A FEASIBILITY STUDY
EXPLORING THE
RELATIONSHIP OF SELF-CARE AND PARENTING
FOR ADULTS
RECOVERING FROM SUD

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Learning Objectives

• Describe parental self-care for parents in recovery from Substance Use Disorders.
• Explore the relationship of parental self-care as it relates to parenting and recovery outcomes.

ACKNOWLEDGMENTS
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INTRODUCTION

Chapter 1
Background and Significance

Parenting—The act of caring for one's children in preparing them to manage the task of life

(Bornstein, 2013)

The Problem

- SUDs negatively affect parenting

- Economic impact > $193 billion (NDIC, 2011) for illegal drug use alone

- Does not include cost associated with alcohol or prescription drug misuse

- SUD can be a major risk factor for negative health outcomes for children (USDHHS, 2009), including:

  - Increased Risk for:
    - Child abuse and neglect
    - Malnutrition
    - Poor academic performance
    - Delinquency
    - Developmental, behavioral, and emotional problems
    - Child substance use disorders

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    - Malnutrition
    - Poor academic performance
    - Delinquency
    - Developmental, behavioral, and emotional problems
    - Child substance use disorders
Challenges While in Recovery for Parents and Non-Parents

- Maintaining recovery
- Physical Health Problems
- Stigma
- Stress and Coping
- Employment
- Health Insurance
- Resource Support (Financial and Social)
- Access to Healthcare Services
- Social and Legal Factors

Parenting Challenges While in Recovery

- Parenting effectively
- Parental self-efficacy
- History of poor parental modeling behaviors
- Child custody disputes
- History of poor parental bonding
- Parenting skills and development
- History of maladaptive coping responses to stressors

Research in Context
“So What?” Factor

A greater understanding of the relationship of self-care to parenting and recovery outcomes is useful to health care providers and researchers that seek to tailor interventions to improve recovery outcomes of parents in recovery in their natural living environments.

How did we get here?

Genesis of Research Constructs

“How do I NOW become a “good” Mom when I have never been a “good” Mom before?”
CHAPTER TWO
Parental Efficacy (PSE)

PSE and Parenting

- The evidence strongly links PSE to parenting behaviors and child health outcomes.
- Higher PSE levels are generally associated with better parent and child outcomes.
- Lower PSE levels are generally linked to poorer parent and child outcomes.

Manuscript #1

- An exploration of the factors influencing parental self-efficacy (PSE) for parents recovering from substance use disorders (SUD) using the Social Ecological Framework.

Summary of Chapter 2

- An integrative review was conducted on PE, parental behaviors, and parents recovering from SUD through the application of the SEM.
- Results indicate that there are many personal, interpersonal, environmental, and policy factors that influence PE for parents with or without addiction.
- Because PE is strongly linked to parenting behaviors and child health outcomes, interventions designed to improve PE may improve the overall health outcomes of families affected by SUD. These interventions would need to address interpersonal factors of guilt and shame associated with SUD, parenting knowledge (individual), social support (interpersonal), social networking of church, and other community support programs. The integral role of community support, multiagency collaboration (organizational), and national policies (policy) impacting funding for SUD should also be considered. Intervening on multiple ecological systems simultaneously can mitigate negative factors predictive of PE, improve access to healthcare and service delivery, and transform and sustain positive behavioral changes for parents recovering from SUD.

CHAPTER THREE

Legislation and Parents with SUD

Macrosystem factors such as national policies that impact funding around SUD should also be considered for parents in recovery in the United States and abroad.
Purpose

The purpose of the policy analysis was to examine selected legislation affecting government assistance for children of parents with SUD and systematically evaluate their conformity to social justice.

Findings and Implications

- Several constructs of social justice were missing.
- Most of the research in this review focused primarily on the negative health outcomes of the addicted parent or adult who became ineligible for government assistance after legislation was passed, with little research or emphasis placed on child health outcomes.
- None of the research examined long-term consequences for children of parents with SUD who lost government assistance, although several noted the potential adverse effect of withdrawing governmental assistance on the children.
- Research findings suggest that policy program funding should target health promotion and prevention initiatives for children affected by SUD.
- When the intended outcomes are to reduce the demand for illegal drugs through drug treatment, challenges arise due to economic barriers, limited access to legal and legitimate drug policies, issues at all governmental levels (Aday, 2001; Golden, 1997; Green et al., 2008).
Chapter 4

An Integrative Review of the Role of Self-Care Behaviors for Parents Recovering from Substance Use Disorders (SUD)

Because I take care of myself first,
I can take care of others even better.


Chapter 4—Summary of Findings

- Lack of stress modifiers, such as self-care behaviors (SCB), can increase vulnerability to drug use for parents in recovery from substance use disorders (SUD).
- The purpose of this integrative review was to determine how the existing literature describes, conceptualizes, and measures SCB for parents in the general population for its application to parents with a history of SUD.
- Framed by Bandura's Social Cognitive Theory of Substance Abuse, four qualitative and five quantitative studies identify SCB, though only one study describes SCB of parents in recovery.
Described SCB: (Women) SCB described by mothers included taking time out for self, engaging in pleasurable activities, periodically delegating child care, taking care of one’s physical and emotional health, sleep, rest, planning, and lowering expectations. Barriers to practicing SCB included limited time, limited financial and social support, difficulty getting and accepting help and setting boundaries. The majority of mothers in the selected studies were White, so the engagement and adoption of these parental SCB for women of color remains unknown. No fathers were included in the qualitative studies describing parental SCB.

Measured SCB: dietary patterns, physical activity, healthy weight, health responsibility, spiritual growth, and stress management, perineal care, breast care, knowledge of nutrition and elimination, and exercise. No studies were found for fathers or mothers with SUD and with pre-adolescent or adolescent children.

Summary of Findings cont.

• Few studies addressed parental SCB, and most of those studies focused on behaviors for new mothers with or without SUD during the early child years.
• Exploring the role of SCB in relation to parental well-being for the general population is a needed area for further research, even more so for parents who are recovering from SUD.
Feasibility Study

Exploration of Self-Care and Parenting Outcomes for Adults Recovering from SUD in Their Home Environment

Parents in recovery—operationally defined as parents who self-report >2 years in recovery and have been living in their natural home environment (community setting) for at least 2 years.

Parental self-care (SCB)—personal health behaviors deliberately employed by mothers and fathers who are in successful recovery from SUD to maintain their personal health, well-being, and parental functioning in response to external and internal stressors. Operational: Total scores on SAHP scale and patient self-report.

Parental Efficacy (PSE)—personal belief in one’s ability to parent effectively. Operational: Total scores on PSOC scale.

Operational Frameworks, Context, and Definitions (1 of 2)

The natural home environment in this study refers to the participants’ homes and not an inpatient, outpatient, or community-based residential support setting.

The term “length of time in recovery from SUD” in this study refers to parents who report abstinence from one or several categories of licit and illicit drugs (i.e., alcohol, cocaine, amphetamines, heroin, LSD, etc.) and maintain their recovery (maintenance phase) for a minimum of 2 years.

“Insiders”—refers to individuals who share personal knowledge and similar experiences of parenting while in recovery.
Purpose

The purpose of this convergent parallel mixed-methods observational study is to determine the feasibility of a study to identify reported SCB by adult parents in long-term recovery from SUD (>2 years) who are parenting in their homes in the community setting as a basis for intervention development in future research.

Specific Aims Overview:

1. Feasibility
   - Recruitment
   - Acceptability
   - Retention

2. Qualitative
   - Probing
   - Coding
   - Themes

3. Quantitative
   - Descriptive
   - Correlational
   - Categorical

4. Integration
   - Interpretation
   - Implications

Impact and Innovation of the Study

- Determine feasibility of approaches to recruiting this hard to reach population in a community-based mixed methods descriptive study.
- Identification of SCB from parents in long-term recovery in order to inform and develop parental self-care interventions.
- The proposed research was innovative, because exploring SCB for parents in their community setting presents a substantial departure from the traditional focus on sobriety for intervention development for parents in recovery from SUD.
Theoretical Framework

- Bandura's Social Cognitive Theory of Substance Abuse

Parent recovering from SUD

Human Agency

Aim 2: Qualitative

Results

Data Collection

Data Analysis

Aim 3: Quantitative

Results

Data Collection

Data Analysis

Convergent:
Quantitative & Qualitative
Data Collected Concurrently

Compare and Contrast

Interpretation

Aim 4: Triangulation Phase

Mixed Method Strategy: Convergent Parallel Mixed Methods Design

Approach: Recruitment (1 of 3)

- Various community-based organizations were approached and purpose of study explained
- Sample recruitment attempted through:
  - community-based centers,
  - churches and other faith-based support groups,
  - solicitation from a state registry of individuals completing mental health peer support state certification,
  - several statewide community-based programs in South Carolina,
  - snowballing techniques
Approach: Recruitment (2 of 3)

- Interested members affiliated with targeted community organizations were instructed in the flyer on how to contact the PI by phone or email regarding participation in a guided semi-structured face-to-face or telephone interview, depending upon the participant’s preference.
- Written consent prior to participation obtained from participants who chose to complete the interview and surveys face to face and by phone. The interviews were scheduled at a time most convenient for the participant.
- Snowball Sampling Methods—participants were asked to share study information and PI contact information with known individuals with shared experiences who may be eligible for participation.

Approach: Eligibility, Recruitment Goal, and Retention

- Recruitment goal
  - Up to 30 participants
  - Target—20 participants
- Inclusion/Exclusion Criteria.
  - > 18 years old
  - At least one child between the ages of 6—18 years
  - Self-report data of at least two full years in recovery from alcohol or drugs
  - Minimum of joint legal custody of their child
  - Parenting in their natural home environment

Approach: Informed Consent

- Full Disclosure: Purpose of study
  - Written Disclosure
  - Written Disclosure (Study Information Sheet)
- Potential risks and benefits
- Voluntary nature of the study
- Compensation for time spent completing the study
- Privacy and confidentiality
- Limits to confidentiality
Approach: Data Management

- RedCap
- Locked-Cabinet
- Password Protected Computer

FINDINGS

Feasibility outcomes, Quantitative Findings, Qualitative Findings, and Triangulation

### Feasibility: Primary Aim

<table>
<thead>
<tr>
<th>Feasibility Focus</th>
<th>Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recruitment</strong></td>
<td>(1) Proportion of number of respondents screened to number of eligible participants</td>
</tr>
<tr>
<td></td>
<td>(2) Proportion of participants who did not follow through with a scheduled telephone or in-person interview appointment out of total number of enrolled participants</td>
</tr>
<tr>
<td></td>
<td>(3) Portion of enrolled participants who requested telephone interview meetings out of total number of enrolled participants</td>
</tr>
<tr>
<td><strong>Retention</strong></td>
<td>(1) Number of community stakeholders who agreed to distribute recruitment flyer out of total number of those approached</td>
</tr>
<tr>
<td></td>
<td>(2) Number of partial versus total completion of the study by participants</td>
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<tr>
<td></td>
<td>(3) Literacy challenges from using guided interview script and standardized surveys as described by participant comments reporting clarifications of interview or survey questions</td>
</tr>
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<td></td>
<td>(4) Number of missing or incomplete survey items</td>
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<tr>
<td><strong>Acceptability</strong></td>
<td>(1) Number of participants referred through snowball sampling methods</td>
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<td>(2) Length of time for recruitment and data collection</td>
</tr>
<tr>
<td></td>
<td>(3) Positive and negative effects on participants as described by participants' comments</td>
</tr>
<tr>
<td></td>
<td>(4) Preliminary cost analysis</td>
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<tr>
<td><strong>Implementation</strong></td>
<td>(1) Barriers to face-to-face attendance or lack of follow through with telephone interview appointments</td>
</tr>
<tr>
<td></td>
<td>(2) Costs and types of resources needed to implement</td>
</tr>
<tr>
<td><strong>Practicality</strong></td>
<td>(1) Length of time for recruitment and data collection</td>
</tr>
<tr>
<td></td>
<td>(2) Positive and negative effects on participants as described by participants' comments</td>
</tr>
<tr>
<td></td>
<td>(3) Preliminary cost analysis</td>
</tr>
</tbody>
</table>

### Results

Guaranteed
Feasibility Results

- Eight community stakeholders out of 14 (57%) that were approached agreed to distribute the recruitment flyer within their networks.
- Some reported not having direct access to parents with at least 2 years recovery (n=2).
- Four community stakeholders did not respond to the PI when approached by email or phone (n=3), or requested additional information about the study, but did not provide consent to distribute the recruitment flyer within their network (n=1).
- Twenty-four total respondents contacted the researcher to indicate interest and willingness to participate in this study.

- Nineteen participants (79%) were eligible to participate based on inclusion and exclusion criteria previously discussed. The following reasons, 5 participants were not eligible to participate: all children ages less than 6 years (n=2) or greater than 18 years (n=1), self-reported less than 2 years of recovery from SUD (n=2).
- Ten participants (53%) were referred by other participants through snowball sampling methods within the organizations that were approached for recruitment purposes.

Feasibility Results cont.

- The total length of time for recruitment and data collection was six months—from January 2015—June 2015.
- All nineteen study participants completed both the interview and survey component of the study. No literacy challenges were reported or described by participants. There were no missing or incomplete survey items.
- As anticipated, there was difficulty in recruiting this hard to reach population generally, and particularly in recruiting minority parents in recovery from SUD. The modest recruitment rate may be attributed to the long-standing recruitment and attrition challenges associated with SUD research (Festinger & Dugosh, 2012).
- Community acceptability of the study was high.
- Challenges with implementation were centered on practicality of location for conducting interviews and scheduling interview times. All participants had a preference for phone interviews because of work schedules and time needed for child care or various personal or professional activities.

Feasibility Results cont.

- Overall, practicality and acceptability for the study was high.
- Participants reported perceiving this study as a very positive way they could help other parents in recovery by sharing their experiences.
- Fifteen of the participants completed surveys online by clicking on a link sent by the PI. Three participants completed the survey portion by phone (per participant request), and one participant completed survey by paper at a State-based Recovery Conference (per participant request). All participants reported willingness to participate in future studies through focus groups.
Descriptive Statistics

SPSS software was used to aid in data analysis. Descriptive analysis using categories, means, ranges, and frequencies was used to describe the study sample of mothers and fathers. This description of the sample was displayed in table form and included age, gender, race, number of children, employment status, marital status, number of years in recovery, drug of choice, and educational level.

The majority of participants were fathers who accounted for 57.9% (n=11) of the total sample. The parents were aged 29-60 years of age, primarily White (73.7%), married (57.9%), college-educated (65%) and employed for wages (57.9%). The majority of participants reported an annual income of less than $75,000 (63.2%). Approximately a third of participants reported length of time in recovery as greater than 10 years (36.8%) and the majority of participants indicated polydrug use disorder prior to entering into recovery.
Associations and Trends

Data Instruments

<table>
<thead>
<tr>
<th>Scale Name</th>
<th>Description/Scoring</th>
<th>Psychometrics</th>
<th>Population</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-rated abilities for Health Practices Scale (SAHP)</td>
<td>28-item, 5 point scale; 4 subscales with 7 items each; items are rated from 1 (not at all) to 4 (completely). Ratings summed to yield subscale scores, which when added together, yields a total score. Total scores range from 0-112 with higher scores indicating greater self-efficacy for health practices.</td>
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<tr>
<td>Exercise</td>
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<td>Nutrition</td>
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<tr>
<td>Responsible Health Practice</td>
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<tr>
<td>Psychological Well-being</td>
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<tr>
<td>Adultst who have disabling conditions: internal consistency reliabilities using Cronbach's alpha were .91, .76, .86, and .77 for total scores for Nutrition, Exercise, Psychological Well-being, and Responsible Health Practices subscales, respectively</td>
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<tr>
<td>General Population</td>
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</tr>
<tr>
<td>Undergrads</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Individuals with disabilities</td>
<td></td>
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</tr>
</tbody>
</table>

Dependent Variables

<table>
<thead>
<tr>
<th>Scales (PSOC)</th>
<th>Description/Scoring</th>
<th>Psychometrics</th>
<th>Population</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parental Sense of Competence</td>
<td>17 item measure; 2 subscales; Items are measured on a 6 point scale ranging from 1 (strongly agree) to 6 (disagree). Satisfaction items on the PSOC scale address the parents' overall satisfaction in the parenting role, while Efficacy items look at the parents' perceived capability to parent children effectively and problem-solve within their parental role. The eight items on the PSOC pertaining to parental efficacy (1, 6, 7, 10, 11, 13,15, 17) will be asked in the study. All numbers will be totaled to indicate participants PSOC score. A higher score indicates a higher parenting sense of efficacy.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Parenting Satisfaction</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Parental efficacy</td>
<td></td>
<td></td>
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<tr>
<td>Johnston and Mash (1989) have reported internal consistencies of .76 for the Efficacy scale, and Lovejoy et al. (1997) have reported internal consistencies of .88 for the Efficacy scale in two samples of mothers with preschool children.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mothers with preschool children</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Quantitative Measures

<table>
<thead>
<tr>
<th>Descriptive</th>
<th>Range of Values</th>
<th>Mean</th>
<th>Std. Dev.</th>
</tr>
</thead>
<tbody>
<tr>
<td>SRAHP</td>
<td>107-135</td>
<td>119.8</td>
<td>8.39695</td>
</tr>
<tr>
<td>cd_mac</td>
<td>8-10</td>
<td>8.8</td>
<td>.85498</td>
</tr>
<tr>
<td>AAPQ</td>
<td>18-31</td>
<td>24.1</td>
<td>3.62819</td>
</tr>
<tr>
<td>PSOC</td>
<td>29-45</td>
<td>37.2</td>
<td>4.67555</td>
</tr>
</tbody>
</table>
Results—Quantitative Measures (Associations and Trends)

- Total scores on the PSOC (e.g., parental self-efficacy) and APQ (e.g., positive parenting behaviors) showed a statistically significant positive moderate correlation.
- As PSE scores increased, so did total scores on the APQ.

Table 3. Spearman Correlation Coefficients among the Study Variables

<table>
<thead>
<tr>
<th>Variables</th>
<th>Age</th>
<th>PSOC</th>
<th>APQ</th>
<th>CD-RISC2</th>
<th>SAHP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PSOC</td>
<td>-0.09</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>APQ</td>
<td>0.38</td>
<td>0.46*</td>
<td>1.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CD-RISC2</td>
<td>0.25</td>
<td>0.23</td>
<td>0.20</td>
<td>1.00</td>
<td></td>
</tr>
<tr>
<td>SAHP</td>
<td>-0.10</td>
<td>0.21</td>
<td>-0.25</td>
<td>0.18</td>
<td>1.00</td>
</tr>
</tbody>
</table>

* Significant at a 0.05 level

Associations and Trends Continued

- Scores on the SAHP were highest for participants who self-reported being in early recovery (e.g., 2-5 years) and lowest among those who reported being in long-term recovery maintenance (e.g., >10 years).
- More self-care behaviors may be needed for parents in early recovery in order to effectively deal with life challenges without returning to drug use as a means of coping. In the late stage recovery cycle, life typically improves for individuals in recovery from SUD, and there is a lesser focus on maintaining self-care behaviors.
- Scores on the PSOC (e.g., PSE) were also higher for the participants categorized in 2-5 years of recovery, and lowest among those participants who self-reported length of time in recovery as 11 years or more. However, the relationship of parental self-care as it relates to PE particularly within the context of recovery from SUD is less clearly understood and has been an under-investigated area in research.

Table 4. Results from Kruskal-Wallis Test for Comparison of Outcome Measures by Length of Time in Recovery (e.g., 2-5 years, 6-10 years, 11 years or more)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Length of Time in Recovery</th>
<th>N</th>
<th>Mean Rank</th>
<th>Chi-square and df</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSOC</td>
<td>2-5 years</td>
<td>7</td>
<td>13.93</td>
<td>6.5</td>
<td>0.040</td>
</tr>
<tr>
<td></td>
<td>6-10 years</td>
<td>5</td>
<td>9.60</td>
<td>2</td>
<td>0.966</td>
</tr>
<tr>
<td></td>
<td>11 years or more</td>
<td>7</td>
<td>6.36</td>
<td>2</td>
<td>0.417</td>
</tr>
<tr>
<td>APQ</td>
<td>2-5 years</td>
<td>7</td>
<td>10.36</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>6-10 years</td>
<td>5</td>
<td>9.50</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>11 years or more</td>
<td>7</td>
<td>10.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CD-RISC2</td>
<td>2-5 years</td>
<td>7</td>
<td>9.43</td>
<td>1.8</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6-10 years</td>
<td>5</td>
<td>12.60</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>11 years or more</td>
<td>7</td>
<td>8.71</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SAHP</td>
<td>2-5 years</td>
<td>7</td>
<td>12.79</td>
<td></td>
<td>0.020</td>
</tr>
<tr>
<td></td>
<td>6-10 years</td>
<td>5</td>
<td>12.70</td>
<td></td>
<td>0.231</td>
</tr>
<tr>
<td></td>
<td>11 years or more</td>
<td>7</td>
<td>5.29</td>
<td></td>
<td>0.004</td>
</tr>
</tbody>
</table>

Associations and Trends cont.

Table 5. Mann-Whitney U Test: the Comparison of Psychological Well-being (e.g., 2-5 years, 6-10 years, 11 years or more)

<table>
<thead>
<tr>
<th>Length of Time in Recovery</th>
<th>N</th>
<th>Mean Rank</th>
<th>U</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSOC</td>
<td>7</td>
<td>13.93</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>ABQ</td>
<td>7</td>
<td>10.36</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>CD-RISC2</td>
<td>7</td>
<td>9.43</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>SAHP</td>
<td>7</td>
<td>12.79</td>
<td>19</td>
<td></td>
</tr>
</tbody>
</table>

MUSC
Associations and Trends

Although not statistically significant (p=0.07), total scores of SAHP were higher for participants with higher education levels (table 5), indicating a clinically significant trend that warrants further investigation.

<table>
<thead>
<tr>
<th>Education</th>
<th>N</th>
<th>Mean Rank</th>
<th>Mann-Whitney U</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>High School graduate</td>
<td>6</td>
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<td>0.200</td>
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<td>24.5</td>
<td>0.570</td>
</tr>
<tr>
<td>College 4 years</td>
<td>13</td>
<td>11.1</td>
<td>26.5</td>
<td>0.072</td>
</tr>
</tbody>
</table>

Approach: Study Limitations

- Self-report data
- Possible recall bias
- Small sample size may have prevented detection of other significant correlations
- Small number of minority participants
- Cross-sectional nature of study
- No conclusions about causality can be made
- Unable to generalize findings
- Time Constraints

Qualitative Component and Interview Guide

- Scripted Qualitative Semi-structured Interview Guide
  - Tell me what the experience of parenting (e.g. taking care of your child) has been like for you from the time you began your recovery up until now?
  - What are your greatest challenges with maintaining your recovery and parenting?
  - Can you share some ways you overcome these challenges?
  - Describe behaviors that you do to care for yourself?
  - How do these behaviors affect your recovery?
  - How do these behaviors affect the care you give to your children?
  - What is the biggest lesson learned through your recovery journey as a parent that you could pass on to other mothers or fathers? (Interviewer will say “Mothers” or “Fathers” depending on gender interviewed)
  - Ask persons for their willingness to participate in future study:
    - Would you be willing to come back to a focus group and discuss some approaches or strategies that helped you in your recovery and your parenting?
Data Analysis Plan: Qualitative

Constructivist Grounded Theory (Charmaz, 2006)

- NVivo 10 (QSR Int., Burlington, MA) software was used to organize and manage qualitative data.
- Individual interviews were audio recorded, transcribed, and checked for accuracy.
- Initial coding of data was performed line by line for each transcribed interview, and the data was categorized under general subject headings.
- Transcripts were analyzed using a process of categorization (coding) based on subject matter and patterns expressed in the texts.
- Each transcript was reviewed several times, and categories began to emerge based on common thematic patterns across responses.
- The most frequently occurring and/or significant codes were identified and compared across transcripts.
- Memos were written to analyze the meaning of these codes and determine their significance as a supportive factor or barrier to parenting, self-care, and recovery.
- Analysis included exploring both explicit text and latent meaning. Descriptive saturation was reached when no new descriptive codes or themes emerged.
- Theoretical saturation was reached when the researcher understood how the texts, codes, and the underlying construct interconnect.

Process of Confirmability

Qualitative Findings

- The Consolidated Criteria for Reporting Qualitative Studies (COREQ) 32-item Checklist was integrated in the reporting of the methods and findings (Tong, Salsibury, & Craig, 2007).

Central Themes Around Successful Parenting While in Recovery

- Challenging both in situations where the parent was in recovery prior to becoming a parent (n=4) and in situations where parents entered recovery from SUD after having their children (n=15).
- The very conscious transitioning to a more integrated person in recovery from SUD while consciously moving away from the sole identity of a person “addicted” to drugs.
- All participants referred to recovery management from SUD as maintaining abstinence from the drugs of prior use.
- Each participant described and employed self-care strategies categorized as cognitive, emotional, spiritual, or behavioral health strategies to promote their continued recovery from SUD as well as their continued parenting of their children.

Qualitative Findings Continued

- (1) Balance the provision of care needs for self as an individual in recovery from SUD to the provision of care for others;
- (2) Identify emotions, people, places, and things that trigger relapse or increase vulnerability to return to drug use and make intentional efforts to avoid them;
- (3) Repair, rebuild, and renegotiate personal relationships in recovery to establish personal stability and maintain sobriety;
- (4) Adjust unrealistic expectations for self and others;
- (5) Incorporate new parenting skills while in recovery;
- (6) Live with regret without returning to drug use; and
- (7) Find life balance in recovery, work, parenting, and sponsorship.
Qualitative Findings Continued

• One participant (#16) stated:
  
  "It's hard work if you put the work in...I always say that it is input and output; if you don't put anything into it, you will never get anything out of it. My analogy to whomever I am talking to even to my family is...I call it a recovery bank. If you don't put a deposit in the recovery bank, which is literature, reading, AA meetings, networking, of course abstinence is #1 cause you have to stay off the sauce, if you're gonna achieve the other 3 which is AA meetings, sponsors and networking. Those things work if you work it."

Sources of Support

Spirituality as Source of Support

• Foundational part of recovery—Faith and Belief in God/Higher Power
• Belief System and Spiritual Practice
• Provided Optimism in a future without alcohol and drugs
  
  • "I remember first having the conversation with myself when I first felt the desire to want to change and to get away from alcohol and drugs and there was a fear for a moment that I had to surrender all that I was going on--the fear that I am going to be some other mess. That's what I was afraid of, that the change would mean that I had to give up the things that I actually enjoyed. And that I was only able to surrender, or that I was able to take a step, and it was actually going to take that much of a step, because otherwise I was actually afraid to take that step. But because if I gave all this up, what would I have to look for? You know...what was the hope? But yet and still...I gave that up and my faith knowing that there is a God and if I take one step, he will take two steps for me". (Participant #17)

• "Spirituality allowed me to forgive myself for a lot of bad decisions I've made, especially, versus which was a burden for the past because of that it allowed me to change, which I needed to help me get over the fear seemed to be an incredible force" (Participant #17)
Family, Neighbors, Friends, and Co-workers as Source of Support

- The majority of participants (n=12) indicated having a strong family support network. Eight reported either limited family support or no family support (n=7). Five participants reported limited contact or major conflict with their family of origin due to the presence of family members (most commonly parents) still engaging in active SUD.
- For example, Participant (#18) reported: “Yeah, I had family support from my Mom, from my wife’s family...I really did not have a role model from my father. My father is in active addiction still to this day. So I couldn’t really look at my dad to learn how to be a Dad.”
- Neighbors, family, friends and co-workers provided help with childcare, emotional support, and encouragement for continuing education. Many obtained college degrees and certifications while in recovery.

Community, Government Organizations, and Civic Leaders as Support

- Community support included actively and routinely connecting to community based recovery groups for ongoing recovery support and community involvement. These groups included Alcoholics Anonymous, Narcotics Anonymous, Celebrate Recovery, and United Way for meetings, networking, and sponsorship of individuals in early recovery.
- Government organizations included the Veteran’s Administration and Vocational Rehabilitation for financial support and job training and the Department of Mental Health for professional services and support.
- The types of civic leaders mentioned as being a helpful resource in the community for parenting and recovery support were a parole officer and the legal system support of a female attorney who worked for the United Way organization.

Reported Self-Care Behaviors

<table>
<thead>
<tr>
<th>2-5 Years</th>
<th>6-10 Years</th>
<th>&gt; 10 Years SD8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meditation, exercise, readings, attend recovery meetings, active participation in community and church groups, prayer, maintaining spirituality, daily self-monitoring/inventory, connecting with community and civic resource support, work, healthy eating</td>
<td>Taking care of health/chronic medical conditions, setting boundaries, healthy eating, exercise, attended recovery meetings, active participation in community and church groups, prayer, maintaining spirituality, daily self-monitoring/inventory, connecting with community and civic resource support, work, healthy eating</td>
<td>Setting boundaries, healthy eating, maintaining spirituality, daily self-monitoring/inventory, connecting with community and civic resource support, work, healthy eating, obtaining higher education</td>
</tr>
<tr>
<td>Exercise, healthy eating, attending recovery meetings</td>
<td>Accessing online support, setting boundaries, healthy eating, maintaining spirituality, daily self-monitoring/inventory, connecting with community and civic resource support, work, healthy eating</td>
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### Self-Care Behaviors Reported by Fathers and Mothers

<table>
<thead>
<tr>
<th>Fathers in Recovery from SUD</th>
<th>Mothers in Recovery from SUD</th>
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</thead>
<tbody>
<tr>
<td>1. Spending quality time with kids</td>
<td>1. Spending quality time with kids</td>
</tr>
<tr>
<td>2. Connecting to spirituality—daily prayer, faith in higher power</td>
<td>2. Connecting to spirituality—daily prayer, faith in higher power</td>
</tr>
<tr>
<td>3. Maintaining recovery support meetings</td>
<td>3. Maintaining recovery support meetings</td>
</tr>
<tr>
<td>5. Setting boundaries</td>
<td>5. Setting boundaries</td>
</tr>
<tr>
<td>6. Going to a non-substance related reward activity</td>
<td>6. Going to a non-substance related reward activity</td>
</tr>
<tr>
<td>7. Interspersed connecting to community or civic group as preferred resource for recovery and/or purpose</td>
<td>7. Interspersed connecting to community or civic group as preferred resource for recovery and/or purpose</td>
</tr>
<tr>
<td>9. Attending recovery support meetings</td>
<td>9. Attending recovery support meetings</td>
</tr>
<tr>
<td>10. Living in the present moment</td>
<td>10. Living in the present moment</td>
</tr>
<tr>
<td>11. Maintaining connections to family (e.g. praying every day, bible studies, participating in prayer group, etc.)</td>
<td>11. Maintaining connections to family (e.g. praying every day, bible studies, participating in prayer group, etc.)</td>
</tr>
<tr>
<td>12. Managing chronic physical health conditions (e.g. diabetes, hypertension)</td>
<td>12. Managing chronic physical health conditions (e.g. diabetes, hypertension)</td>
</tr>
<tr>
<td>13. Connecting to spirituality</td>
<td>13. Connecting to spirituality</td>
</tr>
<tr>
<td>14. Obtained higher education and/or peer to peer support certification</td>
<td>14. Obtained higher education and/or peer to peer support certification</td>
</tr>
<tr>
<td>15. Connecting to community resource or civic center as preferred for recovery and/or purpose</td>
<td>15. Connecting to community resource or civic center as preferred for recovery and/or purpose</td>
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<tr>
<td>17. Maintaining spirituality—daily prayer, faith in higher power</td>
<td>17. Maintaining spirituality—daily prayer, faith in higher power</td>
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<td>18. Mental health counseling</td>
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<td>19. Family members/groups</td>
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<tr>
<td>20. Online support</td>
<td>20. Online support</td>
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### Perceived Benefits of Self-Care to Parenting

**Theme 1: Acceptance of self and others including children**

> "Well, it affects me parenting because it lets me know that kids are gonna be kids. And sometimes I gotta think about my expectations, because sometimes expectations cause resentment. Sometimes we want our kids to be at a level where they are not. So from the moment we get our kids to go through their process, they have to go through their process. And sometimes we want to expedite that. But we’ve gotta do that. Addicts want everything and they want it now (laughs). And it doesn’t work like that all the time." (Participant #16)

**Theme 2: Improved self-esteem—Feeling better about being Mom or Dad**

> "Well, I’ve got more self-confidence. I like my life better. And I feel like taking care of myself and them seeing me exercise and feeding them healthy dinners and going that extra mile is a good role model for them and that makes me feel real good." (Participant #16)

> "Well, when it comes to my 6 year old, it helps me feel confident that I can keep up with her when she starts running. Makes me feel confident that I can protect her pretty much in any situation. Makes me feel confident that when we go out in public, my daughter will feel proud to be with her father. And it makes me feel my whole well-being and makes me feel good about myself." (Participant #16)
Perceived Benefits of Self-Care cont.

- **Theme 3: Emotional Sobriety—thinking clearer in parenting situations**
  
  - "When I stop and think about it and pray, it helps me by not losing my temper and
    thinking things through. I sit down with my kids and have discussions about
    things I might have done wrong. I take a step back from situations and
    don’t personalize them.
  
  - "The years I was drinking I would...I didn’t feel good about myself; didn’t
    feel like I was good enough. My kids would see that and I didn’t want
    that to happen. I started doing things differently.

- **Theme 4: Improves parental care of children—learning to do things differently**
  
  - "I learned behaviors of increased tolerance and patience were cultivated when
    dealing with children and their frustrations."
  
  - "Some parents reported a desire to parent differently than how they were raised.
    They talked about the differences they learned through self-care, such as
    abstinence, attending meetings, learning to not "hold on to stuff", meditation,
    journaling, and daily self-monitoring as positively influencing their parenting.

- **Theme 5: Parenting differently than how I was raised and becoming more involved**
  
  - "I would go to my daughter’s school and then leave. But now I try to
    be involved in their activities.
  
  - "I participate a lot more. I’m still learning, but I am learning.
    I participate a lot more in what they do now."

- "When I was drinking, I would...I didn’t feel good and I knew I was
  beating myself up. Now I’m there to support them and to help them
  feel good about themselves."
Benefits of Self-Care cont.

- Theme 6: Modeling better behaviors and learning to be satisfied as Mom/Dad

Parents reported a greater awareness of the effect of parent modeling on children's behavior. Moreover, they saw positive child outcomes and consequently perceived themselves as better role models. This awareness led to greater satisfaction with parenting in general through the SCBs of maintaining spirituality, connecting with support, and self-monitoring.

“I realize that well, I am much more… I recognize that my behavior… or what I do or don’t say is critical, and hence, I’ve got to think before I react. I’ve got to think about my behavior and what I’m modeling.” (Participant 005)

“They see that I am trying to step up and be a good father you know. I am changing and with God’s help, I will stay this way. You know it’s by the power that I will do things really well with my turn around. So, that is another gratifying point too.” (Participant #10)

Perceived Benefits of SCBs cont.

- Theme 7: A second chance to parent differently with children

Most participants reported living with a certain amount of regret from their life when they were involved with active substance use while parenting. They reported living with this regret as a means of facing the uncertainty of the future with optimism particularly for another chance to parent differently and sober.

“I think every situation even if it is with my older children to the youngest, every situation carries its own burden to a recovering addict so where we feel like I hadn’t done good enough or I could have been different or maybe I shouldn’t have said that or should have done this another way or that sort of thing. But I think that it is a chance to learn, that is an opportunity to learn from your mistakes and that is just as important as learning from your successes. You are always going to face that situation with your children every situation is going to recur with the children. So, I am going to use that as an opportunity. I am not going to turn it into something negative. I am just going to take it as an opportunity instead of me saying like I did the first time, I will do it in a manner where I don’t birth goods in which you cannot another occasion the first time I have been wrong I have grown from that experience. So, that is another gratifying point too!” (Participant #8)

Summary and Conclusions

- Self-Care Behaviors have positive impact on parenting and recovery outcomes

- Self-care for fathers tended to be more behavioral and/or spiritual strategies, while self-care for mothers tended to be more emotional, cognitive, spiritual and relational strategies.

- Self-care behaviors consistently reported by participants across length of time in recovery included connecting to recovery support in the community, learning to live with regret without returning to drug use, taking care of physical health, maintaining spirituality, staying busy, establishing boundaries with self and others, accepting perceived failures/limitations, willingness to seek help when needed, and incorporating time for self.

- Being able to access support is an integral part of positive recovery outcomes.

- Another noteworthy finding is the personal development that many of the participants who successfully were parent, children and maintain sobriety achieved while in long-term recovery. These included gainful employment, continued education and professional degrees, community service and leadership, and networking to aid other organizations in promoting recovery for individuals, families and communities.
Limitations
- Small sample size
- Small minority sample
- The lack of generalizability resulting from the qualitative research design limits the larger potential implications of the study.

Future Research
- Explore the role of SCB as predictor or mediating variable to recovery and parenting outcomes.
- Further exploration of the unique experiences of minorities in long-term recovery to examine how race and culture shape the experiences of self-care, recovery, parenting.
- Future research will need to examine the extent to which different types of self-care behaviors influence parenting and recovery outcomes for parents in recovery from SUD.
- Future clinical trials investigating specific self-care interventions on recovery and parenting outcomes.

Triangulation
- Both through quantitative and qualitative data analysis, a relationship between parental self-efficacy and self-care behaviors exists.
- There is a positive moderate correlation in total scores on the parental efficacy and parenting behaviors measure.
- Quant data showed that scores on the SAHP were highest for participants who self-reported being in early recovery and lowest among those who reported being in recovery the longest. Qual data supported this: "90 meetings in 90 days"
- Higher PSE scores were seen in those individuals with shorter recovery times, while lower PSE levels were seen in those parents with the longest recovery times.
- Each county had its own county-level drug and treatment services that were often incorporated into behavioral health treatment services.
- Participants reported feeling like there were available resources to their county and they reported preferences for accessing particular resources.
Contribution to Nursing and Addictions Science

- Provides a greater understanding of self-care as it relates to the experience of parenting within the context of recovery from SUD for mothers and fathers.
- Highlights perceived health benefits of self-care as a potential means to effectively mediating the unmanageable stress involved with trying to maintain recovery while also parenting children in the home.
- Unique in its focus on the understudied and hard to reach population of mothers and fathers achieving successful recovery from SUD.

Questions?