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Maternal Distress and Women's Reentry into Family and Community Life

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This paper advances conceptualization of maternal distress following incarceration. We utilized a multiple case study methodology based on interviews with 10 mothers who demonstrated various permutations of ''the triple threat'' (depression, domestic violence, and substance abuse; Arditti & Few, 2006). Findings suggest that depressive symptomology persisted and worsened for mothers in our study and that maternal distress was indicative not only of women's psychological state, but also a relational and situational construct that embodied women's core experience. Maternal distress was largely characterized by health challenges, dysfunctional intimate relationships, loss related trauma, guilt and worry over children, and economic inadequacy. Further, maternal distress seemed to be intensified by the punitive traumatic context of prison and lessened by rehabilitation opportunities as well as support by kin and probation officers after reentry. Recommendations for clinicians and professionals who work with reentry mothers center around the need to alleviate maternal distress and better address women's emotional and physical health needs during incarceration and reentry.

Keywords: Incarcerated Mothers; Prisoner Reentry; Social Reintegration; Maternal Distress; Depression; Substance Abuse; Domestic Violence

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The purpose of this paper was to develop grounded theory related to reentry mothers' maternal distress, broadly defined as depression, physiological malaise, and unhappiness (Arendell, 2000). Maternal distress is theorized to link with a host of negative parenting, social, and economic outcomes. In this study, we consider maternal distress in relation to women's time in prison or jail as well as their social reintegration after incarceration. Social reintegration refers to an absence of recidivism as well as vital family and community ties (Travis, Solomon, & Waul, 2001). The present study emerged from our previous work examining the experiences of 28 reentry mothers (Arditti & Few, 2006). Given our earlier results, we were most con-

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cerned about the prevalence of depression and domestic violence, as well as women's struggles with addiction. Based on the existing scholarship on risk and resilience, we conceptualized the presence of these phenomena (depression, violence, and addiction) as a ''triple threat'' in terms of the magnitude of risk they posed to healthy parent-child relationships and women's economic viability (Owen, 2003; Travis et al., 2001). The present study encompasses follow-up interviews with 10 women who participated in our original study. We wanted to incorporate the issue of ''time'' into developing our understanding of triple threat risk factors, maternal distress, and their reintegration trajectories. Having the opportunity to study women over 2-year time period was important given that recidivism peaks within 3 years after release (Travis, 2005).

Women make up about 23% of the nation's probationers and 12% of parolees (Glaze & Palla, 2004). Women are the fastest growing prison population, which is a direct result of the unprecedented numbers of women receiving drug-related sentences (Bureau of Justice Statistics, 1999; Donzinger, 1996). Women offenders brought into the criminal justice system are disproportionately poor, of color, undereducated, and have been subjected to physical, emotional, and or sexual trauma (Bloom, 2003; Browne, Miller, & Maguin, 1999; Chesney-Lind, 1997). Many have complex mental health and medical conditions as well as substance abuse problems (James & Glaze, 2006; Young & Reviere, 2006). Indeed, an estimated 73% of women, compared with 55% of men, in state prisons had mental health problems. Three quarters of female inmates in state prisons who had a mental health problem also met criteria for substance dependence or abuse (James & Glaze, 2006). An in-depth consideration of women's triple threat histories is warranted as they are linked to negative family and economic outcomes, further victimization, and continued involvement in the criminal justice system (James & Glaze, 2006; Kilpatrick, Acierno, Resnick, Saunders, & Best, 1997). Our aim in this study was to advance a core construct to understand mother's experience during and after incarceration. The empirical literature highlights the profound importance of maternal distress in linking to family functioning and children's psycho-social outcomes (see e.g., Arendell, 2000; Downey & Coyne, 1990; Kinsman & Wildman, 2001). Given the recent attention to incarcerated mothers (e.g., Poehlman, 2005) we wanted to consider the issue of maternal distress among a growing and vulnerable population of women as they negotiate the terms of the incarceration or reentry. Informed by our understanding of their histories of multiple risks (e.g., the ''triple threat''), our research questions were broadly: For reentry mothers, what are the facets of maternal distress? What factors intensify or alleviate maternal distress?

We utilized a multiple case study methodology for the purpose of theory development (George & Bennett, 2005; Stake, 2005). We were specifically interested in developing explanatory constructs based on observed phenomena (Gall, Borg, & Gall, 1996) that elucidated the features of maternal distress. A case study involves issues that are ''complex, situated, problematic relationships'' and the selection of key issues is crucial (Stake, 2005, p. 448). In this research, we define the class of events as incarcerated mothers who then reenter the community. We focused our analysis on maternal distress as holistically located by women's triple threat histories, their relationships with their children and intimate others, their support relationships within their families and communities, and their ability to secure adequate resources.

METHOD

Participants

We partnered with the two probation offices to access the 10 mothers who participated in our current study. All mothers had previously been interviewed by us in 2004, and we followed up with each one: interviewed ($n = 10$), unable to locate (such as mail returned or name was incorrect) ($n = 8$), denied access by the jail facility ($n = 1$), or unable to secure an interview because the probation office was unresponsive to repeated inquiries ($n = 3$). Our compliance rate was 53% (participants [$n = 10$] divided by invited participants [$n = 19$]). We interviewed 6 of the 10 case study participants in a private office located at the probation building, 1 participant released from probation at her home, and 3 incarcerated participants in a private room at the prison or jail. Seven interviews were audiotaped (1 participant declined to be audiotaped and the state prison did not allow audiotaping for 2 incarcerated women in our study); detailed field notes were written during all interview sessions by the lead investigator. Two participants were African American and 8 were Caucasian. Participants' average age was 36 years, ranging from 25 to 46. Half of the participants were divorced, while others reported being single ($n = 3$), married ($n = 1$), or widowed ($n = 1$). Most women had either a high school diploma or GED. Mothers had an average of two children with a mean age of 13 (range = 1.5–27 years). Finally, the average sentence for participants was 11.45 months.

Interview and Coding Procedures

The semistructured interviews, lasting from 90 to 120 minutes, incorporated open-ended style questions aimed at eliciting ''information-rich'' responses (Charmaz, 2001; Weiss, 1994). We asked 14 questions about demographics, family membership, criminal justice involvement, mother-child relationships, health support and resources, and intimate relationships. As often occurs, unexpected ''turns and digressions'' occurred as the interview progressed. Because deviations from the interview protocol can be quite productive, we followed participants' lead for awhile, gently returning to the interview protocol when necessary (Johnson, 2001). Although the decision to end data collection was largely due to the fact that we exhausted our sources, we met key elements of Lincoln and Guba's (1985) saturation criteria in that we encountered sufficient regularities with regard to thematic content, and additional information did not build on existing categories or new variables.

The coding scheme reflected modified analytic induction, an approach that calls for a continual interplay between data collection and analysis, to produce a theory. Our analysis was informed by sensitizing concepts based on previous findings from our pilot study and the extant empirical literature (Strauss & Corbin, 1990). Open and axial codes were identified, compared and contrasted, and collapsed to produce themes that aligned with triple threat risk factors, maternal distress, and social reintegration constructs or revealed new codes. The coauthors' independent, line-by-line coding of the transcripts using N6 (previously called NUDIST; QSR International, 2002) resulted in substantial overlap. We then constructed a case study grid (see Appendix A) that summarized major coding categories and themes.

To ensure the trustworthiness of our methodology, we created a ''case study database'' including all case study notes, narratives, and tabular materials (e.g., depression scores and coding grid) (Yin, 2003). Trustworthiness involved the

development of a coding scheme that relied on previous research and theory, member checking, and investigator triangulation via the convergence of major coding categories and themes after repeated readings of the data by both authors (Lincoln & Guba, 1985; Strauss & Corbin, 1990; Yin, 2003). Consistent with recommendations for techniques to insure trustworthiness (Lincoln & Guba, 1985), we solicited participants' views of the credibility of our interpretation of their interview responses and ample opportunities to shape and verify the language to communicate their experience (Stake, 1995). Whenever possible, trustworthiness was also incorporated into the study via data triangulation that included two data sources for each participant: (1) a verbatim transcribed interview, and (2) detailed field notes. All interviews and field notes were coded and content analyzed; analytic output suggested consistency across the two data sources. The field notes also provided additional context for responses such as participant's emotional state, body language, and researcher impressions.

Center for Epidemiologic Studies Depression Scale (CES-D) scores

Before each interview, the lead author administered the 20-item version of the CES-D Scale ($\alpha = .85$; see Radloff, 1977) to the 10 participants in this analysis. The CES-D captures the presence of depressive symptomology with high scores (e.g., >16, possible range 0–60) suggesting (but not substantiating) a clinical level of psychological distress. In a general population, about 20% of people would be expected to score in the clinically distressed range (Brown, Huba, & Melchior, 1995).

Analytic and Interpretive Strategy

The analysis of data for this qualitative study was based on the principles of grounded theory (LaRossa, 2005). Elements of our grounded theory approach involved: (a) the inductive and evolving nature of our coding and interpretive process through multiple considerations of the data and via the manuscript revision process (Strauss & Corbin, 1990), and (b) the incorporation of ''theoretical sensitivities'' (see Allen, 2008) as informed by our previous conceptualization of triple threat risk factors. Consistent with a grounded theory approach, our analysis and interpretation of women's experience was designed to expand and enrich the theoretical concepts rather than identify causal patterns (Marsiglio, Hutchinson, & Cohan, 2000). In this study, we were interested in focusing our attention on maternal distress in light of women's incarcerative and reentry experiences. Our analytic process was consistent with key principles of grounded theory in that (a) maternal distress became central in the study and served as the ''backbone'' of the women's stories, (b) maternal distress was conceptually developed in the course of analysis and interpretive work, and (c) maternal distress was ''well grounded in the textual materials being studied (LaRossa, 2005, p. 838).'' We utilized N6 to assist us in data analysis and detecting common themes. In addition, we read through each participant's coded interviews and field notes holistically, and then read cross case reports of the coding categories and wrote interpretive comments in the margins of these reports. The use of a case study grid also allowed for easy perusal of themes within and across cases.

FINDINGS: FEATURES OF MATERNAL DISTRESS

Our grounded theory analysis yielded a theoretically saturated conceptualization of maternal distress with multiple indicators (LaRossa, 2005). These indicators were (a)

psychological distress most obviously manifested by depressive symptomology over a period of 2 years; (b) relational distress involving intimate others, unresolved loss, and maternal guilt over substance abuse and incarceration; and (c) situational features of maternal distress centering on physical illness and injury and provider concerns. Further, we theorize that rehabilitation during prison, reentry support, and female kin and friendship support likely alleviated maternal distress.

Psychological Distress

Eight of the 10 women in the present study scored in the clinically distressed range (i.e., CES-D score >16). Means and *SD*s of the CES-D for the 10 women in the case study were on average clinically significant (indicative of clinical psychological distress) at Time 1 (2004; $M = 19.9$, $SD = 15.2$) and Time 2 (2006; $M = 25$; $SD = 14.6$) and correlated ($r = .84$, $p = .003$). Women's psychological distress not only persisted between 2004 and 2006, but increased to a level approaching statistical significance ($t = 1.88$, $p = .09$). Correlational analysis also support the relationship between our qualitative coding of depressive symptomology (Times 1 and 2) and the CES-D (Times 1 and 2); r_s .85** and .70*, respectively.

Unmet Mental Health Needs

We were most concerned with participants' unmet mental health needs connected to their histories of depression, current reentry challenges, and persistent and worsening depressive symptomology. The lack of mental health support was particularly problematic as the probation offices involved did not screen for depression or other types of psychological difficulties. Mothers described an array of scenarios regarding their attitudes and use of formal psychological treatment—particularly with regard to medication. Jane explained she ''knows she has to be on medication'' and Lynn described how well she functioned when treated for ADHD and her subsequent decline when the medication was absent during her current incarceration. Other mothers were uncomfortable taking medication—somewhat understandable given a history of bad relationships with prescription and illicit drugs. Leah had a history of depression with one bout of postpartum depression so severe she was hospitalized for a month: ''they had me on Zoloft and stuff like that . . . and I don't want to live on medication so I just . . . I come off of it.'' She was not in counseling or treatment at the time of our interview. Karen struggled with anger management, parenting stress, and a history of depression. Despite elevated scores on the CES-D, she was currently not receiving any counseling or formal psychological support. She had previously been prescribed antianxiety medication and explained why she had stopped taking it: ''I have a paranoia about something altering me like that.'' Jane had been diagnosed with Obsessive Compulsive Disorder, Bipolar Disorder, ADHD, and anxiety. At the time of our interview she was taking three medications and was not in counseling (despite a positive experience with her counselor) because of transportation problems. In summary, there was strong evidence of psychological distress but no apparent systematic mental health care for women in our study.

Relational Distress

Certain relational experiences seemed to propel women into the criminal justice system and were a visible feature of maternal distress. Relational distress centered

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around mothers' past and current struggles in heterosexual intimate relationships, their experience of family loss, as well as their ongoing relationships with their children.

Intimate Relationships: ''He Makes Me Crazy''

Intimate relationship difficulties were prominent in understanding aspects of mothers' distress. Of particular interest was how relationships with intimate partners linked with mothers' histories of substance abuse and continued connections with less than optimal men. Many study participants seemed preoccupied and worried about the men in their lives—often one of their children's fathers. These concerns reflected patterns consistent with the dynamics of intimate partner violence in terms of cycles of abuse and men's attempts to control them—in and out of prison. For example, Jane tells us about her relationship with J, the father of her children and someone she is desperate to be rid of to ensure her sobriety and successful probation: ''He knows how to get inside my head. I won't let him and don't know what to do . . . He's strung out on drugs and . . . and I told him, 'I don't go to a methadone [as boyfriend did] clinic to get high everyday to be sober.' I struggle every single day of my life. There are some days that I wanna go out and get plum-plastered. I have those days.'' She goes on to reflect ''I think he's trying to push me to the point where I'll go back out there [i.e. selling and taking drugs] again.'' Carol, (reincarcerated) discussed her physically abusive intimate partner stating: ''Even though I'm an addict I deserve better. He's good to me but he's good to all the other women too.'' She showed us her scars, and explained that he has done the most ''God awful things to me.'' She poignantly continued: ''I have so much anger. I robbed him. I left him. I went back. He tries to make me think I'm crazy. This (jail) is my escape here.'' (Carol, field notes).

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Family Loss

Relational loss was intertwined with psychological distress as reflected by Amy, who despite periods of ''being clean,'' used drugs after her daughter was killed in a car accident and then again after her husband died. Field notes documented her Percocet and Valium use. After her husband died, she thought the pills were helping. She says: ''I was so depressed . . . I didn't want to do nothing. When I took the pills, I would get up, fix up . . . I was taking more and the Dr. cut me off.'' It was after she lost her prescription, that she tells us: ''I took to the streets.''

Jane's case also reflects connections between family difficulties and loss with mental health issues and drug use. She reported parental alcoholism, family violence, and familial incarcerations, was diagnosed as a manic depressive with adult hyperactivity disorder at Time 1, and was arrested for multiple DUIs and child neglect. She talked about her rapid descent into abusing alcohol and antidepressants after separating from her husband.

> And I never used to drink or anything and then when I went through my separation, it just went crazy from there and I went to pieces. Went on a self-destructive . . . I mean, a doctor told me I was literally trying to die without killing myself. But I didn't know it. It was subconsciously.

Lynn, the mother of three children, was still churning through the system with a series of DUIs and drug violations and serving time again at the time of our interview.

Relational loss was a prominent feature of distress for Lynn, particularly given her family history of abandonment and parental incarceration. She notes:

> When I was 13, my mother too was incarcerated. I was without the one who was my life, my role model . . . I didn't know how to deal with that so I turned to what would numb the feelings I was having—alcohol . . . When my mother left, I was a child going towards life with the best intentions to succeed. When she got home, I was headed for destruction.

She recalled too, how she started drinking at the time of her beloved grandmother's death to ''cope with the grief.'' Each time the binge drinking, embraced as a means to alleviate emotional pain, was an important pathway for criminalized drug related behavior

Mother-child Relationships: ''I Ruined Their Lives''

A key facet of relational distress involved mothers' relationships with children. These relationships seemed to be shaped by leaving and reuniting, regrets and worry about how their incarceration(s) affected children, and concerns around nonmaternal care and nonresidence. Overall, there was a sense that participants' maternal distress was largely characterized by guilt and intensified by parenting challenges preceding and arising from substance abuse and incarceration.

Substance abuse. Substance abuse emerged as prominent feature of maternal distress centered on children. Maternal guilt and tearful regrets were evident in women's accounts of their substance use and not ''being there'' for children. Thus, women equated substance abuse with maternal absence in a both a psychological and physical sense. Lynn, reincarcerated for a drug-related probation violation, reflected: ''It's very hard to be a mother: Physically I'm not there. Mentally, there's no way to make up the time.'' Further, drug-induced states likely compromised participants' parenting. Carol, whose parents were both substance abusers themselves, spoke about her relentless pursuit to get high despite having children, being in and out of jail, and social support. She acknowledged she was so ''strung out'' she did not realize her adolescent son was getting into trouble himself. Although she recognized the effect of addiction on her relationship with her children, it was still hard to stay sober. She goes on to say:

> I'm angry at myself because I've had so many people out there that was willing to help . . . so I could be a mother to my children. But I chose to go in the other direction. So, I can't expect [my children] to have a lot of respect for me because I didn't have any for myself . . . all I did was give birth to them . . . If I could change one thing about my life, it would probably be not to have any kids because I don't raise them . . . I feel bad because I'm not only ruining my life by being an addict, I ruined their lives.

When substance abuse and related activities (such as distributing) leads to incarceration, mothers are physically absent as well. Jane's addiction to alcohol got her into trouble with the law due to a series of DUIs over a period of 10 years. She tearfully recalls her (then) young son's reaction when she left for prison: ''he didn't want to let me go. He thought I wanted to leave him. And I told him that momma had to go away to a place because she made a mistake and this place was going to make her a better person and if I was a better person then I would be better mommy.'' She continued: ''He [my son] wrote me a letter one time that said: 'that stupid mommy school!''' Jane initially did not tell her son that she was going to prison only clarifying for him upon

release that ''it was a correctional facility where I took classes and how they taught mommy not to drink and deal with life.'' Thus, being a better mother for this woman, meant a trip to ''mommy school'' where she was forced to sober up.

Incarceration and mothering. Mothers' distress was also largely due to alterations in mothering that incarceration brings such as visitation during imprisonment, separation, fluctuating nonmaternal care, and the need to renegotiate mothering roles upon release. Children's visits during mothers' incarceration tended to be uncertain and bittersweet. Carol, a mother of four, the youngest of whom was 5 years old, was reincarcerated at the same facility as her oldest son. She reflected on her other three children's visits to the facility where she was held: ''I enjoy seeing them. The hardest part is seeing them walk out the door.'' Lynn, also reincarcerated at the time of our interview, had three children aged 7, 5, and 2. At the state facility where she was held, her children were prohibited from sitting on her lap, a difficult restriction for her young offspring to understand. She described her every other month visits with them as ''overwhelming because you are not able to hold them . . . You can tell that they get upset.''

Pam echoed similar sentiments and begun to cry as she discussed visits from her daughter during her two previous incarcerations: ''She just couldn't take the pressure of leaving me there . . . this really hurts. I know that I did hurt her. I not only hurt [voice trembles] my daughter but I hurt my son.''

Amy remembered her son's visits during her imprisonment. She explained that her sister would occasionally bring him (age 11 at the time), and how the memory of her son crying in the waiting room ''broke her heart.'' Amy explains that ''it really hurt him (her son) that I went to jail, and he said never go back to jail again . . . that he did not have to go back to stay with my sister again and that he didn't know what he would do if I would go back to jail.'' Karen, mother of four, whose 3-year-old twin boys slept on a chair during our interview, recounted that the visits from her oldest daughter, now 11, were emotionally upsetting and that her girl would cry at the end of the visit because she could not leave to return home with them. She said: ''I understand why she didn't come. The visit changed her mood. So the visit upset me, upset my daughter . . . I would write (instead).'' Karen worries her oldest girl will come to emulate her. ''She wants to be a little me, and I'm like, NOOOO. I'm afraid she knows where I've been. I'm scared that she might grow like I did because I'm in her life. It will vibe off of me and go into the children . . . I feel like I'm not a good role model—I feel guilty.''

Two mothers explicitly stated that their guilt about their children's distress as a result of their absence was a strong impetus to avoid reincarceration. Such efforts involved attending rehabilitation and counseling programs regularly, and obeying the terms of their probation. Indeed, relationships with children were cited as a reason for mothers with drug and alcohol problems to keep going and stay clean. As Amy stated, ''I've got kids to be there for so'' (I've gotta stay clean). Pam also reflected on the hurt she believed she inflicted on her children as a result of incarceration as reason enough to do everything she can to successfully complete her probation: ''the past [and her children's distress] for me, stops me from doing something stupid in the future. 'Cause I never wanna be incarcerated again.'''

Reentry also posed its own concerns among study participants—particularly with regard to children's care arrangements and family conflict. Arrangements were fluid and complex, due in part to multiple fathers, multiple paternal grandparents, and complex incarceration histories that required mothers to leave children repeatedly

while they were in jail. Upon reentry, many mothers seemed anxious as they negotiated fluctuating childcare arrangements with guardians or intimate partners while attempting to step back into an active mothering role. These negotiations were further complicated when sibling groups were split up. Karen's 9-year-old daughter was living with her estranged ex-mother-in-law across the state. She had not seen her daughter for over 7 years and had no idea where she was living. Leah was deeply distressed over the disintegrating relationship with her children. Her daughter had been shuffled among relatives and Leah's refusal to award custody to her eldest son caused a great chasm in the family. After the daughter, as a child, had a rather painful visit at the prison, Leah decided it would be best if the daughter did not return for visits. Upon her release, Leah suspected that her family may have told her daughter lies about her. She stated,

> I'm worried about the relationship . . . with my daughter. What has she been told? She might not have been told nothing, But why do you turn on your mother? I just got upset over [my children]. Sometimes, I used to sit and just cry, just cry over these kids and I'm like I can't . . . I can't do it no more . . . I gotta work . . . I gotta live my life . . . I can't sit and cry over it no more.

In another example, Amy observed that her close relationship with her son had deteriorated while she was incarcerated. By the time she returned home, her son had grown into a troubled, distant 16-year-old adolescent who barely spoke to her. Pam was very intentional about projecting her presence during incarceration, into her adopted child's residence. She reported writing letters and sending pictures to her son on a daily basis.

The mothers in our study communicated both gratitude for and jealousy of the "othermothers" who cared for their children intermittently during their incarceration. Othermothers are women who may or may not be biologically related to a child and feel an obligation to care for the child as if the child were their own (Collins, 1990). Having another woman care for children posed challenges for incarcerated mothers—particularly if the woman was not a family member (Young & Reviere, 2006). For instance, Carol was anxious about returning to the active mothering role, yet relieved that the mother and family friend of two former intimate partners consistently had taken care of her children.

> I don't plan on going out there and snatching my children right up because one, I don't have a foundation. I don't think it would be fair to my children and to their guardians now if I just came straight out of prison and snatch[ed] my kids up with nowhere to go when they have a roof over their head, food to eat. I don't have anything to offer my children now but love.

The majority of mothers expressed a strong desire to reunify with their children and to reclaim custody of their children from current guardians. Barb wanted to return to her child quickly and saw herself as a possible intervention for her daughter. She stated, "I see so much of me in her that it scares me. I never want her to see the inside of a place like this."

Situational Distress

Mothers' situational distress centered on contextual factors and originated from a particular condition or external challenge rather than a relationship. Situational

features of distress involved injury, illness, or financial difficulties and were intertwined with mothers' psychological state and the quality of their relationships with children.

Injury and Poor Health

Health problems and injury also seemed to particularly connect with women's substance abuse and depressive symptomology. For example, an injury might trigger the onset of prescription drug usage that eventually became problematic in terms of women's dependency on pain killers and her eventual willingness to obtain them or trade them illegally. Barb, in prison again at Time 2, reported that her doctor prescribed ''powerful medications'' to help relieve pain from her back injury and that her intimate partner also gave her his painkillers when she could not get her prescription renewed quickly enough. Lynn, also reincarcerated, recounted her use of prescription migraine medications, which she started taking ''more and more'' to the extent that she felt sick ''without the medication.'' Her reincarceration was due to her illegal use of the migraine medications—prohibited during her probation. Moreover, 2 additional mothers indicated that the prison medical system was unresponsive to their health and addiction histories and may have unintendedly sustained their addictions. As the women moved from facility to facility, their health histories did not seem to travel with them. It appeared that overlapping dosages of different antidepressants, disruptions in antidepressant or painkiller prescriptions, or the effects of unintentional ''mixed cocktails'' of antidepressants were not monitored closely.

Financial Challenges

Most women in the study discussed a cascade of parenting difficulties, with the most preeminent being economic inadequacies and inability to provide for children. Karen recalled when she was released from prison: ''I came home to NOTHING. No clothes, no possessions I had nothing for my daughter's birthday . . . I don't want her to know.'' When Carol thought about future with her children outside of prison walls, she was pessimistic: ''I don't have a pot to piss in, let alone a home for my children.'' We suspect in Carol's case that *churning* (reentry cycling characterized by reincarceration; Travis, 2005) exacerbated resource shortfalls and undermined the possibility of vital mother-child connections. Faith described a frenetic state of financial instability after being released from prison:

> I'm the one responsible for all the bills now . . . I got to take care of the kids, you know. If they need something, want something. Keep food in the house, gas in the car . . . just day to day. That's stressful enough.

The lack of financial resources, combined with psychological and relational distress, was a recipe for disaster. Carol, who had been a licensed nurse, felt that racism and her felon status worked against her in finding employment as a live-in nurse. She described how this barrier led her into using drugs again. She stated, ''when I got my nursing license, I was the happiest person . . . You see all of the jobs that need nursing. I set up an interview and went out there and I could see it on the woman's face. As soon as she saw that I was Black, they made all of these excuses why they couldn't hire me . . . I shouldn't have never let that be my downfall. I was only looking for some reason to relapse and that just put the icing on the cake.''

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Histories of psychological distress intermingled with economic inadequacy seemed to serve as a foundation for ongoing depressive symptomology. Distressed mothers described themselves as ''being overwhelmed'' by their financial obligations and their difficulties of finding and sustaining employment. Karen had a history of domestic violence, substance abuse, and elevated depressive symptomology. She shared her distress over periods of unemployment while having custody of her three young children. She had a new-found empathy for reentry women and reminisced about the days of no responsibility while in prison:

> I had seen so many women come in and out of prison . . . and I was like 'God, what is wrong with y'all. If I get out this one time, y'all ain't got to worry about me coming back.' And then I get home and I'm like, 'I can't deal with this. Send me back [to prison.]' Because you're looking for a job and you're just all of these things . . . I mean, I came home to nothing.

Despite the challenges of finding steady employment, more than half the women in our study were gainfully employed with diverse perspectives about their employment. Leah lived with her mother and had grown children; she discussed how her job ''kept her out of trouble'' and how work friends were a source of emotional support. She appreciated being extended a chance to work by her mother's friend, in the face of her felony status, although clearly working long hours for low wages at a nearby restaurant was taking its toll. She confided taking a ''sick day'' just to have a break from washing dishes 6 days a week (up to 13 hours daily). Employment with children posed special challenges. Given low wages and rigid work hours, Karen ''hated her job'' and putting her preschool twin boys in day care. She was exhausted by the end of the day. Thus, employment was a family resource yet also a potential source of maternal distress—particularly for a single mother such as Karen with young children.

Maternal Distress Processes

In this section, we discuss two themes that emerged as ''substantively significant'' based on Patton's (2002) criteria. Specifically, examining prison as a context for punishment or rehabilitation, as well as the importance of informal and formal support, *deepen understanding* and *inform intervention and policy* with respect to maternal distress processes (Patton, 2002). We interpreted the incarcerative experience and women's reentry support networks as key factors enhancing or mitigating maternal distress processes.

Prison as a Context for Rehabilitation or Traumatic Punishment

Five mothers explicitly stated that their time in prison was a kind of ''wake-up call'' intervention to reflect on past mistakes and hurts; 2 mothers described prison as a place where they became ''stronger.'' For example, Leah told us that as a result of serving time ''I don't let people walk over me anymore.'' But it was the punitive, traumatic features of prison, rather than any particular rehabilitative factor that were a prominent feature of mothers' distress narratives. The following interview excerpts reflected women's aversion to incarceration and desire to ''never go back'':

> I've spent 15 months in a terrible, terrible place . . . in pure hell . . . having to deal with 5 years of my life . . . mistakes I've made . . . my divorce . . . the heartbreak, the heartache . . . all that.

> And I did all that in a terrible, terrible place. I don't want to backtrack. I want to keep going forward.(Jane)

> I'm not going to do nothing [to go back to prison] . . . that was the worst experience I've ever had . . . I was scared to death, no lie. I was scared to death in prison . . .(Leah)

> I'll never forget my prison experience ever . . . it is so fresh in my mind. I keep it fresh in my mind . . . I'm scared to forget because If I forget, will I slip up?(Amy)

Prisons and jails varied with respect to the extent of rehabilitation services and reentry preparation. Leah discussed her imprisonment in a North Carolina state facility. When asked what programs she participated in she replied: ''mostly church 'cause there wasn't much, you know?.''' Carol, who had churned back into the Virginia system, explained how she came by her precious AA book: ''they don't have nothing here . . . they had alcoholics anonymous . . . and it's a waiting list so long what happens . . . they'll (AA participants released from the facility) leave their books to somebody. So that's how I came across the book.'' She described other programs she participated in during previous incarcerations: ''I've been to the boot camp and I can remember writing home crying because I had to sit in a chair for six hours and shine boots. You know the first thing I did after I graduated? I didn't even come home . . . I went straight to Norfolk (city name changed) and got high.''

On the other hand, time in prison could alleviate distress and contribute to well-being for certain women. Leah credited her current reintegration—particularly her ability to stay out of prison, with a prison work release program, in which participation was contingent on an inmate's good behavior. She explained not only did working keep her sane and out of trouble, but also: ''it's pretty sweet to come out (of prison) with $4,000. Most people come out with [just] bus fare.''

Pam recognized her counselor at a state prison facility as being particularly helpful in terms of her ability to ''keep it together'' and her reintegration success: ''The last counselor I had . . . was very helpful and resourceful as far as giving me things that would help me once I got out . . . resources where I could go.'' Inspection of the case study grid revealed that both Leah and Pam also had a favorable social reintegration profile (i.e., the presence of family connections, resources, and current absence of churning). Jane credited a prison-based cognitive behavioral community program for her ability to recognize her own unhealthy patterns of behaviors and use certain skill sets to make better decisions.

> Absolutely wonderful . . . I was able to use everything I learned in treatment whether I stayed or not . . . and apply it to me. So [I could be] aware of me, of my thinking, my patterns . . . and awareness is a hard thing for me because I live in that little world where everything is ok.

The program provided her with an opportunity to recognize that ''blocking things out,'' although a common self-protective coping strategy, often contributed to poor decision-making.

Reentry Support

Family members and female friends served as continued providers of informal support upon reentry. Family members, especially mothers of the participants, shared

vital resources such as housing, money, childcare, and employment opportunities. Leah credited her mother for not only providing a roof over her head but helping her get a job. Female friends were often coworkers, the friends of mothers, or mothers of (former) male intimate partners. Intimate partners and adult children also were potential sources of emotional support. For example, Pam, who relied on her husband and children, told us she had lots of family support. She noted that it was awkward when she first came home (from prison), but her adult daughter helps, and her son is with her ''all the time.''

After release from prison, formal support largely encompassed meeting with one's probation officer and any programs he or she could make available to the mother upon release. Programs such as drug rehabilitation and community service were named as potentially beneficial resources by several mothers. Five mothers noted that their probation officer was like a ''lifeline'' for them and was a significant factor in motivating them to ''stay clean'' or ''stay out of trouble.'' Clearly, such support alleviated maternal distress and enhanced the mothers' potential for reentry success.

Terri's reintegration success depends on her continued sobriety. A blending of formal and informal supports helps alleviate her distress and ''walk the line.'' She attributed her sobriety to attending Narcotics Anonymous meetings weekly and living with a male intimate partner who did not tolerate drug use. She stated: ''There are still temptations. I try not to talk with people associated with drugs. People relapse because they don't get away [from the drug scene]. It's rough . . . It's different because [my boyfriend] is not a user. If it wasn't for him and I was with a user instead, I'd probably be doing it. It's too tempting. [The boyfriend] is a safe place . . . that's why I chose to go there after I got out.''

DISCUSSION

We began this study with an eye toward exploring features of maternal distress among a group of mothers who were previously incarcerated. Indeed, these data confirm the prevalence of the ''triple threat,'' particularly depression and substance abuse, among the women we interviewed and the challenges it poses to mothers' adjustment and parenting (e.g., Owen, 2003; Travis et al., 2001). However, in this study, we move beyond the triple threat and shifted our conceptualization. Owing to the persistence and worsening of depressive symptomology in the majority of our participants and difficulties reported relative to reintegration, we refine our initial triple threat conceptualization to focus more fully on *maternal distress*. We contend that while the triple threat might signify the prevalence of a set of interrelated risk factors, maternal distress is the core of women's experience. Admittedly, the empirical literature offers no singular definition or operationalization of maternal distress. Broadly conceptualized, it is typically equated with negative psychological states such as depression (Arendell, 2000; Kinsman & Wildman, 2001), depression and anxiety (Kotchik, Dorsey, & Heller, 2005), or depression and stress due to ''daily hassles'' (Loukas, Piejak, Bingham, Fitzgerald, & Zucker, 2001). Thus maternal distress has been largely seen as distinct from economic stress (e.g., Arendell, 2000) or relational aspects of mother's connections to children or intimate others. We argue maternal distress is indicative not only of women's psychological state, but is also a relational and situational construct best understood in terms of mothers' concerns as economic providers,

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their experiences while incarcerated, and the quality of their connections with intimate others and children.

Maternal distress is largely characterized by health challenges, dysfunctional intimate relationships, loss-related trauma, guilt and worry over children, and economic inadequacy. We theorize that rehabilitation while in prison, reentry support, and vital relationships help alleviate or minimize maternal distress and that pivotal support relationships include female relatives and friends.

Our findings also suggest that maternal distress may be a key explanatory construct relative to social reintegration. While we could not clearly demonstrate with our small data set a causal link between maternal distress and reentry success, we speculate based on women's narratives, that maternal distress is important in understanding women's ability to reenter and sustain family and community life after incarceration. Future research can build on this theorized direction of effects with larger samples and analytic strategies designed to test causal relationships. It would also be important to learn more about those participants who were released from probation and successfully engaged in family and work roles.

Our theorizing with respect to maternal distress is not only useful in terms of grounding future research, but also relative to policy making and clinical practice. For example, 3 of the 10 women in our study were reincarcerated at the time of our interview. While our methodological approach disallows statistical comparison, perusal of the case study grid reveals these 3 women had common maternal distress scenarios, characterized by the presence of depressive symptomology, substance abuse, relational violence (i.e., the triple threat), and additional features of situational distress. It may be that the combination of these factors stacks the odds against successful reentry—despite the presence of family support or formal intervention.

Intimate relationships were particularly salient contexts for relational distress and encompassed an extension of difficulties experienced by participants in their families of origin, particularly intergenerational violence and substance misuse. Drug and/or alcohol use in conjunction with an intimate partner seemed to be a primary mechanism for women to get into trouble and land themselves in court or jail. Consistent with Brown (2006), boyfriends and husbands were often involved in the use and distribution of illegal substances. Our findings also suggest a deeper phenomena: women did not get into trouble solely because their men were ''dealing'' or doing drugs. Relational distress associated with intimate others was the underlying reason for problematic behaviors such as binge drinking or abuse of pain killers.

Implications for Policy and Practice

Efforts aimed at preventing or ameliorating mothers' distress likely equate with greater chances for reintegration. These efforts may occur via three portals: holistic health care, parenting interventions, and broad reentry support aimed at empowering mothers and garnering resources.

Comprehensive and Integrated Health Care

As Bloom (2003) proposed, our findings affirm a gender-responsive approach in the criminal justice system that underscores the need to address maternal distress through comprehensive and integrated services that are appropriately supervised and linked to women's prior health history. We extend Bloom's recommendations in

several ways. First, depressive symptomology appears to persist and worsen over time in these mothers. Effective screening of psychological distress upon release and appropriate mental health referrals by relevant agencies (e.g., probation office) is fundamental. Attention to women's physical health is also essential given the connections between poor health, injury and substance abuse. We recommend caution with regard to medications prescribed before, during, and after incarceration for several reasons. Many women have histories of vulnerability and substance use that would contraindicate the use of certain medications. Feminist scholars draw attention to health care practices—particularly the prescription of legal drugs—which are designed to control women in prison rather than treat illness (Boyd, 2004; Young & Reviere, 2006). During the course of our research, study participants reported ''lost paper trails'' of prescriptive care resulting in either overlapping or no prescriptions as they moved from one facility to another. The women shared stories of conditions of debilitation, paranoia, and anxiety aggravated by ''pharmaceutical cocktails'' from different physicians while in prison. Additionally, gender responsive health practices often center around women's trauma histories (e.g., sexual abuse, battering). However, emotional loss, emerging from parental loss and relationship disruption, may connect with involvement in unsavory intimate relationships as well as women's criminal behavior. Social-psychological therapeutic approaches that center around ''loss as gain'' (see Harvey, 2002) hold particular promise for transforming women's loss stories into generative possibilities so it no longer can foster destructive behaviors.

Parenting Support

Our findings confirm that mothering roles and identities may shift during incarceration (Enos, 2001), particularly in the context of prison visitation, and ties to children may become estranged. Vital and positive ties to children potentially serve a unique protective function for mothers during reintegration given the centrality of mothers' concerns about their children and their desire to stay out of trouble for their children's sake. However, as Brown (2006) noted, mothering is troubled for women involved in the criminal justice system. Approaches to strengthening parenting typically involve efforts to facilitate enhanced, ''family-friendly'' visiting or parent education programs (Loper & Tuerk, 2006). We support the positive aspects of such programs, however, we also caution that visitation programs should be carefully undertaken with an eye toward children's developmental status and needs, the ability of the caregiver or ''othermother'' to facilitate visits, and psychological support for all involved to emotionally debrief after visits.

Parenting programs that are disconnected from mothers' emotional struggles and the realities of parenting upon release may be in vain. It is important for service providers to acknowledge maternal distress—particularly mothers' experience of guilt, and find effective ways to assist women in processing their emotions to facilitate a reinvestment in mothering. Providing formal support via probation supervision to regulate emotions, appropriately communicate, maintain sobriety, stay out of dysfunctional intimate relationships, and build social and economic capital are essential features of ''parenting program'' aimed at alleviating distress and supporting mother-child relationships outside of prison walls. Beyond formal programs, vital informal relationships with female kin and friends are crucial in terms of ameliorating maternal distress and supporting reintegration (Mackintosh, Myers, & Kennon, 2006). Female kin are particularly salient due to their role as gatekeepers of children

and resources during imprisonment and reintegration. Kinship caregivers are more likely to facilitate children's connections with their incarcerated mothers than are foster parents (Grant, Gordon, & Cohen, 1997)

Criminal Justice Intervention

The punishment framework of prison typically offers little in terms of addressing maternal distress. Yet, glimmers of possibility emerged in women's narratives of the benefits of prison-based substance abuse treatment and work-release programs. We affirm how important these types of programs are for alleviating distress, aiding recovery from addiction, and laying the groundwork for success outside prison walls. Upon reentry, the role of probation officers is unique given their capacity connecting women with health care, mental health treatment, and providers of advice and support. Unfortunately, while the size of returning prisoner populations has increased, the funding for postincarceration supervision has not kept pace creating swelling caseloads for community probation officers (Lynch & Sabol, 2001). In the absence of sweeping policy changes designed to reverse mass incarceration trends, in the short term, partnerships between the therapeutic community and community corrections are essential.

In conclusion, it is women's distress relative to how they see themselves as mothers and in relation to their children, that embodies a deep, psycho-emotional dimension that is in fact ''maternal distress.'' Based on our analysis, we contend that for mothers who have been incarcerated, maternal distress is best understood as a psychological, relational, and situational construct that likely influences mothers' reentry trajectories and outcomes. Thinking about the effects of maternal distress and integrating this reality of reentry mothers' experience into holistic mental health, addiction, and parent education programming is vitally important in sustaining their family and community connections after incarceration.

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APPENDIX A

TABLE A1

Case Study Coding Grid

Characteristic	Participant									
	Barb	**Carol**	**Lynn**	**Amy**	**Terri**	**Jane**	**Karen**	**Leah**	**Faith**	**Pam**
Family of origin difficulties										
Alcoholism/substance	X	X	X		X	X	X		X	X
Family violence			X		X	X			X	
Sexual abuse	X									
Incarceration	X	X	X		X	X	X	X	X	X
Triple threat history (Time 1)										
Depression	X	X		X		X	X		X	
Substance abuse	X	X	X	X	X	X	X			
Domestic violence history	X	X	X		X	X	X		X	
Psychological distress										
Depression	X	X	X	X	X	X	X			X
Depression elevated score (CES-D 28-47)		X		X	X	X	X			X
Depression score increased		X	X	X	X	X	X			X
Relational distress										
Loss of parent/significant other	X	X	X	X	X	X	X	X	X	X
Intimate relationship dysfunction	X	X	X			X	X		X	X
Mother-child relationships										
Child distress	X	X	X	X		X	X	X	X	X
Parenting stress	X	X	X	X	X	X	X	X	X	
Estrangement	X	X	X	X			X	X	X	
Situational distress										
Injury/health problem	X	X	X	X	X	X	X			X
Financial difficulties		X		X		X	X		X	X
Social reintegration										
Supports										
Family Support/connections	X		X	X	X	X		X	X	X
Friendship connections	X	X	X			X	X	X	X	X
Satisfactory employment			X					X	X	
Formal intervention	X	X	X	X	X	X	X	X		X
Risks										
History of churning	X	X	X	X		X	X		X	X
Reincarcerated at Time 2	X	X	X							

Note. CES-D, Center for Epidemiologic Studies Depression Scale.

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