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"I'm not a bad mother:" The experience of stigma among mothers with substance use disorder in the criminal justice system

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Abstract

This study explores the impacts of stigma on the lives of pregnant and parenting women with substance use disorder (SUD) and justice involvement. We also uncover how some women were able to cope with adversity and take steps to develop resilience. To guide our research, we combined Bos and colleagues' stigma theory with Windle's concept of resilience. Semi-structured interviews were conducted with 20 pregnant or parenting women in Western New York to uncover the contextual factors influencing care, resources, and social support. Our findings suggest that the presence of stigma hinders pregnant and parenting women's access to resources, care, and treatments while reinforcing marginalization, isolation, and continued substance use. Despite these challenges, some participants found ways to navigate and mitigate stigma while promoting resilience. Protective factors and strategies included: maintaining a positive motherhood identity, leveraging social support often outside the nuclear family, and having access to supportive, compassionate justice system resources. Understanding the strategies women with SUD use to overcome adversity can inform approaches that judges, case workers, and health care providers can use to engage and support women in recovery and reduce their experience of stigma.

Keywords

substance use disorder; stigma; motherhood; addiction medicine; women's health; criminal justice system; qualitative methods

Introduction

This qualitative study explores the experiences of pregnant and parenting women with substance use disorder (SUD) and justice system involvement. These women confront

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multiple health-related and structural challenges compounded by a triple stigma of justice-involvement, substance use, and negative societal judgment about their parenting ability (Adams et al., 2021; Fuentes, 2022; Knight, 2015). They have been described as invisible; their experiences have not been studied as extensively as those of justice-involved men (Fuentes, 2022). This study addresses this research gap through examining women's experiences in the justice system in relation to motherhood and recovery from substance use with a focus on stigma.

In 2016, approximately 1.2 million women were involved in the US criminal justice system, which includes correctional facilities and community supervision programs (The Sentencing Project, 2022; Thomas et al., 2019). The incarceration rate for women continues to increase and is mostly driven by substance use with nearly 60% incarcerated in federal prison for a drug-related offense (Carson, 2020). Women in the justice system have higher rates of drug use and psychological distress compared to men (Mildrum Chana et al., 2021).

Stigma and shame present formidable barriers to treatment and recovery among women with SUD, especially those who are pregnant or parenting (Crawford et al., 2022; Gueta, 2017; Lee & Boeri, 2017; Weber et al., 2021; Wolfson et al., 2021). Women with SUD experience greater stigmatization than men (Lee & Boeri, 2017; Radcliffe, 2011). Moreover, pregnant and parenting women with SUD face the additional stigma of not conforming to the societal ideal of the "good mother" who is altruistic, child-focused, protective, patient, and provides substantial material comforts (Adams et al., 2021; Couvrette et al., 2016; Fuentes, 2022; Lee & Boeri, 2017; Radcliffe, 2011). Fear of child removal is a powerful deterrent to seeking treatment or social services, promoting isolation among mothers with SUD (Adams et al., 2021; Crawford et al., 2022; Gueta, 2017; Knight, 2015; Wolfson et al., 2021).

The objective of this study was to explore the impacts of stigma on the lives of pregnant and parenting women with SUD who also had justice involvement. We also aimed to uncover how some women were able to cope with adversity and take steps to develop resilience. To guide our research, we combined Bos and colleagues' stigma theory with Windle's concept of resilience (Bos et al., 2013; Windle, 2011).

Stigma and resilience

The sociologist Erving Goffman defined stigma as a deeply discrediting attribute or characteristic causing individuals or groups to be classified as having a "spoiled identity" (Bos et al., 2013; Goffman, 1963; Pryor & Reeder, 2011). Psychologists Pryor and Reeder elaborated upon Goffman's concept of stigma and developed a theoretical model consisting of four interrelated components: self-stigma, stigma by association, structural stigma, and public stigma (Bos et al., 2013; Pryor & Reeder, 2011). Bos and colleagues further enhanced this conceptual framework (Bos et al., 2013; Pryor & Reeder, 2011). Self-stigma refers to the socio-psychological impacts of stigma upon an individual. Stigma by association refers to the adverse reactions of family, friends, and contacts to the stigmatized individual. Structural stigma involves how society's institutions and ideologies legitimize and perpetuate stigmatized status. Public stigma refers to the devaluation of people or groups by others in the wider society, based on a stigmatizing condition. Taken together, these four stigma components are interacting and inter-connected (Pryor & Reeder, 2011).

A growing body of literature examines resilience as a dynamic process, with risk and protective factors, interacting with an individual, their social networks, and their environment (Goodman et al., 2020; Rudzinski et al., 2017; Windle, 2011). Gill Windle developed a theoretical model that considers the dynamic interrelationships between internal and external factors, along with assets and resources, that help people manage adversity and develop resilience (Goodman et al., 2020; Rudzinski et al., 2017; Windle, 2011). Windle identified four levels of interacting protective factors or strengths which contribute to resilience: the individual level, family/household relationships, neighborhood/social context, and social policy (Goodman et al., 2020; Windle, 2011).

In our study we adapted Windle's concept of resilience through identifying protective factors and resources used by some study participants to cope with personal challenges and stigma. We incorporated this resilience concept into Bos and colleagues' theoretical model of stigma. This enabled us to examine the effects of stigma on participants' experiences and to identify protective factors and personal strategies that some women drew upon to cope with stigma and build resilience.

Materials and Methods

We chose a qualitative design to learn about women's experiences as justice-involved mothers with SUD. Pregnant or parenting women over 18 with a history of SUD and current or prior involvement in the criminal justice system were invited to participate in the study.

Participants were recruited from a women's residential treatment center, a transitional case management program, local behavioral health agencies, and a family treatment court in Erie County, New York. We used a multifaceted approach for recruitment. Flyers were posted at recruitment sites. Nurses at the residential treatment center, a certified peer from the transitional case management program, and agency providers distributed business cards with study information to interested eligible clients.

The The University at Buffalo Institutional Review Board granted human subjects' approval (ID: UBIRB STUDY00006390). To maintain confidentiality, participants provided verbal consent. Our IRB advised us not to collect written, personally identifiable information from our participants who constitute a vulnerable population. Therefore, we read them an IRB-approved verbal consent script document and collected verbal informed consent.

Data collection

From June 2022 through July 2023, we conducted in-depth, semi-structured interviews lasting 30–90 minutes, followed by a brief demographic questionnaire. We developed an interview guide in consultation with a certified peer with lived experience as a mother in recovery with justice-involvement. Interview questions asked about participants' experiences as mothers in recovery from SUD, their experiences with the justice system and with health care. Study participants received a $20 supermarket gift card. We arranged the interviews at a time and location of the participants' choice. The interviews were recorded with the participant's permission. To ensure confidentiality, we assigned a unique identification code to each interviewee and an alias for reporting purposes, also used in this article.

Analysis

We used an inductive thematic content analysis approach to identify themes (Burnard et al., 2008; Charmaz, 2014). Following this method, researchers identify themes as they emerge from the qualitative data rather than utilizing an outline or template (Burnard et al., 2008). The team independently reviewed the transcripts and derived a list of overarching themes and major code categories. The themes and code categories represented overriding concepts or major ideas that emerged repeatedly or persisted within and across transcripts. This is an iterative process whereby data are continuously reviewed until no new themes or codes emerge and saturation is reached (Bernard & Gravlee, 2014). Once consensus was reached, the team constructed a codebook. Team members met together to conduct line-by-line coding of themes in Atlas-TI. The themes were then organized in alignment with the four interrelated categories of stigma (Bos et al., 2013). Within each category of stigma-related themes, we also identified sub-themes corresponding to protective factors or strengths that participants adopted to cope with stigma or adversity.

Results

Twenty (20) pregnant and parenting women with SUD and criminal justice involvement were interviewed (Table 1). The mean age was 35 years. More than half (55%) were single and two were married at the time of their interview. Nearly all (95%) had completed high school or received a GED, and over half (70%) were unemployed. A substantial portion (55%) of the women lived in a residential treatment facility at the time of the interview. The majority (85%) of study participants had health insurance through Medicaid, and most (70%) interviewees reported that they received public assistance and relied on public transportation (70%). Two thirds (75%) had two or more children, with 70% having some form of child custody.

We identified four thematic categories and sub-themes corresponding to the interrelated categories of stigma: self-stigma, stigma by association, structural stigma, and public stigma as well as protective factors promoting resiliency (Table 2).

Self-Stigma

Self-stigma encompasses feelings of guilt, shame, and low self-esteem or self-worth (Bos et al., 2013; Pryor & Reeder, 2011). Study participants felt guilty about the effects of SUD and justice involvement on their children's lives, noting the traumas and difficulties their children experienced. Talia blamed herself for not doing enough to protect her child from her substance use: "I feel like I'm supposed to save my daughter from the mistakes and the evils of the world, and I brought them into the house. I feel like a failure." A related concern shared by interviewees was that the children would struggle with addiction, either due to genetics or from growing up with parental SUD.

Shame and guilt inhibited participants from asking family for help. Following a positive urine toxicology test in Family Court, Amy's children were removed from her care. She chose not to seek help from family: "I didn't want to come to my family and tell them I was addicted to alcohol. I was addicted to crack, and I couldn't truly provide for my children.…"

Participants' reluctance to seek help from family reinforced social isolation, exacerbating addiction struggles.

Despite these challenges, many participants maintained a positive attitude toward motherhood which served as a protective factor. After learning she was pregnant, Laura tried to stop using crack on her own and then sought treatment after two recurrences of use. She saw motherhood as a turning point, motivating her to initiate SUD treatment to ensure the well-being of her child, and viewed pregnancy as a second chance to improve her life and reinvent herself.

Another participant, Ruth, was enrolled in drug court but suffered a recurrence of use after the sudden passing of her father. She emphasized that despite her struggles in drug court and with recovery, her motherhood identity kept her grounded: "Being a mom doesn't stop. So, it doesn't matter what comes your way." Among these women, a positive motherhood identity served as a protective factor, providing the resilience to cope with negative stigmas they faced.

Stigma by Association

Stigma by association occurs when family, friends, and others distance themselves from the stigmatized individual to avoid judgment or devaluation (Bos et al., 2013; Pryor & Reeder, 2011). Some interviewees reported that due to their history of SUD, their parents did not want contact. Alia described herself as her family's "first addict" due to her drug use, even though other family members had alcohol use disorders. This included her mother who ostracized Alia: "She thinks I'm a terrible person and wants nothing to do with me if I'm using." Due to lack of trust, her mother would not let Alia see her oldest daughter until she deemed that Alia was well into recovery.

Several interviewees spoke about the effects of SUD on relationships with children. In some cases, older children blamed their mothers for causing hardships. Leah's two young adult children blamed her for their biological father's death from a drug-related accident. Another interviewee, Anna, worried that her daughter would be ostracized from classmates -- that if their parents learned of her SUD, they would restrict contact with her daughter. Interviewees' concerns about avoidance and devaluation exacerbated feelings of self-stigma, reinforcing social withdrawal.

To cope with the avoidance behavior from close family and friends, some participants drew upon relationships outside of their nuclear families. Instead, they sought support from extended family and non-family members, who actively supported the participant with survival needs and childcare. When asked who plays a key role in helping raise her children, Zara named her ex-boyfriend's grandmother who: "is helping me become a better mother…."

Some participants received instrumental support through relationships formed in self-help meetings, such as Alcoholics Anonymous, including sponsors and peers. By developing alternate support networks, participants turned to people who could help with survival

needs, providing a modicum of stability and, in some cases, the ability to remain with their children.

Structural Stigma

Structural stigma occurs when social institutions impose differential treatment of groups based on a stigmatized condition or characteristic, often resulting in socioeconomic inequalities and marginalization (Bos et al., 2013; Pryor & Reeder, 2011). Interviewees experienced structural stigma across a variety of contexts, including courts, jails, residential treatment facilities, and healthcare.

Interviewees complained that the courts treated them disrespectfully - especially when judges or court authorities made denigrating remarks about the women's role as mothers. Holly had been involved in the criminal justice system for 15 years: "I have had judges tell me that I make them sick because why would I choose the streets and drugs over my kids?" Laura reflected that "there is a lot of judgment." She elaborated:

> I think they feel like a mother wouldn't do such things, and maybe we don't deserve to be mothers. Mother to them has a specific identity and a particular box to fit, and since we suffer from substance use and are involved in criminal activities, that's not something a mother would typically do.

Study participants spoke about the persistent need to prove their worthiness and competence as mothers to the court, where they felt disrespected and mistrusted. Nina experienced a medical emergency, which the court incorrectly attributed to a side effect of illicit substances. Even with a doctor's note, the courts did not believe her. In turn, her daughter was removed from her care.

Several interviewees described incarceration experiences, especially physical and emotional mistreatment by the jail guards. Alia was eight months pregnant when she was incarcerated and had her wrist broken by an officer handcuffing her. Carly spent the last trimester of her pregnancy in jail, giving birth to her daughter with two guards present. She discussed the poor conditions she endured, including isolation, limited space due to COVID restrictions, and inadequate food.

Structural stigma occurred during interactions with healthcare providers. For example, Marly's OBGYN scolded her for having substances in her system when her daughter was born, even referencing "crack babies," and commenting that he has "seen what drugs can do to them." She recounted how bad he made her feel, especially his scornful remarks about substance use when she was trying to seek care. The medical practice discharged her and as a result, she had to wait until she was established with a different OB/GYN to obtain access to birth control.

In the face of structural stigma some interviewees found opportunities to develop resilience. Several women availed themselves of court resources and supports to aid in their recovery and augment their roles as mothers. Others drew upon family resources to help them manage their court requirements, which often required them to arrange for transportation and childcare.

Kiara found the experience of sitting in court and hearing other people's stories helpful in developing personal insights, especially regarding addiction. She confided:

> … there were days where I would see myself like, yep, that was me. I made those same excuses…. Look at her. She's saying what I would've said and things like that. Or to watch somebody just try to play the "system", try to manipulate or get around. And initially that was kind of what I thought I could do with addiction. And so, I realized that it is nothing to be played with. But so, it was very helpful to be able to sit in a court and watch the people and the judges

A compassionate family treatment court judge and two court case managers helped Amy alter the course of her life. She described the case managers as very supportive, and the judge as someone who "always encouraged me to maintain my sobriety." She added that "there are not too many judges out there who will say, 'keep doing the right thing.'" Amy keeps a family picture on her wall taken on her graduation day with her children and the judge and commented that "Judge [Name] is my family. I had a 10-year [sobriety] anniversary party, and she came to it."

Some interviewees found adhering to court requirements helpful for developing personal strength and self-efficacy. After Nina's daughter passed away at 3 weeks old, Nina experienced a recurrence of heavy alcohol use before the family drug treatment court intervened. The court sanctioned Nina to a residential treatment facility which became a lifeline. She stated that "this [residential treatment] is helping me to gain stability, gain trust back into myself… the main thing is my kids." Other participants attested that they benefited from residential treatment facilities' services, including parenting skills workshops and mentoring.

Amy described her experiences at a residential facility where she enhanced her motherhood skills from the parenting classes and other resident mothers. She learned the importance of simple activities that she could do with her children, such as taking them to the park and having a picnic, which she continued after completing her stay at the facility.

A few women with stable family ties drew upon these for support as they navigated the criminal justice system. Ariana's family operated "as a team," with her mother taking in her children as a legal foster parent, her father supporting her mother, and her aunt providing additional childcare as needed. This close family support provided security and protection in the face of uncertain treatment by the court system.

Public stigma

Public stigma involves the wider society's devaluation of individuals or groups based on a stigmatizing condition (Bos et al., 2013). Our study participants experienced public stigma in a variety of settings.

Social media presented a mechanism for public stigma. News reports of criminal cases and easy access to personal information through social media can promote public stigma. This occurred when Alia was convicted of stealing a car while under the influence of benzodiazepines. The story appeared in the local newspaper, provoking strangers to

criticize her on Facebook commenting “You shouldn’t have kids,” and “You must be the worst mother ever.’” After multiple negative online comments, Alia retreated further into substance use.

Anonymous CPS calls by strangers or neighbors represent another type of public stigma experienced by study participants. The specter of CPS weighed heavily on interviewees, who believed that CPS took a punitive rather than a supportive approach, causing them to constantly fear making a mistake and worry about CPS appearing at their home with the intention of removing their children.

One participant, Ruth, received help from a compassionate CPS worker who provided reassurance to Ruth about CPS and validation that she is a good mother. Ruth recounted how multiple anonymous calls were made to CPS about her household. Each time, the agents found no evidence of neglect and closed the case. A CPS worker reassured her that “this happens a lot, people call and make up lies….” and that her children were perfectly fine. Following that conversation, Ruth could cope with subsequent anonymous calls to CPS, “…I know what type of mother I am. I know my kids are well taken care of and they’re fine.”

Self-help groups advocating complete abstinence and disparaging medication-assisted treatment (MAT) as “replacing one drug with another” provided venues for public stigma. This was a common complaint among our participants.

One interviewee, Marly, used a harm reduction approach to fortify herself when encountering negative public judgment directed toward MAT at some self-help meetings. She countered this stigmatizing attitude by viewing recovery as a stepwise process, quoting a harm reduction slogan on a poster at her MAT clinic: “Reducing drug use is a form of recovery.”

Discussion

This study investigated the impacts of stigma on the experiences of justice-involved pregnant and parenting women with SUD. Our findings underscore the challenges posed by stigma across every aspect of these women’s lives, limiting access to support and resources, while worsening social isolation. Applying Bos and colleagues’ theoretical model and extending it with Windle’s concept of resilience, enabled us to distill and analyze key contextual factors contributing to interviewees’ experiences and responses to stigma as well as protective factors used by some participants (Bos et al., 2013; Pryor & Reeder, 2011; Windle, 2011). To our knowledge, this is the first application of this theoretical model of stigma to women with SUD in the justice system.

The overall impact of stigma on justice-involved women with SUD in our study resulted in marginalization and isolation, limiting access to social supports, resources, and treatment. Despite these challenges, some participants found ways to navigate and mitigate stigma while promoting resilience. These protective factors and strategies included: maintaining a positive motherhood identity, leveraging social support often outside the nuclear family, and having access to supportive, compassionate justice system resources.

Participants' perseverance in maintaining a positive motherhood identity in the face of negative societal judgment was evidenced throughout our interviews. Other researchers have documented how mothers with SUD have tried to reframe their identities in response to the societal good mother ideal (Couvrette et al., 2016; Fuentes, 2022; Gueta & Addad, 2013; Radcliffe, 2011). For example, in Fuentes's (Fuentes, 2022) study of incarcerated mothers, the women viewed themselves as good mothers despite structural inequalities, marginalization and the mainstream "good mother" ideal. Fuentes advocates for adopting diverse "good mother" models, including "the struggling good mother" (Fuentes, 2022). Conveying the diverse good mother models to judges, case workers, and healthcare providers might reduce stigmatizing comments and facilitate support for pregnant and parenting women in recovery from SUD.

In the face of stigma and isolation, several study participants turned to people outside their immediate family to meet instrumental needs such as housing, transportation, and childcare. The practice of drawing upon extended family ties and outside contacts for survival has been documented in studies of people living in poverty (Lubbers et al., 2020; Stack, 1974). Studies of women with SUD have reported smaller personal networks compared to those of men, resulting in women's limited access to social support (Tracy et al., 2016; Woodall & Boeri, 2014). Matthew Desmond developed the concept of "disposable ties" to describe how people living in poverty create brief but intense reciprocal relationships with acquaintances or even strangers for immediate survival needs (Desmond, 2012). Although we could not follow our study subjects longitudinally, we observed that some participants depended on people who were neither family nor friends for survival. Judges and healthcare providers might consider asking women clients about instrumental support they receive from people outside the nuclear family, recognizing the positive social capital they provide. Pro-social activities to develop women's positive social supports can play an instrumental role in maintaining recovery, especially after leaving residential treatment facilities or graduating from drug treatment court (Boeri, 2021).

Several mothers in our study described how a compassionate, respectful judge, residential program, or CPS worker helped them to feel better about themselves and in some cases helped them attain stability. For other women, the structured requirements of a treatment court or parenting classes in residential treatment, enhanced their feeling of self-efficacy. Recent studies have documented the importance of kindness, encouragement, and praise from judges in improving women's likelihood of completing drug courts, rather than shaming or stigmatizing comments which are associated with negative outcomes (Gallagher et al., 2021). Moreover, offering women-specific treatments and resources has been shown to result in greater satisfaction, increased comfort, longer continuity of care, increased affiliation/comradery, and improved feelings of safety (Gallagher et al., 2022; McHugh et al., 2018; Morse et al., 2014). Incorporating harm reduction principles into justice and health care settings might also help mitigate the harmful effects of stigma. One study participant shared how she adopted a harm reduction slogan to counter stigmatizing anti-agonist comments at self-help meetings. Harm reduction policies and practices advocate treating people who use drugs with dignity and compassion, thereby reducing the negative impacts of stigma and shame (Hawk et al., 2017; Kahn et al., 2022).

There are several limitations to this study. Participants represented a convenience sample of volunteers from a Western New York county and may not be generalizable to all justice-involved pregnant and parenting women. In addition, most participants were recruited from a women's residential treatment center. The interviews were conducted at a single point in time, due to budgetary and time limitations.

Despite these limitations our findings shed light on strategies some mothers in recovery use in the face of adversity to combat stigma, and can inform approaches that judges, case workers, and health care providers might consider to engage and support women in recovery and reduce their experience of stigma.

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Table 1:

Participant Characteristics (N=20)*

Characteristic	Mean (SD) or %(N)
Age (years)	35 (8.9)
Relationship Status	
Married	10% (2)
In a relationship	30% (6)
Single	55% (11)
Widow	5% (1)
Housing	
Independent living	45% (9)
Residential (Lighthouse)	55% (11)
Employment status	
Unemployed	70% (14)
Full-time work	25% (5)
Part-time work	5% (1)
Education	
8th grade or less	5% (1)
High school/GED	95% (19)
Some college/Training after High School	20% (4)
College Graduate	10% (2)
Health Insurance	
Medicaid	85% (17)
Medicaid + Medicare	5% (1)
Private/commercial	10% (2)
Receive Public Assistance	70% (14)
Transportation	
Public transportation	70% (14)
Private vehicle	30% (6)
Justice involvement	
Total prison time (months)	11.17 (20.3)
Misdemeanor convictions	2.85 (3.8)
Felony convictions	0.25 (0.6)
Number of children	
One child	25% (5)
Two children	40% (8)
Three children	10% (2)
Four children	20% (4)
Five children	5% (1)
Currently pregnant	20% (4)
Any form of custody of their children	
Yes	70% (14)

Characteristic	Mean (SD) or %(N)
No	25% (5)
N/A	5% (1)
Ever lost custody of their children	
Yes	45% (9)
No	50% (10)
N/A	5% (1)
Children Living with Someone Else Due to a Child Protective Order	
Yes	25% (5)
No	75% (15)

* Characteristics are based on self-report. Not every participant answered every question.

Table 2:

Thematic categories and subthemes

Thematic Category	Subthemes	
	Stigma Experience	**Protective Factors**
Self Stigma	• Guilt and shame • Reluctance asking for support	• Motherhood identity
Stigma by association	• Avoidance by family & friends • Frayed relationships with children	• Ties outside nuclear family • Sponsors & peers
Structural stigma	• Courts treating mothers disrespectfully • Incarceration dehumanizing • Healthcare providers & stigma	• Court resources & requirements • Family support
Public stigma	• Public shaming on social media • Anonymous complaints to CPS • Anti-agonist self-help groups	• Helpful CPS workers • Harm reduction philosophy