitude. Stigma contains "both extreme negative perceptions and social rejection of the marked individual" (Sallmann, 2010, p. 147). This concept is crucial when explaining the power differential in the society. Even though the stigmatized groups may have negative views and attitudes toward the "regular" population, they do not have the power to stigmatize against them (Link & Phelan, 2001). As explained, stigma includes the attitudes as well as the power and the will to disallow someone the access to resources (Sallmann, 2010). The underprivileged and stigmatized populations can't stigmatize against the dominant groups because they do not have the power to withhold resources.

Goffman (1963) explains that term stigma is used to "refer to an attribute that is deeply discrediting, but it should be seen that a language of relationships, not attributes is really needed" (p. 3). His statement echoes the previously discussed concepts of constructionism. Goffman emphasizes the importance of language and the importance of human relationships. As previously discussed, words serve as catalysts to attitudes and actions (Parton & O'Byrne, 2000). This is especially true with language related to stigma. What something or someone is called by the dominant culture determines their very value and nature (Heiner, 2006). Link and Phelan (2001) explain that "dominant cultural beliefs link labeled persons to undesirable characteristics—to negative stereotypes,"

consequently, "labeled persons are placed in distinct categories so as to accomplish some degree of separation of us from them" (p. 367).

As language assigns values, no single phenomenon can be automatically seen as stigmatizing (Room, 2005). Instead, it is the meaning that society assigns through relationships and language to phenomena that makes them stigmatizing or not. So for example, depending on the societal and historical context smoking opiates can be perceived as pathological and therefore open to stigma, as is the case in present-day the United States of America, or it can be seen as socially acceptable and normal, as was the case in the not so distant past of the same United States of America (Heiner, 2006). The idea of normalcy also opens itself to scrutiny. Who can be considered normal? Goffman (1963) explains that "those who do not depart negatively from the particular expectations at issue" shall be called "normals" (p. 5). Standing out of the sea of normalcy can mean many different things in different societies. Traditionally, in the United States, not being English speaking, White, male, financially secure, heterosexual, with formal education, a house, and children made one stand out and ultimately be open to scrutiny, disenfranchisement and stigmatizing (Lee, 2001).

Stigma and Substance Abuse

Individuals with substance use related problems are widely stigmatized by the modern culture (Corrigan, Watson, & Miller, 2006). Those individuals are ostracized by the general population, as well as the professionals who are meant to help them (Lovi & Barr, 2009). Stigma is an unbendable force which deprives persons with substance use related issues of their humanity. Individuals with substance abuse disorder are faced with contempt and judgment, which create barriers and block their growth, recovery and prosperity (Semple et al., 2005).

Wiechelt (2007) explains that persons with substance use related problems are disadvantaged in more ways than one. Substance abuse carries natural consequences of its own and it can have devastating results, such as death of a user, criminal behavior, loss of family members and friends, loss of employment and material goods (Wiechelt, 2007). Individuals with substance abuse disorders are even further disenfranchised, disadvantaged and punished through social sanctions and by "being deprived of life, liberty and property" (Room, 2005, p. 147). The punishment is administered in a form of denial of social and economic opportunities (Luoma et al., 2008).

Substance abuse and substance dependence disorders are according to the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV-TR*), considered to be mental disorders and are a part of Axis I diagnosis (American Psychiatric Association [APA], 2000). NIDA defines addiction as "a chronic, relapsing brain disease" (NIDA, 2007, p. 5).

General public and some helping professionals do not perceive and treat substance abuse related disorders as medical conditions (Lovi & Barr, 2009). Substance abuse related disorders are still perceived as moral failings and the individuals affected by it are assumed not to be willing to stop their use (NIDA, 2007). Research shows that substances change the function and the physical structure of the brain and that the individual who is using is not physically capable of thinking and functioning as before her use (NIDA). NIDA explains that "the initial decision to take drugs is mostly voluntary," but "when drug abuse takes over, a person's ability to exert self control can become seriously impaired" (p. 7). The drugs affect the part of the brain responsible for "judgment, decisionmaking, learning and memory, and behavior control" (NIDA, 2007, p. 7). Still, despite the new technology that can literally show the

changes in the brain, society fails to change its treatment of individuals who use substances (Room, 2005). Room explains that in the United States substance abuse is still perceived as deviant criminal behavior instead of a health disorder.

Not all users are treated with the same societal contempt. More affluent persons who use expensive drugs, and especially White males, are less susceptible to scrutiny and judgment (Room, 2005). In fact, Room (2005) further explains, their drug of choice (i.e., cocaine or expensive alcoholic drink) can be perceived as a desirable status symbol. On the other hand, less affluent minorities using inexpensive, more harmful drugs are often additionally punished by society (Room, 2005). This is especially true for women who use substances (Sallmann, 2010).

Stigma, Substance Abuse and Gender

Women, in general, are an oppressed group in the society (Lee, 2001), and substance use disempowers them even further. One of the finest examples of a societal double standard can be seen in the case of substance use. Sallmann (2010) explains that women and men can display the same behaviors and they will be judged differently. When a man engages in socially inappropriate behaviors, "he is bad for what he does," and when a woman engages in the same behavior, "she is bad for who she is" (Sallmann, 2010, p. 146). So women are discredited at the deep level of their very being, and as Goffman (1963) noted, they are seen as "tainted and discounted" persons (p. 3). On the other hand, men's whole identities are not assumed to be flawed based on their socially inappropriate behavior.

Mothers and pregnant women in substance use are one of the most stigmatized groups in the society (Murphy & Rosenbaum, 1999). Murphy and

Rosenbaum further explain that "when people believe the hand that rocks the cradle would rather be smoking rocks, diverse constituencies unite in moral outrage and condemnation" (p. 1). It is a uniform societal view that a mother is supposed to take care of the children, and that the children's needs should be her priority (Murphy & Rosenbaum, 1999). In contrast to that, the brain of a substance dependent individual has one goal, and that is to find ways to maintain the addiction cycle (NIDA, 2007). According to Murphy and Resonbaum (1999) "being labeled an unfit mother has horrendous consequences of personal and social condemnation and social isolation" (p. 134).

Societal stigmatizing and devaluing of women who use substances is well represented in endeavors of The Meth Project. The Meth Project is prevention program geared toward preventing first time use of methamphetamines (Siebel & Mange, 2009). The project is implemented in eight states including Arizona, Colorado, Georgia, Hawaii, Illinois, Idaho, Montana, and Wyoming and its marketing has a nationwide reach. The Meth Project television, Internet, radio, newspaper and billboard ads are designed to deter youth from trying methamphetamine and the research indicates that the campaign has been successful (Siebel & Mange, 2009).

The images in the ads could be perceived as disturbing. They portray young adults, especially women, in situations that compromise their integrity, worth, even humanness. For example, one of the television ads titled "Sister" (The Meth Project Foundation, 2010) depicts two young sisters approaching a group of men on the street corner. The older sister appears to be 14 or 15 years old. She is portrayed as a meth addict and has bruises and cuts on her face. The younger sister is standing in the background and looks like she might be 12 or 13 years old. The older girl approaches the men and states that she would allow

them to do anything to her for $50. One of the men looks at her younger sister and asks if she is included in the price. The older sister looks back at her young, timid and scared looking sibling and answers, "Sure" (The Meth Project Foundation, 2010). The men and the two girls enter the public restroom and the last thing the viewer sees is the young sister standing in the corner while one of the men is starting to undress himself.

Another printed ad, titled "Sex" (The Meth Project Foundation, 2010) shows a teenage girl laying on her stomach and there is a partial view of a middle aged man mounted on her back. The ad is not explicit but it suggests that the man is copulating the girl. Her hair is in disarray and darkness circles the skin around her eyes. She gazes numbly in the distance as if removed from the reality of the situation. The script above the picture reads: "15 bucks for sex isn't normal, but on meth it is" (The Meth Project Foundation, 2010). Yet another printed ad, titled "Prostitute" (The Meth Project Foundation, 2010), shows a wall with flowered wallpaper and a framed photograph of a little girl. The girl is 7 or 8 years old with blonde hair and a sweet, innocent smile. The text reads: "Before meth I had a daughter. Now I have a prostitute" (The Meth Project Foundation, 2010).

These gruesome, troubling images may be effective in creating a negative image for methamphetamine use, but they are also successful in dehumanizing women who use methamphetamines. These young women are portrayed as unsightly, immoral, and worthless creatures. Ad after ad sends a message that these women and girls used to be someone of worth prior to methamphetamine use, but that the drug had stripped them of humanness, grace, and integrity. They are perceived as objects deserving of humiliation and disgust. These ads reflect the society's view of women addicts. The media just reinforces the societal

prejudice and stigma against the women with substance use lifestyle. Social workers and helping professionals are a part of society as much as anyone else and they are not immune to media strategies and persuasions.

Differences Between Shame and Guilt

Shame and stigma are closely related, but distinct concepts. While stigma is the world's negative view of an individual, shame is individual's negative view of self (Gray, 2009). They are interconnected and stigma can fuel and intensify individual's feelings of shame. According to Gilbert and Andrews (1998), "stigma has to be related to social values and social good," while shame can be experienced in private (p. 126). Brown (2008) describes shame to be a feeling none can evade. It is not the most popular topic for research or even for a friendly conversation (Brown, 2008). Members of Western culture have been brought up in the environment where vulnerability and sensitivity are considered to be character flaws (Wiechelt, 2007). One is supposed to be emotionally and mentally strong, proud and self-reliant. Emotions such as shame, openness, guilt, remorse or even grief are not experiences Western culture embraces and defines as a part of living (Wiechelt, 2007).

Shame just may be one of the most potent of all the taboo emotions humans experience. Brown (2008) refers to it as a "full-contact" emotion as it can invoke powerful "visceral and physical" reactions (p. 5). In Western culture, shame is an elusive concept. It has been suppressed to the point of not being identifiable any longer. Many are often not aware that what they feel is actually shame; instead they describe their feelings as disgust with one's self, insecurity or low self-esteem (Rahm, Renck, & Ringsberg, 2006). The fact that society refuses to acknowledge the presence of this complex experience does not make

its consequences any less powerful or damaging. To the contrary, not recognizing or hiding shame only amplifies its effects (Brown, 2008). Shame is a "silent epidemic" that overwhelms people and it is ignored, avoided and not spoken of.

As mentioned in the previous chapter, shame and guilt are "self-conscious emotions that also include embarrassment and pride" (Potter-Efron, 2002, p. 1). Shame and guilt are often mistaken and confused for one another. According to Potter-Effron, "the shamed individual laments 'How could *I* have done that?" while the guilty party asks "How could I have done *that*?'" (2002, p. 2). Shame is the emotion of worthlessness and feeling poorly about one's self, while guilt is the emotion about feeling badly about one's actions. Brown (2008) explains that there are no specific events that cause guilt or shame or embarrassment and that an event can cause one person to feel guilt while it will evoke shame in another (Tangney & Dearing, 2002).

Guilt is a more benign of the two emotions. In fact, a moderate dose of guilt can be healthy and helpful in one's life. Tangney and Dearing (2002) state that when feelings of guilt are unaccompanied by feelings of shame, they can help build relationships, increase responsibility, and promote socially acceptable behaviors. Guilt moves people to action. It mobilizes one's energies toward restitution and making amends (Potter-Efron, 2002). Individuals who feel guilty are likely to try to apologize, right the wrongs, or seek forgiveness in order to ease the discomfort guilt causes.

Shame is a masterful liar that can persuade individuals that their painful feelings of isolation, worthlessness and self-disgust are unique to them and are just another proof of their flawed nature (Gray, 2009). Feeling shame is shameful and people can experience devastating effects of this emotion just by listening to

someone share her own shameful experiences (Brown, 2008). Shame is hard to define and put into words, since it is an all-encompassing, debilitating state accompanied by different physical sensations (Benetti-McQuid & Bursik, 2005). Brown's chilling definition seems to sum up some of the most important and damaging aspects of shame: "Shame is intensely painful feeling or experience of believing we are flawed and therefore unworthy of acceptance and belonging" (Brown, 2008, p. 5). Shame is more than just feeling badly about one's self, it is feeling that something is so wrong with one's being that she is unworthy, undeserving of being loved (Gray, 2009). This feeling of dread, rejection and isolation fills every pore of person's existence and it guides her thoughts and actions. Unlike guilt, shame is a destructive and immobilizing emotion (Tangney & Dearing, 2002). It does not urge one to repair relationships and restore homeostasis, to the contrary it is paralyzing as it causes an individual to withdraw from society and sever relationships. Research shows that unlike guilt, shame often results in anger and interpersonal hostility (Tangney & Dearing, 2002). Though, anger and hostility are directed toward self, they can also be turned towards other who are perceived as judgmental and shaming.

Shame is a deep personal concept, but it can also be understood from systemic aspects. Shame is experienced when "failing to live up to socially prescribed behavior" (Efthim et al., 2001, p. 431). According to Efthim et al. (2001), the further an individual digresses from her or his socially prescribed role, the more shame and guilt he or she will experience. Since cultural expectations vary for men and women, shame can be understood through the lens of gender roles.

Shame and Gender Roles

Brown (2008) describes that "shame is organized by gender" (p. 18). Societal gender expectations that fuel shame are different for men and women. Women are found to be more prone to shame and men are found to me more prone to guilt (Manion, 2003). Manion further explains that this does not mean that men do not experience shame, or women guilt, but that women and men have different experiences and perspectives of the social world and social relationships. Men's sources of shame are different from sources of shame of women. Men are most likely to experience shame in "situations involving task failure and sexual potency, whereas women are more likely to experience shame about physical attractiveness and failure in relationships," especially mothering (Efthim et al., 2001, p. 431). Women tend to internalize their feelings of failure and externalize their successes, while men tend to do the opposite (Manion, 2003). Women are likely to attribute their successes to luck, positive circumstances or other people and not reward themselves for a job well done. They are also prone to blame themselves for perceived failures and punish themselves for personal inadequacies (Manion, 2003).

In fact, research has shown that shame and guilt are not necessarily dependent on the sex assignment within the population, instead they are found to be related to one's sense of gender role (Benetti-McQuid & Bursik, 2005). Efthim et al. explain that women's shame stems from personal sense of failing, the internalized ideal related to gender role, as well as from social disapproval. The combination of the two pressures results in feelings of shame. Men and women who subscribe to the values of a feminine gender role were more prone to experience shame than men and women who identified with a masculine gender role (Efthim et al., 2001). The values of feminine gender role include

interpersonal dependence and connectedness, and relationship building (Manion, 2003). It also condones independence and open expression of aggression and frustration. Because society condemns women openly expressing anger, aggression and disappointment, women often turn those emotions toward themselves (Manion, 2003). This internalization of negative emotions can lead to shame development in women. The further one appears to digress and vary from her socially prescribed gender role, the more she is prone to shame and shaming (Efthim et al., 2001).

Women, Substance Abuse Disorder and Shame

Research indicates that women with substance use problems "have experienced high rates of violence during their childhood and as adults" (Miller & Downs, 1993, p. 137). According to Miller and Downs (1993), the acts of violence include both physical and sexual abuse by parents and, later in life, intimate partners. Many of the women in substance use were victimized and brutalized from the earliest age. According to Murphy and Rosenbaum (1999), "basics, such as their right to control their own bodies, were violated through incest, molestation, rape and battering" (p. 130). Great numbers of women were removed from their families of origin and became dependents of the court, while others were forced into early emancipation (Murphy & Rosenbaum, 1999). Murphy and Rosenbaum suggest that these women were often faced with poverty, teenage pregnancy, homelessness, lack of education and chronic unemployment. These conditions often make it difficult for women to maintain themselves and their families, so some of them turn to illegal activities such as prostitution and drug selling in order to maintain their addiction (Taylor, 2010).

The described life experiences are a source of shame for women in substance abuse. In the research on violence against women, shame is understood to be an intense, far reaching consequence of physical and sexual abuse (Buchbinder & Eisikovits, 2003). Women who experienced childhood and domestic abuse feel marked, less than others and shameful. Unfortunately, these unresolved and hidden feelings of shame often prevent victims from seeking help, which perpetuates the cycle of abuse (Buchbinder & Eisikovits, 2003). Women in shame report feeling alienated, betrayed, inadequate, powerless, hurt, worthless and unworthy of love (Rahm et al., 2006). The unexpressed feelings of dreadful shame often cause women to seek escape from pain in substance use (Potter-Efron, 2002).

Once in substance abuse lifestyle, women are faced with unexpected new sources of shame. Substance abuse has its own repertoire of shame traps, such as domestic violence, prostitution, and child abuse and neglect (Murphy & Rosenbaum, 1999). This way shame becomes an instigator and a perpetuator of substance use (Potter-Efron, 2002). Women in addiction often break socially prescribed rules of femininity. These women are often perceived as self-serving, unfit mothers, and "sluts who deserve to be raped" (Wechsberg, Luseno, & Ellerson, 2008). They often internalize the public stigma and turn it into self-stigma, which induces shame (Sallmann, 2010). Shamed women believe that they are failures as mothers, daughters, wives and women in general. Most of the women in substance use have the same standards about mothering as the rest of society. They believe that "mothers should protect their children from harm, keep them fed, warm presentably dressed, and clean; and see that they are educated, prepared for the work world and shown right from wrong" (Murphy & Rosenbaum, 1999, p. 135). As previously mentioned, mothering is one of the

great sources of shame for women, therefore not being able to successfully fulfill parental role results in shame.

Women in addiction daily face stigma and are constantly reminded of their powerful feelings of shame. Being ostracized, humiliated and shamed by others reinforces women's feelings of unworthiness and shame (Gray, 2009). Women in substance use, especially mothers, are faced with anger and outrage of the general public and helping professionals as well (Murphy & Rosenbaum, 1999). Their feelings of deep shame often prevent them from seeking help, since they are afraid of being ridiculed and humiliated by professionals (Taylor, 2010).

Most of the pioneer research about shame was done using quantitative methods. Tangney has done much quantitative research with undergraduate students as participants (Tangney, Miller, Flicker, & Barlow, 1996). A considerable amount of research focuses on making distinctions between shame and guilt and it develops scales that help measure shame and guilt proneness (Tangney & Dearing, 2002). One of the developed tools is Test of Self-Conscious Affect (TOSCA) which is built on scenario-based measures (Tangney & Dearing, 2002). TOSCA is composed of 15 different scenarios, which help distinguish feelings of shame, guilt, and pride. Recently, qualitative research about shame has started to emerge, led by Brown. Brown's grounded theory study included women of diverse ethnic backgrounds between ages of 18 and 75 (Brown, 2006). There is still a limited number of qualitative studies developed on participation of individuals with substance abuse disorder, especially women. Since shame plays a crucial role in substance use, there is a need for a research that will allow for voices of women with substance abuse disorder.

The contemporary research and literature describes the overwhelming impact shame has in lives of women in substance use. Shame can often be a

reason for start of use, maintenance of use and evasion of treatment (Potter-Efron, 2002). It is crucial for social workers to understand and recognize the cycle and sources of shame in the lives of women with substance abuse related problems (Gray, 2009). It is even more important for social workers to understand how systems, which they are a part of, possibly exasperate the problem of shame for women they mean to help.

Child Welfare Social Workers, Women with Substance Abuse Disorder and Shame

According to Lee and Wheeler (1996), "shame is an interactive occurrence," which means that "potential for shaming is present in any relationship" (p. 315). As child welfare social workers and mothers with substance abuse disorder engage in interpersonal communication and relationships, "shame becomes an unavoidable occurrence" (Lee & Wheeler, 1996, p. 315). As discussed in the previous chapter, research shows that helping professionals, such as therapists, nurses or social workers, often have stigmatizing attitudes toward their clients (Alpert & Britner, 2005; Kelly & Westerhoff, 2010; Lovi & Barr, 2009). These stigmatizing attitudes create even greater possibility for occurrence of shaming. It is shown that mothers with substance abuse disorder are shameful and they often experience stigmatizing and shaming from various societal systems (Murphy & Rosenbaum, 1999). Women often "bring to each interaction the accumulated history and reactivity known as transference" (Lee & Wheeler, 1996, p. 315). Clients can react in previously formed patterns of behavior, which could be ridden with shame, at the same time helping professionals can "themselves be instruments of shame" (Lee & Wheeler, p. 316). The perception and feelings of shame are amplified in the relationship between child welfare social workers and mothers with

substance abuse disorder, because of power differential. According to Lee and Wheeler, the power differential, creates conditions under which, helping professional's "words or silence have much greater impact than those of a friend or acquaintance who occupies a more mutual position" (p. 316).

So, women's feelings of shame, their previous experience of shaming and stigmatizing, child welfare social workers' attitudes towards mothers with substance abuse disorder, and the undeniable power differential between them, creates a fertile ground for potential shaming within the relationship. Due to emotional and ethical weight and long-term consequences that relationship between child welfare social workers and mothers with substance abuse disorders have, it is important to explore the way shame affects the relationship and its participants.

CHAPTER 3: METHODOLOGY

This chapter discusses the methodological framework for conducting the research and collecting the data. The chapter also explains the actual procedures and steps taken toward performing the research.

Research Design

Qualitative research methodology, specifically the grounded theory model, was chosen as the most appropriate means to accomplish the purpose of the study. Grounded theory is used to "generate or discover a theory, an abstract analytical schema of a phenomenon, that relates to a particular situation" (Creswell, 1998, p. 56). According to Creswell (1998), the heart of grounded theory design is generation of a proposed set of relationships related to the studied phenomena. Grounded theory research starts with the observation of phenomena and search for patterns, themes and common categories (Rubin & Babbie, 2005). According to Rubin and Babbie (2005), grounded theory research is based on inductive process and is driven by the phenomenon and the researcher's interpretation of it. Glaser and Strauss (1967) state that "in discovering theory, one generates conceptual categories or their properties from; then the evidence from which the category emerged is used to illustrate the concept" (p.23). The advantage of grounded theory is its ability to generate comprehensive knowledge through researcher's involvement. Dey (1999) stresses that theories do not independently emerge; instead they are a product of researcher's critical thinking. Grounded theory was chosen as a model for this study because it allowed the researcher to explore diverse individual experiences as well as similarities of the shared experiences of women with substance abuse disorder who are also in recovery.

Research Participants and Participant Recruitment

The participants in the study are women with substance abuse disorders who graduated from a residential substance abuse treatment program and have been in recovery for at least two years. These women are all staff members at a women's substance abuse program in Central California. These particular participants are selected for the study because they have personally experienced the lifestyle and the consequences of substance abuse. Being triumphant in their recovery, and maintaining it for a considerable amount of time allows the women to have a mature insight and retrospective view about their feelings and experiences during the past times of active use.

The staff in recovery is also in a very unique position of being able to participate in interdisciplinary staffings and can observe the interactions between the women with substance abuse disorders are currently in the residential treatment and the child welfare social workers. The staff's position is unique due to the fact that they used to be recipients of the services and are now providers of the services. This creates the dual relationship with the child welfare system, which enables them to develop the insider/outsider perspective (Louis & Bartunek, 1992). This duality allows them to have a keen understanding and observation of the client-social worker interaction. Finally, the selected participants have the ability to speak of experience with shame in recovery, and if and how, it impacts their lives today.

The concept of empowerment was one of the guiding principles when choosing research participants. According to Linhorst (2006), "the potential for empowerment through participation in research increasingly has been recognized for people with mental illness and others" (p. 244). The empowerment can be facilitated through participants' ability to tell their stories

and also by being able to influence policy and practices that impact them (Linhorst, 2006).

The participants for this study were selected through a non-probability, convenience sample of staff from the substance abuse treatment for women in Central California. The units of analysis are individual interviewees. The researcher formally asked for access and cooperation from the program in order to conduct the study. After reviewing the study proposal, the administration of the treatment program had provided the researcher with the approval letter which allowed her to conduct the study and interview staff on agency's premises.

The researcher provided the agency's director with the informational flyers about the research study, and the director distributed them to the eligible staff. Interested parties were able to contact the researcher in order to get more information and schedule the interview.

Study Procedures

The one-on-one interviews were conducted at the confidential area at the agency where each participant was granted full privacy. The participants in the study were interviewed about their experiences of shame during the times of their active use and while in recovery. The interviewees were asked the following questions:

a) How has shame affected your life during the times of your active drug use?

b) In what ways have social workers contributed to or helped you with your feelings of shame?

c) How did you respond to these social workers? What did you think and feel?

d) How do you perceive interactions between your clients and their social workers during staffings?

e) How do you see your clients respond to social workers? Do they share their thoughts and feelings with you?

f) How do you experience shame now that you are in recovery?

g) Can you please explain how your environment is contributing to or helping your feelings of shame now that you are in recovery?

The interviews lasted no longer than one hour. Upon the participant's consent, the interviews were recorded using a voice recorder.

Data Analysis

The information collected during the interviews was analyzed using grounded theory methodology. The process was inductive and it allowed the researcher to gain knowledge about women's experiences by listening to and analyzing their stories. After all the interviews were conducted, the researcher listened to the tapes and transcribed the recorded interviews. Researcher made notes about the interviews during the process transcribing. The transcripts were re-read during the process of open coding, where the individual interviews were examined and compared to each other in order to capture dominant phenomena. Process of axial coding was used in order to connect the phenomena and organize them into categories, or themes. Selective coding was used in order to position emerging categories around the concept of shame and social worker interaction. This process was repeated until the researcher felt that all recurring themes were exhausted.

After the data were analyzed the researcher met with each of the participants and discussed the findings in order to make sure that the data analysis accurately reflects interviewees' views, attitudes and intent. This was an important part of the process since giving a voice to the women with substance abuse disorder is one of the essential aspects of the study.

Ethical Considerations and Protection of Interviewees

The name of the agency and the participants remained confidential, and there are no indications of individuals' identities in any of the documents and reports. To ensure anonymity and confidentiality the consent forms required only the participants' initials, instead of their full signatures. In order to protect their identities, the participants were given random first names. The researcher alone listened to and transcribed the recorded interviews. The interview tapes and transcriptions were locked in the researcher's filing cabinet. After the data was analyzed all the tapes were destroyed.

The interviewees were given an informed consent form, which discussed the nature of the study and explained their rights during the study; such as confidentiality, being able to stop the interview at any time and any reason, having the right to not answer questions that may cause them distress etc. The potential interviewees were informed that their acceptance or refusal to participate in the study would in no way affect their relationship with the researcher, the agency or California State University. The interviewees were given a $15 Target gift card, as a gesture of appreciation for their valuable time and willingness to participate in the study. Providing a reciprocal concrete incentive was important as one of the principles of empowerment through participation in research (Linhorst, 2006).

The researcher was observing participants for the signs of distress and discomfort in the case interviewees become upset when discussing shaming, unpleasant or negative experiences. The interviews were to be stopped if the participant was experiencing distress. Licensed marriage and family therapists on site were informed of the research being conducted and were willing to provide support to the interviewees if needed. The participants were advised that they had the right to stop the interviewing process at any time and that they did not need to answer the questions which they felt could cause them disconcert.

The interviewees are women who have been in recovery for more than 2 years and who have maintained their employment for at least one year. They were all considered to be highly functional adults who have the full capability to understand and initial the consent form.

Background Information

It is important to note that I spent nine months in 2009 and 2010 as an intern at the said agency. I had minimal exposure to substance abuse and the issues of the lifestyle that often accompany it. I also did not have the most comprehensive understanding of substance abuse disorder. Spending time with mothers with substance abuse disorder, learning about the disorder and teaching psycho-educational classes had drawn my attention to the impact of shame in women's lives. At the same time I was allowed to attend staffing meetings and be able to observe interactions between clients and their child welfare social workers. At the time of the internship, I developed a professional relationship with the participants in the study. Because of this I was also in a position of an insider/outsider I found this to be beneficial for the research as trust was already

developed and the women were comfortable with me as a researcher. I feel that these previously built relationships granted me the privilege of participants' honesty and openness.

CHAPTER 4: FINDINGS AND DISCUSSION

This chapter tries to capture the wisdom and insight of the interviewees and compare, contrast and organize their answers around meaningful themes. The purpose of the research is to allow for women's voices to be heard. Interviews with women were rich, insightful and powerful. They uncovered women's understanding, intelligence and unexpected honesty and desire to share their stories. And some stories they are. We laughed and cried, moved by the power of memories. I cried afterwards while transcribing, humbled and touched by the sadness and wisdom of their voices. The women articulated many wonderful and important ideas that due to the scale of the study could not be conveyed. The four distinct categories or themes weaved through all of the women's testimonies are Past, Family, Self-Worth and Hope. These themes dominate the narratives and have a major impact on women's shame, their interactions with social workers and the course of their lives (see Appendices A and B).

The past haunts women with substance abuse disorder. The memories of active use and the consequences they had on their families are always present. Women reminisce the past and they are also reminded of it by child welfare social workers. This remembering and reminding increases women's feelings of shame, their interactions with social workers and often the course of their child welfare case.

Familial relationships, especially with children, can be a source of shame and a source of healing for mothers with substance abuse disorder. Concept of family can also be used by child welfare social workers as a weapon of shaming, as well as a tool to encourage and motivate women.

The notion self-worth is something that mothers with substance abuse disorder often wrestle with. Years of physical, sexual, emotional and substance abuse, as well as losing children to the child welfare system strip women of any sense of self-worth. One of the goals of recovery is for mothers with substance abuse disorder to regain sense of self value, respect and acceptance. Child welfare social workers play a major role in the way their clients succeed in this endeavor. Social workers' behavior and attitude san help women strengthen their sense of self-worth and it can also tear it down.

Hope is crucial for women's healing, recovery and reunification with their children. Having hope for the future often makes a difference between women fighting for their children and working towards recovery and giving up. Child welfare social workers' attitudes and actions speak life or death to mother's view of hope. Perception that their child welfare social worker is not working for them, can quickly erode women's hope and ability to progress in their child welfare case.

Research Participants

The participants' names and descriptions are altered in order to protect their confidentiality. The interviewed women are an eclectic group. They are of different ages, ethnicities, and stage of recovery. They come from diverse socio-economic background and have a various number of children. A couple of women were incarcerated, some had lost children to the system, and a couple had only one child welfare case. They've been in recovery from 1 to 8 years. Some grew up in poverty; some were sexually abused as children, while others lived a privileged lifestyle. As different as they may seem, the interviewees all shared the anguish of their children becoming dependents of the court. They

shared horrors of addiction and the destructive path it took them on. They share feelings of shame and loss, as well as sense of victory, hope and new beginnings. Like a phoenix, they rose from ashes of destruction and brokenness to become vibrant, powerful beings.

Mary is a beautiful woman of color. She is in her forties, and has stunning hair and deep understanding doe eyes. She is not aware of her regal beauty and her fluid movements. Mary's voice is deep and she carefully chooses her words.

Camille is a statuesque woman in her late forties. She is a Latina and during days of her active use has had a reputation as a fierce gang member. In recovery, she is softly spoken, with a sharp wit and a great sense of humor. She wears long skirts and her hair in a braid. She uses endearments when she talks to other women. Her approach is motherly and calming.

Donna is a Caucasian woman in her mid fifties who is proud of being big and beautiful. Her piercing green eyes and her quick tongue don't let anything get unnoticed. She is proud of who she has become and it shows in the way she presents herself. She wears bold, bright colors and daring clothes. Donna treats herself as an open book and she bravely shares her experiences with anyone who could learn and benefit from them. She is passionate and her speech is fast and spicy. As a reminder of her victory over addiction she proudly wears a tattoo of a phoenix rising from the ashes.

Ann is a Caucasian woman in her early forties who wears her loss and melancholy on her sleeve. She is compassionate and unafraid of her emotions. She is spontaneous and quick to laugh. Anna is warm and inviting and was raised in affluent home. She has three children whom she talks about any chance she gets. She is grateful for the new start in life.

Marcelina is a Latina in her early thirties. She has long glossy hair and fiery eyes. Her dress is stylish and professional. Marcelina speaks with authority and has much experience which allows her to connect with anyone. She commands attention and she gets it as she is intelligent and eloquent. In recovery Marcelina is an amazing, accomplished woman full of life.

Jody is a quiet, Latina in late twenties. She is new in her position of a case manager and seems still unsure of herself and her role. She only wears dark colors and she plays with her shoulder length hair. Jody has a nervous laugh and a soft voice. A couple of tattoos that peek from underneath her clothing indicate her past. Jody and Donna met each other in prison.

Juanita is an attractive Latina in her early forties. She is a mother of four children. Her delicate features and pretty face stay in contrast with the infamous reputation she had during days of her active use. Juanita is wise beyond her years and she seems to look straight through the person while peeling off the layers of pretense. Her demeanor is cool and collected and it seems as if nothing can take her by surprise.

Terry is the youngest of the interviewees. She is a Caucasian woman in her mid-twenties. She looks younger than her age, with her hair in a ponytail and no trace of make up on her face. She is a mother of two small children and is a new bride. She was raised in a traditional and strict home. Terry has been in recovery for the shortest amount of time and still seems amazed at her fresh lifestyle. She is enrolled at the local community college.

All of the women talked in one way or another in terms of past, family, self-worth and hope. These themes run through their experiences of shame and interactions with child welfare social workers.

The Past

The past was knitted through every woman's interview. It was brought up by every interviewed mother and its importance is undeniable. The past is multifaceted and it serves various functions in women's recovery and their relationships with child welfare social workers. Remembering the traumatic and regretful events is toxic for mothers with substance abuse disorder, and it becomes even more so when it is recalled by child welfare social workers.

Past, like a tidal wave surges through women's lives and seeps through the porous matter of their present and their future. It is an all encompassing force that affects women's view of self, and the world. The past is always with them, whether they are aware of it or not, it stalks and attacks at the time of vulnerability. The past of physical, sexual and psychological abuse, as well as substance abuse and the correlated lifestyle is a source of women's shame. Donna who was sexually abused as a child, and was raped twice in her adult life explained in her matter-of-fact way:

> I don't want to say all of them, but 98% of the women here have been molested or raped. And they do carry that, and what they've done to their children and what they've done to their families. And they do carry it with them.

The bone-breaking load of pain and shame of the lived experiences does not sleep, it is watchful and it follows women and seeps through every pore of their being. It is something they carry with them and which weight they feel on their tattered bodies. Since women do not let down the burden of shameful past, it is present through all of their interactions and it colors their perceptions of self and others.

The past can also become a shaming weapon in the hands of child welfare social workers. The past can be used to remind women of their inadequacies as mothers and members of society. Social workers knowingly or unknowingly contribute to the weight and the toxicity of the women's past. All of the interviewed mothers in one way or another discussed the havoc that can happen when past is continuously brought up. Mary explains the way some social workers use women's past and how that contributes to women's shame:

> Some social workers are very hard on their clients. When I say very hard on their clients, for instance if there is a past that they've been involved with child welfare or even a Calworks, if they've been involved in that at any time and failed then the same social worker will look at the past and pull a rope on them a little bit harder, be more stern with them. And that tends to make the client angry because the client feels like the social worker should be working with them not against them. And when that happens it outs a distance between the social worker and the client. Or client can never get a hold of her social worker, and whenever she does talk to her she says well you had this amount of time and you haven't done anything. But yeah, I'm doing something right now and I'm doing very well, you can ask my case manager. Well that doesn't matter, this is what you've done in the past. And you haven't shown me any reason to go on with your case more rapidly than what was happening at the time.

Mothers who had previous involvement with the child welfare system seem to be treated differently by their social workers. The past transgressions, relapses and perceived failures in treatment are used as weapons against women who found themselves in the middle of a child welfare case. Regardless of women's strides and efforts toward recovery, their past looms over them as a

reminder of all the previous shortcomings and faults. This approach is destructive to women's efforts to better themselves, to work toward recovery and to establish positive relationships with their social workers. When child welfare social workers constantly bring back women's past, it causes mothers with substance abuse disorder to become frustrated, angry and distrustful. It amplifies their shame and it lessens their hope for a positive outcome.

Ann recalls some of the interactions she witnessed between child welfare social workers and the women with substance disorder who are working toward recovery and reunification to further explains the way social workers use past in their interactions with women:

> They've been with the department many years and they're either so jaded by the women or you know, they feel like I've heard that before: O.K. Sure. Now you're in a program; now you want to change your life; now when you got these things happening to you. Why weren't you trying to get of the drugs before your kids got taken? Why weren't you trying to get your house cleaned up before your kids got taken? You know, why weren't you doing all these things?

Ann realizes that histories can often be repeated and that social workers could become "jaded" from working with families who enter the child welfare system generation after generation. Just like Ann, other interviewees understand the complexity of working with women with substance abuse disorder. They too understand the cycle of addiction. At the same time they believe that women deserve second chances, and understanding and acknowledgement for their current efforts. Being acknowledged for their efforts and accomplishments, no matter how small, encourages women with substance abuse disorder turn away from the shameful past and focus on recovery.

Young Jody described another situation when bringing up the past was a part of an unsuccessful meeting between the woman in treatment and her social worker:

> Because she's been through a program already he was just kind of telling her what makes her think she was not gonna go out and do it again and go out there again. Then there was like an English-Spanish barrier and you know she got confused and she got overwhelmed it was just when he as questioning her he was just pressuring her and to where she didn't know what answer and she got confused. When she was with staff she knew what she wanted and what she was gonna say. When she was with the social worker then she just got kind of stuck.

Using past in this way is perceived as confrontational; it increases women's shame, and as previously mentioned it widens the gap between the social worker and the woman. It can make a women feel as if the social worker is working against them and not for them. This affects the women's attitudes and reactions to child welfare social workers and the system they represent.

The undesirable past is not brought up by the social workers alone, women also engage in self-reflection. They mourn the loss of things that could have been in the past, but that did not happen due to their substance use. Teary-eyed Ann reminisces about her past and the way it has helped determine her present:

> I have a lot of shame and guilt about that because I didn't, other women weren't given a chance in life that I was given and I blew it. I took that chance in life and I threw it away. You know I mean I could've been a doctor and a lawyer, my parents would have paid for school, you know. But instead I did nothing with myself. I went to travel agent school. I went

> to computer school. I went to secretarial training, you know. I did little trade school things and little no university. And I could have provided a much better life for my kids if I had not been so much strung up on drugs. I just feel like you know I could've been so much better they could have been so much more if I had nurtured like I was supposed to but I was selfish and I didn't and I do what I can now do the best I can be now but its maybe too late you know there are already who they are you know and its probably thanks to more influences than just mine.

As she spoke of her loss and regret tears streamed down her face. She did not wipe them off, instead she kept talking. Through the tears, her strength and grace shone. Ann is not a weak woman. She carries her loss with poise and quiet resolve. Even though Ann has been in recovery for 5 years, her children are in her care, and she has a job and a place of her own; she experiences loss for the past that could have been. Remembering her past brings back feelings of shame and guilt which prevent her from acknowledging and fully enjoying her successes. Ann is not alone in her reminiscing of past. Terry also discusses the way bringing back her past and focusing on it affects her:

> You have to let it go. You can't focus on the bad past. You can process it, accept it and be done with it, but you can't process, and process it, and process it, and process it over and over because that is still shame. And you're not gonna work through it if you don't get through it, accept it, and let it go. There's no possible way.

Terry describes the power the past can have on a woman in substance use and in recovery. Shame which, stems from the past, is reborn with every recollection of the painful events. And while woman's past needs to be addressed in order for her to learn who she is and be able to accept and love

herself; if constantly rehashed it will disable a woman and prevent her from moving forward in her life and her recovery. Donna also describes what the consequences of living in the past are like for her:

> I tell my girls I work with: "Let's move on." After we talk about it, we don't talk about it no more because there's no reason to keep bringing it up. That's just the way I think. I process it and I get rid of it because I'm not gonna live in the past. If you always have your head turned back looking at the past you never see what's in front of you and you never get to see your future because you're always looking at the past. I refuse to do that anymore because that doesn't help me. I know what I did. I know where I came from. I know what that was about. I'm trying to concentrate on here and now so that I can look forward to tomorrow instead of always worrying about the past. And that helps a lot with shame too, just to give it away. It's not mine. I don't have to feel shame.

Donna expresses the important idea that women in substance use and in recovery already know what their past was like. It is a part of who they are and they daily carry the burden of it. Mothers with substance abuse disorder work hard on distinguishing themselves from who they used to be in the past. They do their best to develop new skills, to become better mothers and daughters, better women. This culture tells them that life is full of second chances, but it is difficult to leave your undesired self behind, when the reminders of it are everywhere. Child welfare social workers have a responsibility to assist mothers with substance abuse disorder to reunite with their children and to become the best possible parent. When child welfare social workers bring up the painful, shameful and regretful past, it is counterproductive to women's recovery, healing of shame and developing relationships with social workers. It erodes

women's sense of adequacy and accomplishments and it enforces and strengthens feelings of shame and failure.

Family

Interviewees described that their families are a big source of shame as well as support during active use and recovery. Children especially have a great impact on women's feelings of shame. Hurt caused to families during active use, specifically to children, can become a weapon in hands of child welfare social workers. Mothers with substance abuse disorder whose children are dependents of the court are well aware of a child welfare social worker's power over their families. If social workers do not exercise their power carefully and graciously, they will end up shaming women and causing further damage to their vulnerable families.

Women perceive their worth in terms of how successfully they fulfill their familial roles. The perceived failure in fulfilling roles of a mother and a daughter are especially damaging to women as they cause feelings of shame. Camille described the way shame was closely tied to her interactions with her family and how detrimental the shame was for her substance use:

> Really I couldn't look at my kids in the eye. That was a hard one. Especially getting out of my room and them going: Mom what are you doing? What are you doing? That was kind of hard. Looking certain family members in the eye, like my grandpa. He was a big, you know, he was the top guy in the family and I stayed away from him you know and that's kind of hard. There was a lot of shame 'cause I disconnected from my father I disconnected from my family I just ignored them because I didn't want them to know I didn't want anyone to know. My family was

> very close, but you know, you work through it. It just made me do more drugs. The shame just made me do more and more.

Being ashamed in front of the family members caused women to seek solitude and alienate themselves from their families, their natural support system. Instead of seeking help Camille isolated herself from her loved ones and suffered under the weight of back-breaking burden of her shame. Camille dealt with her shame the only way she knew how: by using substances. The shame, which grew out of her perceived failure in family roles perpetuated the cycle of substance. Ann further describes the relationship between her shame and her family:

> So my shame was about the way I treated people; the fact that I was not present for my kids. My shame was about not remembering important things in my life. I can't even tell you the day my grandmother died and I was there. My grandfather's funeral, my father's funeral… I don't even think that I went to my father's funeral, you know. I wasn't there for the people that loved me my whole life. I wasn't there for them, you know. That was very shameful for me…And the shame and the guilt for going to prison and leaving my kids… The guilt that my mom was dying and I was in prison, how unnecessary is that? You know, no one to care for her the way she should have been taken care of, the way she took care of us. She lay in the hallway for hours, hours, hours because she fell out of her wheelchair and nobody was there, you know. I stole money from her. I lied to her and I left my kids to be her responsibility. And I was not, I was not a good person when I was using.

Because Ann felt that she did not succeed in fulfilling her duties as a daughter, granddaughter and mother, she believed that she was not a good

person. The shame of failing those who loved her had been a significant part of her cycle of substance abuse. While talking about her feelings, Ann lowers her eyes and looks at the point on the floor beyond the tips of her shoes. She further describes her perceived failures in a role of a mother:

> I kept my kids at poverty level with this man. I had every single privilege that could possibly have been given to me when I was growing up. I came from privilege and my children have never had anything but, you know, discount this and that and cheap Barbies and, you know, Payless shoes. I never gave them what was given to me and I have a lot of shame and guilt about that. Shame affected me very badly shame was a big trigger for me. I sedated myself with whatever my substance was at the time because I could not allow it to affect me because it really brought me down and the shame of all the things that I was doing to my family my children my loved ones it affected me severely.

Women define themselves and determine their worth by how well they fulfill gender roles. The shame of failing as a mother is devastating. The shame reaches far and deep so that a woman sees the effects of her failure as a mother even in "substandard" Barbies and inexpensive shoes. Everything can become a reminder and a proof of their inadequacy as a parent. And again, the shame results in perpetuated whirl of substance abuse. Jody also describes the shame of not being with her children and missing out on the important moments in their lives:

> I felt shame when I was using because there were times when my kids wanted to do things and I put them off. And then, I think, when I was incarcerated and they were taken away from me. They were with family but you know I should've been with them you know. I didn't see my son

> go from junior high to high school and my little one was 3 years old and when I got them back it was 2 years later. So I missed out on a lot of that. So when I was incarcerated, the time away from them is when I realized all my shame and guilt and stuff like that. It's when I was using it hit me every now and then, but it hit me harder when I was away from my kids.

The impact that removal of children has on women's feelings of shame is tremendous. Women in substance use often numb their feelings of shame by increased drug use. They find ways to distract themselves from focusing on the engulfing monster breathing down their necks. But removal of children breaks all the smoke mirrors and it exposes shame for what it is: "an ugly feeling," according to Mary or a "gut wrenching feeling" as Terry described it. To the interviewees, removal of children was a proof that they had officially failed in their roles as mothers and women.

Ann's situation was even more challenging because while she was incarcerated her children were not staying with her family, as in Marcelina's case, but were placed in a foster home:

> I've been an inmate, I've been… My kids were taken by into CPS [Child Protective Services]. My mom got too sick to take care for them. It was only for 2 months, but it happened. So for those two months I was in prison and, and I didn't know who was touching them, who was taking care of them, if they had their pajamas on, if they were getting baths, if there were sheets on the bed, if there were, you know. I didn't know all that stuff so I know what all these women go through with their kids in foster care. Because you hear horror stories every day and, you know, they are terrified for their kids and they know that their kids are there because they didn't do their job. So there's guilt and the shame and that

> manifests with them as anger, and a lot of it. And we have to understand that.

Ann describes the fear and the anxiety women experience when their children are placed in foster care, in the unknown place, with strange people. Again, the shame of "not doing their job" of nurturing and protecting their children takes over rationality and drives women to respond emotionally to others. As previously mentioned anger and aggression are common responses to feelings of shame. The shame that mothers of children in foster care bear often presents as anger and it could be misinterpreted by child welfare social workers as non-compliance or defensiveness.

Families, especially children, have a primary role in women's fight against shame in recovery. Children have a dual role in the shame of their mothers. They can serve as a source of shame and they can also help alleviate shame. Donna describes the way her children evoke shame in her life in recovery:

> My kids…When I look at my kids it makes the shame worse sometimes, when I look at them and think: "God what did I do?" And they are grown. My youngest is 18. I look at my kids and think: What did I do to them? Especially when my older daughter calls and says: Mom, you really fucked up back then. And I'm like: Yeah, I did. And she's at that age now, she's been married for seven years and she has two kids and it's like she's never dealt with it. So in order for my daughter to heal I have to hear what I've done to them whether I want it or not. That brings the shame back to my life. My God I screwed up so bad that my baby's been affected by it now, six years later, you know. And I have to come to grips with those feelings and talk to her and talk through it and be able for us both to be ok with it.

Even after conquering the drugs and living successfully in recovery, women's shame lurks in the corners of their consciousness. Just a look at their children is enough to unleash the beast and cause havoc in women's sense of self-esteem and self-worth. The children are constant reminders of the shameful past. The trauma they experienced through their mother's active use surfaces at unexpected times and women are forced to revisit some of the places that are best left behind. Despite the destructive effect remembering has on them, women willingly engage in these conversations of rehashing past in order to help their children heal and grow. Ann explains how even minute, daily conversation can cause a flood of shame:

> Being here every day we understand, we understand that, you know, our kids deserve, they deserve to say whatever they need to say to us, you know. We bought and paid for that in our addiction. My daughter, for instance, you know, I said: "Oh my gosh that was the best shower I've ever taken!" She was like: "What's different? What was different about the shower?" And I'm like: "Usually I get in the shower, then I soap up my hair, and I wash my body, and then I wash my face and then I rinse it all off. But this time I got out of the shower, I washed my hair first, I washed my body, and then I put conditioner and washed that all off. I don't know", I go, "what was different about it, but it was just better". She goes: "That's weird. I take my showers like that too. I soap my hair, leave it on there, I wash my body, then wash my face, then I wash it all off", I go: "Why wouldn't you? Who taught you how to take a shower?" She goes: "You weren't there". And I'm like: "OK, what makes you think I wasn't there? Why would you do it the same way I do if I wasn't there, you know?" She said: "Well, I don't remember you being there. I remember

> grandma". You know, and that kind of thing makes me ashamed that my kids don't remember my contributions to their life.

Ann describes how shame is buried in interactions with her children, even in most innocent daily conversations. Shame is like a hidden improvised explosive device that can go off at any moment and in one hit destroy the painstaking efforts rebuild and the sense of dignity. Both Ann and Donna express what the rest of the women have indicated and that is that no matter how much they've grown and how successful they've been in their recovery, shame is always near, and their children have an uncanny ability to bring it up to surface.

As children have the power to revive feelings of shame in mothers in recovery, they also have the ability to ease the pain and quiet shame. Jody describes how the great role her children have in her being able to tame her shame and keep it at bay:

> I'm there for them now and you know they're happy with me. They're re proud of their mom that she goes to work. So, I mean, they're just proud of their mom now so I don't have to feel guilt and shame. They know that I'm taking the right steps.

Having children who are proud of their mom makes women feel as if they are successful in their role of motherhood, which lessens their feelings of shame. Juanita reflects on how her family and her perceived success in fulfilling familial roles impact her shame:

> I think you will always feel that as an addict you will always feel somewhat shameful of your experience but is not as strong I've changed I've become a better person a better mother a better sister, a better daughter.

Women indicated that shame is a crucial part of addiction and that it lingers through recovery. Families, especially children are a powerful source and aid to shame in women's lives. Shame exists, but women could learn to choose not to engage it and dwell in it. Child welfare social workers have the power to use women's attachment to their families to bring about shame or to bring about encouragement and healing.

Self-Worth

Feelings of self-worth or feelings of unworthiness greatly impact women's experience of shame, their relationship with their social worker and ultimately their recovery. Women with substance abuse disorder whose children are dependents of the court are constantly given messages that they are worthless as mothers. Women often engage in this way of thinking, and child welfare social workers, as well as participants in other governmental systems commonly relay these messages of worthlessness to women. This notion of lacking individual worth only deepens feelings of women's shame.

Shame is all-encompassing; it fills empty spaces with its thick and heavy mess. It weights down the women, it saps their energies, their joy and it extinguishes their fighting fire. The sense of worthlessness is what shame capitalizes on, and whenever a woman loses a sense of self-worth the shame claims victory. Child welfare social workers have a major role in helping women to either build up their self-worth or to tear it down. Social workers can willingly or unwillingly do this. The teardown can happen with harsh words, or a condescending look or the unreturned phone calls. Donna explains:

> Not all social workers are the same some are like well this is your fault. And it makes it worse 'cause you're already feel bad enough that you

> fucked up, that you messed up this bad. And for your social workers to say this is your fault. Yes it's my fault but how can we fix the situation?

Women are aware that they are responsible for their children being taken away and becoming dependants of the court. They tirelessly carry the burden of guilt and shame and social workers' blame does not result in epiphanies instead they are resounding old reminders of women's perceived worthlessness. Mary further explains this phenomenon:

> They are already shameful. They've been kicked. They've been abused. They've been there. They don't need it any more. They're doing it to themselves. And you can imagine the way a woman, how she would feel after she's been through the system. She knew better, she did it again. She lost her kids; she's fighting for her kids. She's kicking herself: Why did I do this? Why did I do that? So she's kicking herself probably more than anybody else can and that is hard to pull yourself out of. It just sets as an ugly feeling you know.

Mary captures the way feeling of ugliness, self-loathing and shame impact women. She also stresses the lack of necessity for social workers to reiterate women's blame and responsibility for the unfortunate situation she has found herself in. There is no need for punishment, women already punish themselves for everything that they ever did or that was done to them. It is cruelty to pour vinegar to women's wounded, bleeding sense of self-worth. It is not just cruel, but it is also counterproductive. It does not help women heal, move forward toward their recovery or resolve their personal issues. Blame coming from social workers only reassures women in their belief that they have no worth. Marcelina talks about the way women's shame and lack of self-worth influence their interactions with child welfare social workers:

> I think that the social workers should understand where these people are coming from. Some clients are gonna go within themselves and some are gonna be angry and come out of themselves, you know. And just depending on where that client is in their life, just depends. I've seen some girls get really angry and cuss out their social worker. And I've seen some girls just be very timid just because they have issues with the authority. They have fears whatever it might be so they are more timid and they go within which doesn't allow for them to use their voice and know their rights and speak up for themselves. And I think those are the ones that get left behind a lot.

Depending on women's past experiences, personality and mental health, they react in different ways to their social workers. Some mothers with substance abuse disorder are more prone to express anger and interpersonal hostility, while others direct their negative feelings inward. Both models of behavior can be detrimental to women's child welfare cases. As previously described, if a mother acts out in anger toward the social worker, she can be labeled as non-compliant, difficult and defensive. On the other hand, if she withdraws and does not advocate for herself, she can be labeled as disinterested, unattached and can be "left behind".

Just like all interpersonal relationships, a relationship between a child welfare social worker and a client is dynamic and two-fold. Donna explains the effects social workers' treatment may have on women's recovery and child welfare case:

> Your social worker, they have control. And the courts have control, but the courts listen to what child welfare worker has to say. Whatever that social worker says to that judge, or recommends, that social worker has

> your children in her hands. So you have people that are just bowing down. Women that are just giving up and bowing down saying: "Fuck it". If you have to bow down to somebody it's like as if you're in the abusive relationship. They give up sometimes because of the social worker. They give up and you see them broken and it's worse than when they came in.

The power of child welfare social workers can't be denied or ignored. As Donna stated they have legal power and they determine the fate of the child welfare case, and they also have psychological power over women with substance abuse disorder. As previously described by interviewees, women with substance abuse disorder often come from the background of violence and abuse. As survivors and victims, they already have a set of assumptions about individuals in power. As Donna stated, their previous experiences with persons of authority can determine the way they will react to social workers. If social workers do not approach women with care and compassion, they can further injure their sense of worth. As social workers are meant to assist women in reuniting with their children, if women do not feel that social workers are on their side, they can feel defeated, shameful and worthless.

Marcelina talks about the way sense of worthlessness envelops women and how the messages of lack of their worth come from many sides:

> If somebody removes your children and are focusing on your shame and are judging you and belittling you it's gonna make it really hard for you to overcome and surpass and overcome that obstacle in your treatment. Because you are getting it from everywhere, especially the ones that are supposed to be giving you your children back so and that stays in the back of your mind constantly even though you are trying to process, you

know. For some women, they might be strong enough to surpass that, but what about those that aren't?

Women in substance abuse are victims of societal stigma, and are experience forms of belittling from different sources in their environment, as previously noted law enforcement, the court system and social services can all take toll on women's sense of self-worth. It seems as if the insult is the most painful coming from those are supposed to help. Child welfare social workers are supposed to work with women toward the goal of reunification with their children. Their role is to lift up and strengthen women's sense of worth, self-esteem and empowerment. When social workers belittle or talk down to the mothers in substance abuse the women feel as if they are not worth helping. Camille wearily describes the thought process and its effect on women's feelings of shame and self-worth:

> Why doesn't she like me? You know, I'm doing all this and I'm not progressing anywhere in my case. Is it me? They internalize a lot of it so they are really beaten, not just that they're beat by the social worker they are beating themselves up no matter how much we try to lift them. Just because social workers have their children they're the shot caller. I have some social workers that are just great and then I have these ones that just, you know, tear down everything. Like you're the one that put yourself here, all that stuff. Well they know all of that and they're working through all that but why do you keep throwing that in their face especially if they've made progress? Why do you have to? They've made two steps forward and are starting to feel better especially through therapy and then: remember what you did. That's bringing the shame up again. Let them move forward, you know. Don't keep pulling them back down.

When child welfare social workers show dislike, distance or contempt for mothers in substance abuse , the women internalize the causes of social workers' behavior an assume that something is wrong with them, that they are not good enough, worthy enough for social worker to show them kindness and respect. It seems as if child welfare social workers willingly or unwillingly use their power in order to emotionally punish women. Not recognizing women's progress and reminding them of their blame for the situation only shatters their newly earned sense of worth.

The shattering of sense of self-worth is achieved not only by obvious, intentional coarse and uncompassionate interaction. Messages of worthlessness can be subtle and unintentional, but every bit as damaging and powerful. Mary describes this:

> For instance, my child's care provider, I don't get along with her. She always looks down on me. She looks at me like I'm a piece of dirt. And when I ask her questions about my child the care provider will say something to me that will make feel like: "Why are you asking that you're in a program? I'm the one taking care of your child, not you." That's shame. And really just talking about it, it doesn't seem like it would, but when you're talking with a client, that really just puts them down. And when they're already down in the first place, you put them down in that way and we're dealing with blood to blood. That's my child. And they use their child and say something like that. That puts them even further down and it's hard to get back up. It lowers their self esteem. Their shame is tremendous and then they walk around: "What did I do? How do I fix that?" They don't see no way to fix it. That puts a client in a spot where she feels like she has no right. She is unfit. Your child is with care

> provider, you're not fit to be a mom. The client was angry because she's trying to tell the social worker what the care provider said and she didn't feel it was right. And also when the care provider brings my child here he's got two mismatched socks on, he didn't have a sweater, he was dirty. And talking to the social worker about it, the social worker would probably respond like: "Every time I've gone out to the home everything seems fine, they're well taken care of." And the client is like well I see it but the social worker is saying no because the social worker is working with the care provider to make sure that the child is being taken care of. And when you're put down like that or you feel ugly; it's an ugly feeling.

As Mary observed, not validating mothers' concerns about their children can be lethal to their sense of self-worth. Making a mother feel like she has no right to of having a say about her children's care, because she is in the program and children are removed from their care escalates their feelings of shame and minimizes feelings of self-worth. The core and the purpose of their being is questioned and dismissed.

A child welfare social worker's dismissive attitude toward mothers with substance abuse disorder can send a message that the women are unworthy, incompetent and unimportant. This amplifies women's feelings of shame:

> When I would get more into depth into why I was acting the way I was acting or why I would ask certain questions, I was being shut down. Not kind of like not being able to, I don't want to say finish your sentence, but shutting down like: "O.K. You don't know- I know what I'm talking about."

Throughout the interviews women stressed inability to have a voice and a say during the times of active use. Many women were victims of abuse and

domestic violence and interacting with a child welfare social worker with a dismissive attitude can evoke feeling of shame and worthlessness. Marcelina also talks about the way things are said and the messages that are received:

> I think a lot of it is not just in what's said but also in their tone and their mannerism and also how they approach the client. Because you know, we can feel our shame but how you approach me and how you speak to me about it is gonna affect my end results, you know. So somebody can come at me and say: "Well you know you were a terrible mother, you chose drugs over your children," comparing to: "Yes, at the time you were not making good decisions." So there is a whole different way in which to approach the client and how they're going to take that.

Marcelina understands the difference in intent and delivery of messages. She has experienced both and knows the difference in effect they can cause. Often times women's feelings of shame and worthlessness are amplified not by something social workers do, but what they don't do. Terry talks about those situations and the impact they have:

> I do notice that when social workers come and check on client, like they're supposed to, instead of calling on the phone; when they actually physically show up they feel important. They feel somebody cares enough to come here and see me. When they get a phone call it's like: "Oh my God, they never come see me. They're only calling I never can get a hold of them." And it's like, it makes them feel like they are worthless because somebody doesn't have the time to come physically see whom they dealing with. But they can sign some papers to court case and they can have the power to basically do whatever they want to this piece of paper that says: "OK this is how your life is gonna go." But they won't come and

> see them, and haven't come to see them, and don't know what they look like. And they don't know what the kids look like. They just have a piece of paper that has kids names, ages and it says what the visits are gonna be. And if they sign that piece of paper, that's what this person's got to do. But I think women are frustrated that somebody can have so much power and yet not be humble enough to come and give them the respect, that of knowing who's controlling their situation.

If child welfare social workers do not visit women at the program, the message sent is that women are not worthy of social workers' time. In those situations mothers with substance abuse disorder feel all the weight of power differential between them and a social worker. As Terry explained, it is as if women do not have input or influence in the course of their case and futures of their families.

Instead of for tearing down women's self-worth, social workers' power can be used for building up and strengthening their sense of worth and empowerment. If women are treated as just another case, another number, and are not treated as individuals worthy of professionals' time and effort, this adds to women feelings of shame and worthlessness, the very feelings that often lead women to substance abuse.

On the other hand, treating mothers with substance abuse disorder with dignity and respect, allowing them the time to tell their stories and getting to know them on the personal level, can help them rebuild the brokenness shame had caused. Donna describes her experience with a child welfare social worker:

> She never put me down for who I was. And she always tried to make it known that it was a disease and that it could, you know, be put into remission. So she never really downed me for it she always tried to help

me through it. She was a really good social worker; she never put me down so I guess that's what she did to help me. She never threw it in my face: "Well you're just a drug addict you had your kids taken away; you're no good." No, she never did that to me. She was always like: "This is what happens and were gonna get help and this is why we are doing this process so she always made me feel good about it she never put me down about it so yes she did help. She was very understanding of many things, even though she hadn't lived the life I lived. She was very understanding about it, so that helped me a lot. It made me feel good because I was so frustrated at the whole thing and knowing that I caused it was even more upsetting. And just to have her be there and not say, you know, stupid things to me like, you know, she never said to me: "well, it's your fault", or anything like that. She was always like: "It's an addiction. It happens to people." So she was real understating and if she wouldn't have been so understanding it would have been a lot worse. But because she was so understanding and was helping me through it and explaining things to me, and if she didn't know something she would ask somebody and she would get back to me. I mean she would come down to the jail and talk to me, you know. So she did a lot far beyond that she needed to do, you know. So I think she helped with my shame a lot in that manner.

Women's sense of worth soars when they are not constantly reminded of the blame and shame they feel about the damage that was done to their families. As previously discussed mother with substance abuse disorder understand about the impact their addiction and related behaviors had on their children and family life. They receive contempt from every angle of society so they are not

lacking in messages of worthlessness, stigma and shame. What they do not receive are messages of encouragement.

Ann also had an encouraging experience with her social worker:

> Oh, my gosh, I'm gonna cry. This woman would call me. She would call; she would call to the prison. They would get me on the phone. I would go and I would talk to her. She would call me and ask for my permission. I remember in particular she called and asked if my daughter could go on vacation with a foster family (trying not to cry). And if you've been in prison for a minute you're not asked anything. You have no human rights, much less parental rights. You're told what to do how to do it and not in a very dignified and respectful way, you know. So that this woman called and asked me to make a decision and give permission for my child she was just, (crying) she was awesome. My social worker left intact my dignity. She made my kids feel that I still loved them, that I didn't abandon them, that I was coming back (crying). And for that I can never thank her enough. Her name was Marlene and she was from God. She never one time made me feel like I was this lagger, loser mom that let my kids get taken away from me. She never ever, ever made me feel that way and she never portrayed that to my kids ever. She didn't make me feel ashamed of myself. She always made me feel like it wasn't my fault. We all know it was, but she didn't put that on me because she knew I was already putting enough on myself.

Child welfare social worker calling Ann to ask for permission to allow her daughter to go on a vacation with foster parents was a part of the standard child welfare protocol, yet that smallest sign of courtesy and acknowledgment of he as a mother and a person meant so much to Ann. She felt worthy and her shame

was diminished. The social worker allowed Ann, if even for brief moment, to feel like untainted and "normal". Social worker behaved in a way that allowed Ann to see herself as a woman and a mother, and not just a prisoner or a drug addict. The impact this social worker had on Ann's life and recovery was tremendous. As she spoke of her, more than four years ago, Ann could not hold back her tears. All of her anger, anxiety and fear were disarmed by the simplest act of kindness from her social worker. Being treated with dignity and respect from someone in authority gave Ann strength and encouragement to continue fighting. It also enabled her to drop her guard and to proceed with calm and reciprocated respect which had helped her in her child welfare case. As with previous testimonies, the fact that social worker did not blame Ann or emphasize her responsibility for the situation her family and most importantly her children were in, aided Ann in her recovery. Like other interviewees, Ann knew very well that her actions and her addiction were the reason her family was torn apart and her children were removed from her care. Ann did not need brutal honesty; instead she needed kindness, acceptance and forgiveness. Being treated with respect and care greatly increased her sense of worth and diminish her feelings of shame. Donna describes her view of importance of encouragement and acknowledgement of women's efforts:

> She's a good example if you're doing what you're supposed to she's patting you on the back and she's giving these women encouragement. That's a good social worker. Because you're lost when you first get into the system. You're lost and she is one that would verbalize: "God you're doing such a good job!" And really, that's what you want to hear. It makes it less when you have a social worker who really honestly cares about you and isn't just going through the motions and isn't just that robot. When

> you found one with that empathy, empathy? Is that the right word? To honestly care about your situation and not the other 50 cases they have, but you personally. It helps a lot because you stop feeling so bad about what's happening and you start trying to do the right thing to counteract all the shame and guilt that you feel. When you have a good social worker it makes all the difference in the world it really does because it helps you to come down and for you to accept, yes this is my fault and for you to learn what you have to do to get out of it and it doesn't happen overnight. The feelings of shame…The shame doesn't go away. You have to learn how to work yourself through that. But when you have good social worker behind you saying you're doing such a good job and now we have to do this and once this is done were gonna get this done that helps a lot cause you're not sitting in the corner thinking: "oh my God I suck", cause you do think that sometimes. Oh my God here's just another one on the list of life that I messed up. And when you have that good social worker that says yes you messed up but there's a way out that helps a lot with the shame and the guilt and feelings of worthlessness that you have.

Donna expresses the way feeling cared for by the social worker makes a woman feel important, worthy and less shameful. She stresses the importance of not feeling like a number or just another case. When social worker has empathy and she sees and acknowledges woman's strengths, effort and progress, it helps woman in combating her feelings of shame and it reinforces her sense of worth. It seems as if women in substance use can discern if the social worker genuinely cares and empathizes with her client. The relationship between a child welfare social worker and a woman with substance abuse disorder built on trust,

kindness and respect can have a long term therapeutic effect on women, their recovery and the way they interact with the system.

Women's sense of self-worth and their shame is diminished when a child welfare social worker advocates for their needs. Terry describes her experience:

> My social worker personally made my shame feel better. She advocated for me and said that she'd give me a chance to have my children in a program with me and to be able to show my progress without having the courts involved. And it was basically they put their faith in me and it was up to me if I sank or swam. I remember that she called in her manager her supervisor and she and her supervisor were sitting at the staffing basically fighting for me. And I'm grateful for that. They said that there's no need to have all the extremes out on me. This is my first time ever being in trouble; they should give me a chance. And everybody else was like no we should send her to court; we should take her kids and make her have visits at facility. But they really dug their heels in the ground and got me the plan that we had aimed for and it helped out a lot. It changed my life.

By advocating for her needs, Terry's social worker showed her that she believed in her, and that she saw value and quality in her as a person and mother. As Terry stated, this helped her feelings of shame and it made her feel worthy enough to have another chance and to apply herself. As interviewees described, women with substance abuse disorder are often beat down, belittled and shamed by the systems they interact with. They are told directly or indirectly that they are flawed, worthless and that they won't amount to anything. After uncountable letdowns, wrong turns and mistakes, women begin to believe it to be true. As in Terry's case, it takes one committed and compassionate child welfare social worker to show them respect, faith and trust. As Terry did, other

women in substance abuse want to prove their social workers right, and not let them down. This renewed sense of purpose and worth reflects in women's heightened efforts in the program.

Hope

Hope is necessary in order for women to be able to rise above their circumstances and break the cycle of addiction. Without hope women can't see possibilities the future holds. Having hope gives them motivation to work towards recovery and reunifying with their families. Social workers have a great impact on women's thoughts of hope and perception of future. Social workers have the power to squelch or to ignite hope in women with substance abuse disorder. Donna describes the way social workers intentionally or unintentionally kill hope in women:

> When you have a social worker that's not getting back to you in a timely manner it leaves you with these thought in your head of who's on my side. Because your social worker is supposed to be on your side and if you're feeling that they're not doing their job all those get bigger: the shame, the guilt, the frustration. All that just gets bigger if there's not a good line of communication. A lot of those girls end up with a social worker that has no understanding of what their specific need is, nor do they ask. So that just leaves you sitting in the corner thinking: "why should I give a shit nobody else is really caring", and all those feelings are still there.

Feelings of shame, worthlessness and hopelessness are symbiotically connected. They form a dark, isolated, emotional space that makes a woman feel like she is backed into the corner, without options or hope. Social worker's

power and women's powerlessness can be a lethal combination for mothers with substance abuse disorder. Donna further explains:

> Promising a visit and because of something foster parent did it's cancelled, that breaks all trust. But those are my kids and the foster family is supposed to be working in the better interest of my children. And you get these promises and at the end of the day if they are not kept you only end up feeling worse than you did when you came in. You feel betrayed. All those feelings of shame come back up because you start realizing once you start coming down, it is my fault. And you end up feeling worse about yourself. So it is really bad for the women because they already feel bad as it is and then you have all these promises and broken promises and nothing's happening you feel like crap again. I think in cases like that it does hurt with shame and guilt cause you already feel bad enough like you've done this to yourself and your children and family. As any human being, if you don't get that feedback that you need. You need that. And you need that honest feedback and you're not getting it. And if you've never gotten it when those promises are broken you're just figuring it's just one more thing and it's not a good thing for the women, their hope is gone.

When visits get cancelled, or some things do not happen as they were supposed to, social workers can see them as change in plans. But what is a change of plans, or a cancellation for social workers; it is a broken promise in a life of a woman with substance abuse disorder. And it is just one more in the string of let downs and disappointments. The broken promises bring back feelings of shame and they kill trust and hope. Marcelina further explains:

> I've been in staffings where the social worker is almost being judgmental just being uncompassionate and it just doesn't work. The social worker is rolling her eyes just being judgmental, being short with them, you know, you could see the difference. It's gonna affect them when they don't feel that their social worker is on their side. It affects their treatment and it makes them feel powerless. Their shame starts coming up, they lose hope, they feel like they're never gonna get passed a lot of their stuff. And if they don't have the strong support that they need in their treatment program and this is something that's not addressed, then they're left out there on the street carrying their shame which is gonna most likely bring them to the place that is not healthy again, whether its new addiction or is their behaviors.

As other interviewees discussed, not feeling that child welfare social worker is on your side is detrimental to the women's well-being, their healing and their efforts toward recovery. The women with substance abuse disorder are vulnerable when they are trying to reunify with their children. In addition, women's bodies are getting clean from drug use and women are working on their treatment, which often includes addressing painful and shameful memories in their therapy sessions. The combination of highly stressful conditions makes women highly sensitive to their environment, especially to the influence of child welfare social worker who in women's estimation holds the key to family reunification. As Marcelina describes, judgmental, or uncompassionate social worker can be more than a woman can handle in her frail state. Hope can be broken beyond repair.

If child welfare social workers have the power to kill hope, they also have the power to revive it. Jody describes the ways her social worker helped her lessen feelings of shame and evoke thoughts of hope:

> I don't know it was all just it was encouraging. It was kind of like looking at your mom and the encouragement and stuff like that since my mom is not with me anymore. I guess that just encouraged me more. I think when the clients are starting to go toward their goals and everything, you know, is getting positive and certain things when they hear those social workers encourage them and stuff like that it makes them feel proud of themselves, that they are achieving stuff and it makes them go forward. And I always want to see the positive, you know, so I think it just really brings them out of that shame just the encouragement and everything that they are doing so that will always bring them out.

Jody describes social workers having a perceived parental role for some women with substance abuse disorder. An ideal parent is someone in authority, who cares for a child regardless of her faults, encourages her and supports her in becoming independent and reaching her goals. As Jody mentioned, some women with substance abuse disorder do not have, or have never had, parents who could fulfill those needs. Child welfare social workers have substantial power and influence on their clients. Sometimes all it takes is a kind word and encouragement to allow women to reach for their potential. Marcelina also talks about the way compassionate, caring social worker can help build women's hopes for the future:

> When you see a compassionate social worker sitting with a client, you can tell right away the client is going to respond. You can see it in their body language, in their eyes, the eye contact, and their demeanor and how they

> are when that social worker leaves. It just leaves a sense of peace, of hope that social worker is real, is appropriate in the way she speaks to them. She speaks to them at their level, at their eye level, is aware of certain issues like shame and guilt, just anything that could be aspects of treatment, you know. They are aware of it and they are bringing to the eyes of the client you know that shows the client that they're caring and it shows hope and that they are compassionate.

The impact of even the most subtle of social workers' behavior is tremendous for the women with substance abuse disorder. The eye contact, physical proximity, body language can all speak volumes about social workers' intentions and attitudes. Feeling that a child welfare social worker is compassionate, non-judgmental and warm gives women hope for the outcome of her case and it encourages her to trust the system and to apply herself toward recovery.

Juanita describes the importance genuine connection between child welfare social worker and her "client" has on women's feelings of hope and her efforts toward reunification:

> When I don't see a connection between the client and the social worker there's a huge big space in between and nothing gets done. Not just with a social worker but nothing gets done on the client's side as well neither because now she's not performing, she's not participating, she's not, you know, reaching for her goals and for the good when I do see a really good social worker that's really helping their client. The client actually flourished. They've been planted a seed and they are the ones that been growing enormously they participate they do everything possible to try to get their children back they become what we like to call our model client

> because they are so excited and they are so gung-ho about becoming a different person that is just it is amazing when we have what we like to call a team if you have anybody that is for an addict. If you have anybody that is just sitting there listening to you and acknowledged the good points, not only the bad points, that's when the client will actually do what she has to do to become a different person.

Child welfare social workers are sometimes the only encouraging, positive influence in women's lives. Many women have experienced abuse and neglect as children, as well as adults. They've been victims of societal stigma and their own feelings of shame. When someone, especially someone esteemed and powerful, shows kindness, trust and faith in women's qualities and worth, women with substance abuse disorder feel empowered. They thrive toward earning the given trust and fulfilling their potential. This helps women's relationships with child welfare social workers and it affects the outcome of their cases.

This chapter discussed categories and themes discovered in interviews with women in recovery by using grounded theory methods. The Past, Family, Self-Worth and Hope are four concepts which arise from interactions of mothers with substance abuse disorder and child welfare social workers. The upcoming chapter will discuss strengths and challenges of the study, as well as the applicability and recommendations for the field of social work.

CHAPTER 5: DISCUSSION AND RECOMMENDATIONS

This chapter discusses the findings of the study, its strengths and limitations, its scope and its applications to the field of social work. The chapter also summarizes the findings and relates them to the existing research; and it provides suggestions for future studies and actions.

Discussion of Findings

Analysis of interviews supported the premise that shame plays a major role in interactions between mothers with substance abuse disorder and their child welfare social workers. The study shows that shame truly is like a proverbial "elephant in the room," which often blocks the view, intercepts communication and stands in the way of interaction. The research indicates that child welfare social workers have a great deal of power and influence over mothers with substance abuse disorder. Social workers can help alleviate women's feelings of shame by giving them respect, undivided attention, acceptance and encouragement. This can be achieved by smallest of gestures, such as maintaining eye contact, returning phone calls, visiting women at the program and not blaming them for their family's circumstances. Child welfare social workers also have the power to evoke and intensify women's feelings of shame by judging and blaming them. Both subtle gestures and blunt statements can be devastating for women. Mothers with substance abuse disorders can feel shamed by social workers that have closed body language, bring up women's past, blame women for the situation they are in, or who do not return women's phone calls.

As the interviews indicated, women with substance abuse disorder who are going through rehabilitation and are in the middle of a child welfare case, are

vulnerable, confused and shame-ridden. They view child welfare social workers as sources of authority and power that are supposed to help them reunify with their children. The women in the recovery program often cannot identify their feelings and motives of their behavior, especially shame, which is by nature elusive. Their minds and bodies operate without the affect of substances and they are in the process of learning about themselves and their environment. Mothers with substance abuse disorder face many stressors and the way they are treated by their child welfare social workers makes a great and often irreversible impact.

The responsibility of child welfare social workers is immeasurable, as so much depends on their actions. As interviewees indicated, clients seek approval, encouragement, and support from their social workers. Social workers need to demonstrate empathy, patience, acceptance and respect in order to be effective in working with women with substance abuse disorder.

It appears that stigma against mothers with substance abuse disorder may be present in the field of child welfare. As interviewees indicated, stigmatizing, blaming and shaming are often evident in the social workers' interactions with their clients. The way mothers with substance abuse disorder are treated by their child welfare social workers affects women's responses and reactions to the child welfare system and it can also affect the outcome of their child welfare cases.

It is found that perceived failure in motherhood is one of the greatest areas of shame and vulnerability for women with substance abuse disorder. When child welfare social workers imply the inaptness of women's motherhood, the damage to self is immeasurable. Being dismissed and discounted as mothers, and feeling like they do not have rights and say in their children's lives is detrimental to women's sense of self-worth. This acute feeling of shame creates

barriers to women's treatment, open interactions with child welfare social workers and the child welfare case. The study supports Brown's (2006) and Manion's (2003) findings about importance of fulfillment of feminine roles for experience of shame.

The findings maintain Potter-Efron's (2002) theory about the possible ways shame affects person's behavior. The interviewed women explained about feeling angry, or depressed and responding with violence or withdrawal to the social workers who are perceived as shaming. The research also aligns with Tangney and Dearing's (2002) findings about anger and hostility being one of the venues for reacting to feelings of shame and shaming behaviors. The study also aligns with Potter-Efron's (2002) findings that shame perpetuates a cycle of substance abuse, as the interviewees discussed the way shame caused them to use more drugs. It also aligns with findings of Manion (2003) and Efthim et al. (2001) that women's shame stems from sense of failure in feminine roles. And just like Rahm, Renck, and Ringsberg (2006) discovered, the study shows that women are often not aware of feelings of shame. They misunderstand them for anger, depression, or self-loathing.

The study also uncovers new aspects of the way shame affects lives of women with substance abuse disorders. There are no studies that specifically address the ways shame is related to relationships and interactions between women with substance abuse disorder and their child welfare social workers.

Limitations

The limitation of the study is in the small number of participants. All the interviewees are also staff of the same agency in California's Central Valley. This may limit range of applicability to the general field of social work. It would be

beneficial to conduct a study with women from different agencies, different geographic regions and at varying stages of recovery.

Implications to the Field of Social Work

The area of interface between mothers with substance abuse disorders and child welfare system is critical for the future of children, families and communities. This research is important for the field of social work because it addresses previously unexplored interactions and relationships between mothers with substance abuse disorder and their child welfare social workers and the way these relationships are affected by shame. The study unveils certain aspects of reality, which usually happen behind closed doors. The interaction between child welfare social workers and parent-clients is often a private matter and a cornerstone upon which the child welfare case is built. Understanding the dynamics, motives and nature of these interactions is paramount to the social work field. As previously indicated, quality of relationships between child welfare social workers and mothers with substance abuse disorder, especially in regards to shame can influence the outcome of child welfare cases. The study's relevance also lies in its role of a medium for women in recovery to express their opinions and speak their minds, which is a step toward empowerment. Child welfare social workers and other helping professionals who work with women with substance abuse disorders must learn about women, from women. This oppressed and marginalized group needs a venue for asserting themselves and letting themselves be heard and known. Research is one of the possible tools though which this expression is possible.

Recommendations for Future Research

The information gathered from interviews with the women in recovery shows the depth of the unresearched areas about the way shame impacts relationships between women with substance abuse disorder and their child welfare social workers. Prevalence of substance abuse related problems of parents in child welfare cases creates urgency for generating new research that will help individuals in helping professions better understand the experiences of individuals with substance abuse disorder. Shame, being a critical component of reality of substance abuse deserves a deeper exploration, especially the way it affects interfacing with governmental systems.

Being human in Western culture, child welfare social workers, and social workers in general, also fall prey to shame. Their own feelings of shame may affect the way they respond to and treat mothers with substance abuse disorder. The social workers' sources, experiences ad reactions to shame should be further explored.

The study opens the door for future critical research of services provided to mothers with substance abuse disorder and the impact those service have in reunification and health of families and communities. Recipients of services are experts on their experiences, and they should be consulted in research. This will give the commonly oppressed population a voice and a sense of empowerment. Social workers' attitudes towards women with substance abuse disorder need to be further explored, since as the study indicated, they have monumental impact on women.

Policy Suggestions

The study points to the importance of child welfare social workers having a comprehensive understanding of substance abuse disorder, its causes and

effects and shame related to it. This can be accomplished by providing comprehensive training about substance abuse disorder, its roots, causes and effects.

Also, shame could be further discussed with social workers in child welfare system. There is a need for child welfare social workers to learn about the concept of shame, how it affects them and their clients and how they can identify it and help combat it in themselves and women they work with.

Child welfare agencies could create aggressive anti-stigmatizing campaign in order to remind social workers of what stigma is, and how it affects recipients of services. The agencies could also make it clear that they condone stigmatizing behaviors.

A different hiring procedure for child welfare social workers may need to be designed in order to ensure that they share the values of the agency and that clients receive the most therapeutic, and professional treatment.

Mothers with substance abuse disorder are experts on their lives. Child welfare agencies should get input from women with substance abuse disorder when creating programs and services geared toward them.

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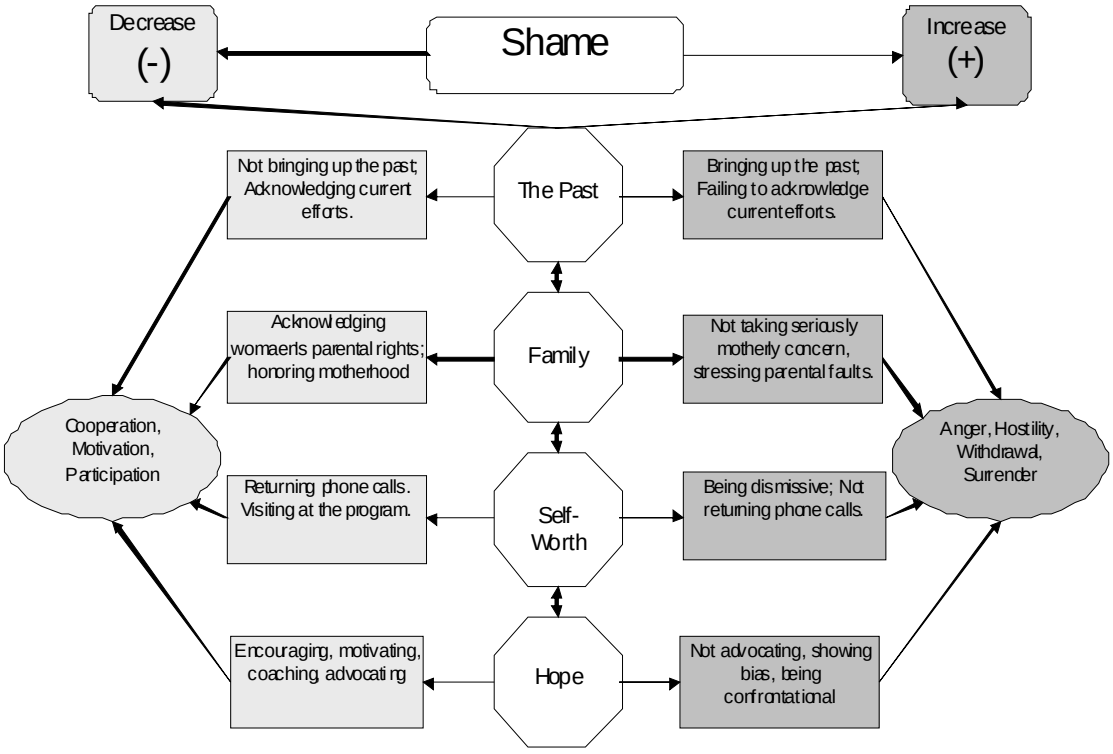
APPENDICES

APPENDIX A: VISUAL REPRESENTATION


Decrease
(-)
Shame
Increase
(+)
Not bringing up the past; Acknowledging current efforts.
The Past
Bringing up the past; Failing to acknowledge current efforts.
Acknowledging woman's parental rights; honoring motherhood
Family
Not taking seriously motherly concern, stressing parental faults.
Cooperation, Motivation, Participation
Anger, Hostility, Withdrawal, Surrender
Returning phone calls. Visiting at the program.
Self-Worth
Being dismissive; Not returning phone calls.
Encouraging, motivating, coaching, advocating
Hope
Not advocating, showing bias, being confrontational

APPENDIX B: AXIAL CODING MATRIX

Major Themes	Sub-Themes	Worker Behaviors/Attitudes that Provoke/Reduce Shame	Worker Behaviors/Attitudes that Reinforce/ Diminish Shame	Emotional/Cognitive/ Behavioral Consequences for Client
The Past	Remembering regretful past events, previous child welfare cases	Social worker bringing or not bringing back past digressions	Social worker doubting women's ability to succeed because of her past, not acknowledging present successes and progress.	Increase or decrease in shame followed by, either anger and hostility or openness, trust and motivation
Family	Positive or negative feelings and memories associated with being a mother and a daughter	Social worker blaming or not blaming woman for her family's circumstances	Social worker reminding mother of the consequences her behavior had on children's lives, or social worker threatening women by using children	Increase or decrease in shame followed by, either anger and hostility or openness, trust and motivation
Self-Worth	Feelings of worth, positive view of self, seeing self as valuable	Social worker showing or not showing empathy, social worker's dismissive or accepting attitudes	Social worker returning or not returning phone calls, listening or failing to listen, seeming preoccupied, interrupting, visiting women in person or failing to do so, social worker's facial expressions, showing interest	Increase or decrease in shame followed by, either anger, self-loathing, hostility, withdrawal, relapse or participation, empowerment and motivation
Hope	Positive outlook, belief in better future	Social worker encouraging or not encouraging woman, social worker working alongside woman toward the same goals	Social worker expressing hope, faith and trust in woman's abilities to overcome her circumstances	Increase or decrease in shame followed by, surrendering, withdrawing or openness, trust and motivation

California State University, Fresno

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