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"I Thought There Was No Hope for Me": A Behavioral Intervention for Urban Mothers With Problem Drinking

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Abstract

In this article, the authors evaluate the effects of a behavioral intervention for mothers with problem drinking who were infected with, or at risk for, HIV. They randomly selected 25 mothers from a larger longitudinal randomized controlled intervention trial for a qualitative interview. The authors found that mothers' participation in the program was facilitated by the development of a strong therapeutic alliance with the intervention facilitator and the use of a harm reduction approach toward alcohol and/or drug abuse. Mothers also reported that training in coping skills and the emphasis on parent-adolescent relationships were beneficial for program engagement and behavior change. The authors conclude from these results that treatment approaches that take into account the complexity of urban mothers' lives and substance use patterns can successfully engage and treat these women at high risk for adverse outcomes.

Keywords

alcohol abuse; HIV/AIDS; women; behavioral intervention; parenting; mixed-method design; evaluation research

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Alcohol and drug abuse and HIV infection are considered twin epidemics in the United States, disproportionately affecting those of racial or ethnic minority and low socioeconomic backgrounds in urban communities, including women and their children (Amaro, Raj, Vega, Mangione, & Perez, 2001; Centers for Disease Control and Prevention [CDC], 2004; Schable et al., 1995). Among HIV-infected women, the prevalence of drug use is almost twice that of those in the general population (Lee, Lester, & Rotheram-Borus, 2002; National Institute on Drug Abuse, 2003). Although a substantial proportion of HIV-infected women decrease or cease substance use after discovering they are HIV infected, more than 40% continue to use alcohol, with at least 15% abusing it (Lee et al., 2002; Petry, 1999). Problem drinking among HIV-infected women is of great concern. It is associated with poor adherence to antiretroviral medications (Meyerhoff, 2001; Samet, Horton, Meli, Freedberg, & Palepu, 2004) and might hasten progression from HIV to AIDS (Petry, 1999; Palepu, Horton, Tibbetts, Meli, & Samet, 2004). Problem drinking also commonly co-occurs with both drug use and mental health problems, complicating treatment efforts (Grella, Anglin, & Annon, 1996; Kessler et al., 1997).

A number of researchers have found few differences between lower income HIV-infected women and their demographically similar uninfected peers in the areas of mental and physical health, level of substance abuse, and psychosocial functioning of their children (Macalino et al., 2003; Mellins, Brackis-Cott, Dolezal, & Meyer-Bahlburg, 2005; Moore et al., 1999). These similarities might be due to the primacy of psychosocial stressors shared by HIV-infected women and their peers, such as persistent poverty, high rates of unemployment, homelessness, exposure to violence, and a greater likelihood of having family members with substance abuse problems (Boyd-Franklin, Steiner, & Boland, 1995; Mellins, Ehrhardt, & Grant, 1997; Wechsberg et al., 2003). Similar to the effects on their HIV-infected peers, problem drinking has deleterious effects on the physical and mental health of women uninfected with HIV and on the well-being of their children (Chang, Behr, Goetz, Hiley, & Bigby, 1997); furthermore, these women remain at elevated risk for HIV (Moore et al., 1999; Rabkin et al., 1997; te Vaarwerk & Gaal, 2001).

Women experience a wide range of barriers to effective substance abuse treatment not shared by men. For those parenting minor children, these barriers include a lack of access to child care (Harwood, Fountain, & Livermore, 1998; Klein, Crim, & Zahnd, 1997), fear of losing children (Harwood et al., 1998; Semaan et al., 1998), stressful interactions with children (Rotheram-Borus, Robin, Reid, & Draimin, 1998), and disruption to the family system in parenting capacities (Lewis, Haller, Branch, & Ingersoll, 1996; McMahon, Winkel, Suchman, & Luthar, 2002). Women's feelings of shame and guilt regarding their substance abuse might restrict their ability to seek treatment or reach out to family and friends for support (Amaro, Beckman, & Mays, 1987; Finkelstein, 1994). Compared to men, women are less likely to complete substance abuse treatment programs, probably in large measure because of these personal, familial, and social issues (McCaul, Svikis, & Moore, 2001).

Cognitive-behavioral skills training (CBST) has been found to be an effective basis for treatment of problem drinking (Longabaugh & Morgenstern, 1999; Miller & Wilbourne, 2002). Rooted in the principles of social cognitive theory (Bandura, 1986), CBST focuses primarily on increasing self-efficacy and developing effective coping skills, particularly in situations where participants are most likely to drink. However, despite a large body of evidence for the effectiveness of CBST in treating alcohol problems, the mechanisms by which CBST —and most other treatment approaches—work are poorly understood (Longabaugh et al., 2005; Miller, Wilbourne & Hettema, 2003). Typically, attempts to identify the specific mechanisms of effective alcohol treatment have used mediational analyses of the relationship between the predicted antecedents of change and the active ingredients that actually produce

the desired outcomes (e.g., Longabaugh et al., 2005; Morgenstern & Longabaugh, 2000). Few researchers have employed qualitative techniques to address this, although qualitative methods are particularly useful for understanding how participants make sense of the specific techniques used in interventions and how this understanding influences their behavior (Maxwell, 1996). In addition, qualitative interviews are useful for understanding the contexts in which the intervention was delivered, the processes by which individuals change behavior, and the salient characteristics of the intervention, as well as identifying unanticipated phenomena and influences (Maxwell, 1996).

The present study is a qualitative examination of the effects of the Family First (FF) intervention, a multisession, individually based behavioral intervention that was designed for mothers with problem drinking who were either infected with or at risk for HIV infection and currently parenting adolescent children. The FF intervention was originally evaluated in a longitudinal, randomized controlled trial, using structured, quantitative instruments over five waves of data collection. We learned from our quantitative analyses that the FF intervention was effective in reducing alcohol and drug use and related problems, although women who received the brief control intervention demonstrated comparable improvements. However, for mothers with greater alcohol and/or drug use problems, the FF intervention was more effective than the control intervention in maintaining reductions in substance use over a longer period of time (Gwadz et al., 2005). Furthermore, when compared to those who received the control intervention, mothers in the FF condition tended to demonstrate greater improvements in coping skills and mental health outcomes (Gwadz et al., 2005). Our goal in the present qualitative study was to examine participants' experiences in the FF intervention. In particular, we were interested in gaining a better understanding of the specific intervention processes that influenced the behavioral changes participants made in alcohol and/or drug use, parenting behaviors, coping skills, and social support networks. Our primary aim was to identify and describe which elements of the intervention were most effective in engaging participants and fostering behavior change, which elements were less effective, and the reasons for these discrepancies. We also sought to expand our understanding of intervention efficacy by exploring elements, such as context and motivation, that might have contributed to these behavioral changes.

METHOD

Characteristics of Participants in the Larger Study

Mothers were eligible for participation if they met criteria for problem alcohol use on a validated screening instrument, were currently parenting adolescent children, and had not injected substances in the past 3 months. We randomly assigned eligible mothers to either the 14-session FF intervention or the control condition, a one-session video-based motivational intervention. We enrolled 118 mothers in the larger study, and 48% were randomized to the FF intervention condition. Mothers completed a baseline and four follow-up interviews over the course of 18 months. Retention rates for both assessments and intervention were high: An average of 96% follow-up interviews were completed over the 18-month period; 86% of mothers completed the first component of the intervention (7 sessions on alcohol and drug use), 79% completed all 14 sessions (average dose, 12/14 sessions), and 97% attended the single-session control intervention.

Procedures for the Qualitative Substudy

After completion of the final quantitative follow-up interview, we randomly selected 25 intervention condition mothers to participate in qualitative interviews. Mothers provided informed consent prior to participation. None of those contacted refused to be interviewed. Most of the interviews were conducted in person and were tape-recorded with participants'

consent. Interviews lasted approximately 45 minutes, and participants received a modest ($30) stipend and public transportation expenses. The Institutional Review Board of the National Development Research Institutes, Inc., approved all recruitment procedures and interview guides.

Description of the Subsample

The qualitative subsample of 25 women we randomly selected for the qualitative study closely reflected the composition of the total study sample of 118 participants in terms of baseline demographics, HIV, and substance use characteristics. The subsample was composed entirely of women of color, with 64% African American, 32% Latina, and 4% multiracial. The larger study comprised African American (56.8%), Latina (28%), multiracial (9.3%), and White (5.9%) women. The mean age of the subsample was 40.7 years, with a standard deviation of 5.7 years; in the total study sample, the mean age was 40.9, with a standard deviation of 6.1. The mean number of adolescent children in the qualitative sample was identical to that of the total study sample: 1.5, with a standard deviation of 0.8. All of the women in the qualitative subsample were receiving Medicaid, compared to 88.1% in the total study sample, and 96% of the women in the qualitative subsample and 90.7% of the total study sample reported having used illicit drugs in addition to problematic alcohol use. Of the women in the qualitative subsample, 60% were HIV infected, compared to 55.1% in the total study sample. Among the qualitative subsample, the mean number of years since HIV diagnosis was 9.7, with a standard deviation of 4.6. The total study sample yielded 9.0 years since HIV diagnosis, with a standard deviation of 4.5. All of the participants in the subsample and 86.2% of the total study sample reported experiencing one or more HIV-related symptoms in the past 6 months; 33% of the qualitative sample and 38.5% of the total study sample had been diagnosed with AIDS. HIV-infected and uninfected mothers were very similar in background characteristics and in self-reported mental and physical health assessments, reporting generally poor physical and mental health (Leonard, Gwadz, Cleland, Rotko, & Gostnell, 2005). The demographic characteristics of both the larger sample and the subsample closely resemble those of the general population of women infected with, or at risk for, HIV (CDC, 2004).

The length of time between the participants' last intervention session and their qualitative interview averaged 15½ months (range 12 to 20 months). The length of time between each participant's first and last intervention session averaged 4.6 months (range 2.5-14.75 months).

Description of the Family First Intervention

The FF intervention consisted of 14 individual sessions delivered in two integrated components. The first 7 sessions were designed to assist mothers in reducing or eliminating problem drinking and/or drug use and their associated harms. The second 7 primarily targeted parenting skills (e.g., communication, monitoring, behavioral contracting) and built on skills learned in the first component. The FF intervention was guided by Social Action Theory (SAT) (Ewart, 1991), an integrative model that enlists both individual and social-contextual influences to support health-promoting behaviors. SAT encompasses principles of social-cognitive theory (Bandura, 1986), which articulates a model of behavior change wherein goals are set, skills are identified and learned, and self-efficacy is supported. We designed the structured, manualized intervention to promote behavior change related to problem drinking and drug use and to assist mothers in developing effective strategies for parenting adolescents, particularly in the areas of communication and monitoring behavior. A primary focus was assisting mothers in engaging members of their social network to support their substance use and parenting goals. Moreover, we paid particular attention to the multitude of interpersonal and psychosocial challenges that many women in this population experience, including variability in motivation to change problem drinking, the effect of illness on the mother and her family, changing custody

arrangements, and difficulties obtaining basic needs such as food and housing (the intervention curriculum is available from the third author, Marya Viorst Gwadz, PhD, gwadz@ndri.org).

Mothers in the FF intervention were generally not seeking treatment for problem drinking at the time of recruitment. Thus, engagement into treatment was addressed in the intervention in two ways. First, the intervention incorporated the challenges of parenting adolescent children, particularly in light of problem drinking and ill health. Second, the intervention used a harm reduction approach toward mothers' substance abuse. Harm reduction encompasses a wide range of strategies for addressing substance use that can include, but are not limited to, abstinence. The concept of reducing the harm associated with substance use can be an effective tool for individuals who are receptive to engaging in services but who might not yet be interested in reducing or eliminating their drug and alcohol use (Tatarsky, 2003). Treatment strategies based on a harm reduction approach are geared toward assisting individuals in developing personal goals related to the negative consequences of their substance use without necessarily eliminating it (Des Jarlais, 1995).

Female, master's-level clinicians with training in counseling and psychotherapy delivered the intervention. Facilitators received intensive, weekly supervision that focused primarily on the complexities of providing harm reduction treatment and adhering to the intervention manual while individualizing session content for each participant. Supervisors supported facilitators to consistently engage participants to attend the intervention through intensive outreach via phone calls, letters, addressing barriers to attending, and multiple rescheduling of appointments for participants' convenience.

Qualitative Interview Development

We constructed the preliminary interview guide as an open-ended, initial inquiry into mothers' experiences with the FF intervention. We sought to examine the kinds of changes, if any, that participants experienced in areas of alcohol and drug use, parenting, and social support, and how these changes might have come about. First, we conducted a pilot study with 4 participants, after which minor revisions were made to the order and content of the interview guide. The final interview guide addressed four domains: (a) current alcohol and drug use and associated problems, (b) relationships with children and other members of the social network, (c) experiences during and related to the intervention sessions, and (d) other general life concerns and challenges. Although we indicated to mothers that we anticipated the interview would take approximately 45 minutes, we adopted a flexible approach and frequently extended the interview to accommodate participants' desires to speak at length in response to the questions posed.

Data Analysis

The first author conducted the majority of the interviews and performed the data analysis. After each interview, she reviewed the taped session and prepared a summary and brief analysis note. She selected passages that were particularly relevant to the questions under investigation for verbatim transcription and then entered these passages into a database and coded them for further analysis using ATLAS.ti (Muhr, 1997). A second coder listened to a proportion of the interviews and independently selected passages for transcription, which, in most cases, were identical to the first coder's selection of emergent themes. We then entered these additional passages into a database and coded them for further analysis using ATLAS.ti. In this article, we assign mothers pseudonyms to maintain confidentiality.

FINDINGS

Reduction in Substance Use

To increase self-efficacy for reducing or eliminating problem drinking and/or drug use, we focused the FF intervention to help participants assess and identify problems associated with their substance use, and develop manageable goals to reduce the harm these substances caused in their lives. Each session commenced with a review of the mother's substance use–related goal and her progress toward it (or not, as the case might have been). As the sessions progressed, mothers revised their short- and long-term goals based on their current circumstances and needs.

The participant's relationship with her intervention facilitator emerged as a core aspect of engagement and behavior change. Across all domains of inquiry, the facilitator emerged as crucial to the ways in which participants valued the intervention. In particular, participants identified four aspects of the therapeutic relationship as most salient: the facilitators' compassion, honesty, helpfulness, and the fact that they were not judgmental about the participants' lifestyle, particularly her use of alcohol and drugs. The primacy of the relationship between the participant and the facilitator is reflected in the sections that follow.

Esperanza's experiences working with her facilitator to reduce her alcohol use expressed the collaborative quality of the sessions, one in which the facilitator and the participant employed a team-oriented approach to support the participant's goals. Esperanza described her facilitator's approach as welcoming and supportive of her goal to drink less, in contrast to her family's demands to give up alcohol entirely. Using the harm reduction approach, facilitators did not demand or require mothers' adherence to a particular outcome, such as abstinence; rather, they supported each participant in developing realistic responses to her substance use that suited her needs. This approach to goal setting was particularly useful because participants generally required ongoing education regarding the harm reduction approach; most were well versed in the salience of abstinence in most substance use treatment approaches and typically chose abstinence as their goal, even when, on closer questioning, they were neither willing nor ready to eliminate substances entirely. Esperanza, for example, chose as her goal to drink less, and over a number of sessions, her facilitator guided her in developing and implementing several manageable steps that led to significant reductions in her alcohol use:

> [Facilitator] knew how to talk to you. And she's like, "Why don't we set a goal here? Instead of drinking ten, why don't you drink four?" … And then she would ask me when I come the following week, "How many did you drank? Be truthful." And then I would tell her how many I drank, one in the morning when I usually drink five. I would tell her whatever I drank. And that's how I started cutting down.

Several of the participants remarked that the broad focus of the harm reduction approach, and the FF intervention's emphasis on family concerns, were major factors in treatment engagement and encouraged them to reduce their substance use. Many participants contrasted the FF intervention with other forms of treatment they had attempted in the past. Maria described that

> I thought there was no hope for me because I was a relapser … And so like a lot of the groups weren't workin' for me, I wasn't feelin' it … And the AAs and all that, they don't tell you, they just say "Keep coming back," but Family First it helped me with the situations of how to deal with my teenagers, how to deal with the grieving that I had of my husband, how to deal with a lot of things that also my teenagers didn't understand. So they really helped me.

Aiesha described the striking effects of these risk reduction processes on her ability to take care of herself and her children. With the help of her facilitator, Aiesha set several goals: to

pay bills, buy groceries, wash her clothes, and spend less money on drugs. She worked toward these goals incrementally. Her desire to continue using did not preclude her from taking care of herself as best she could, and she found that these efforts reduced the amount and frequency of her drug use. Paying her bills brought her satisfaction, and she experienced a sense of pride at her ability to take care of herself and her family. ”I may be an addict, but I don’t want to be the kind of addict who has no apartment, no light, no food, nothing. I’ve done that, I don’t wanna go there no more.” Aiesha’s experience illustrates the diverse types of outcomes that emerge from interventions taking a harm reduction approach, many of which are unlikely to be captured in structured assessments.

Social Support

A recurring theme throughout most of the interviews was participants’ isolation, which intensified the stress they experienced with regard to substance use and parenting. Many women reported that they could not speak openly with family members and friends about their substance use because of the potential for judgment, criticism, loss of confidentiality, and scrutiny of their behavior. Although these responses from friends and family members might indicate concern and care, from the participants’ perspectives, such judgment and rejections exacerbated the shame and stigma many of them already experienced and further marginalized them from their support networks.

Shauna, for example, depicted her fiancé’s attitude toward her cocaine use as stigmatizing. She described that during several recent attempts to stay “clean,” she began to feel provoked by his “nagging” her not to use and noted that this stress exacerbated her cravings for cocaine.

In the intervention sessions, women freely shared the challenges they faced with alcohol and drug use, free of judgment. This experience stood in stark contrast to their personal relationships, where such discussions were more complex and challenging. Yolanda greatly feared her partner’s and family members’ reactions toward her substance use, which, in turn, encouraged her withdrawal into riskier contexts, such as trading sex for money and drugs. She described how the FF facilitator’s willingness to listen with encouragement and support diminished her fears about examining her substance use problems and her sense of isolation. In the absence of punishment or judgment, the facilitator encouraged examination and discussion of the effects of substance use that had been kept secret. Yolanda said the facilitator could

> take things out of my heart, take things I could never speak to my family … the drug habit, the cocaine, my boyfriend left me, I would never speak to, not even to my mother. … You feel very good that you spoke to somebody who understands. No one (in FF) is sending you to hell for doing drugs.

Stress and Coping Skills

Many participants said that the inordinate amount of stress they encountered in their daily lives often thwarted their desires and efforts to reduce or abstain from problematic drinking and/or drug use. In the following passage, Tamika describes how cutting back on marijuana actually intensified the pressures she experienced as a parent:

> The kids stress me out all day long. Please stop crying, please go to your room, stop doing this, stop doing that … This is what it’s like being sober? [Sighs] Goodness. That’s why I was gettin’ high all the time. You have to understand the pressure, the children fightin’ all the time.

Typically, when trying to reduce or eliminate substances, many users find that they are also removing a valuable coping mechanism (Stein & Nyamathi, 1999). Facilitators encouraged women to examine the ways in which their alcohol and drug use functioned as important coping

mechanisms in their lives. Part of each session was devoted to practicing relaxation techniques to manage the stressors and challenges they faced. Facilitators also trained participants to conduct relaxation exercises independently, particularly in the context of stressful situations. Mothers described some of the benefits of these exercises; among them were immediate feelings of peace and comfort, and many reported that they continued to use the exercises in their daily lives. The most frequently cited use of this tool for affect regulation and coping outside the intervention setting was in response to the pressures, stresses, and outbursts participants regularly encountered in interactions with their children.

Tamika described that her favorite exercise from FF was to count down with each breath. She continued to do the breathing and meditation exercises, especially whenever she felt worn out:

> When I had problems, (Facilitator) would help me solve them in ways that I don't have to come and argue and scream and yell at them (her children), y'know? She taught me that it's better off to wait for my anger to leave and then just go back and talk to them and explain to them why I was angry, instead of just storming through a door. That don't help, she told me. … If there's a problem now, we wait until the anger leave and then we'll talk.

Improving Relationships

A core element of SAT is the recognition that health protective actions are embedded in one's social network; thus, networks can either hinder or support efforts to change or eliminate problem drinking and/or drug use. A primary goal of the FF intervention was to assist mothers in building skills to improve and sustain positive relationships with family, friends, and other members of their social networks. The strengthening of communication skills was critical to this objective and led to substantive changes in participants' relations with others. Mothers described developing awareness of feelings in particular situations, receiving support to express and identify their needs to others, and engaging in active listening, especially with their children.

In particular, they noted that the application of these new skills was enhanced by the facilitator's ability to tailor the skill to their unique situation. In another example, Francesca described that at her facilitator's suggestion, she and her children began to participate in activities together:

> They would tell me to do things with my kids … start a conversation, to have with dinner with them, or sit them together and talk or watch a movie together. Something that was, y'understand, doin' things. When I was doin' the drinkin' and all that I wasn't caring about what the hell they felt … it was just about what I'm gonna get out of it. The program taught me how to deal with them, y'know, and understand what they're goin' through.

It is also important to note that the positive outcomes Francesca and her children experienced as a result of the time they spent together were closely linked to her reduction in alcohol and drug use, indicating the interconnections of substance use and parenting. Her past drinking and drug use depended in part on her ignoring any effects her use might have had on her children. Francesca's examination of the effects of substance use on her children strengthened her relationship with them and bolstered her commitment to reducing her use.

Relationship With Facilitator and Termination

The importance of the therapeutic alliance was evident in participants' discussions of their experiences at the conclusion of the intervention and/or project. Although facilitators provided referrals for community-based treatment after completion of the intervention to those who requested it, several participants expressed the loss they felt on completing the sessions.

Alnisa described that she formed a strong bond with both her intervention facilitator and study interviewer:

> [Study interviewers and facilitators] were very considerate. Very helpful and compassionate. Y'know what I'm sayin'? The only thing, there's nothing really wrong with this study, the only thing is maybe it should have been longer. That's about it. You got attached to people.

DISCUSSION

Our qualitative analysis illuminated many of the positive changes mothers with problem drinking and drug use made during and after participation in the FF intervention. Many of these behavioral changes were not captured in our quantitative analysis; thus, these findings highlight the utility of a qualitative approach for furthering our understanding of the mechanisms by which interventions such as FF might effect behavior change. In particular, the qualitative analysis captured some of the unique ways mothers used the FF intervention sessions to reduce the personal and situational harms associated with their substance use and develop positive parenting strategies with their adolescent children. Moreover, the analysis highlighted the importance of a gender-tailored, contextual treatment approach and the role of the therapeutic relationship for engaging and retaining mothers and contributing to positive behavioral changes.

Our findings also contribute to an understanding of the value of a harm reduction approach for mothers with problem drinking and drug use and provide evidence that harm reduction might be an active ingredient of the FF intervention. Although participants were not seeking treatment for alcohol abuse at the time they enrolled in the study, their narratives indicate that mothers made significant changes in their patterns of alcohol and/or drug use and adopted a variety of coping skills in an effort to deal with these changes. Participants had long histories of alcohol and drug abuse, as well as many substance abuse treatment attempts. The introduction of harm reduction principles was a novel aspect of the intervention that served to engage and retain mothers in treatment and appeared to increase their motivation for change. Moreover, mothers appeared to value the harm reduction principles articulated by facilitators, particularly the concept that alcohol and drug use is likely to have been adaptive in their lives (Denning, 2000) and the focus on learning specific skills to replace the role substances play in their lives. Our interviews revealed that the use of a harm reduction approach served to lessen mothers' isolation regarding their alcohol and drug use by freeing them to discuss the quantity, frequency, and consequences of their use honestly, something many of them were unable to do with those in their social network or in previous treatment. Future research with non–treatment-seeking women should focus on this latter aspect of an overall harm reduction strategy, as it has significant implications for the ways in which substance abuse treatment is presented to women by providers in clinical settings.

We also learned that attention to the individual context of these women's lives, particularly their roles as mothers raising adolescents in severely challenging conditions of urban poverty, facilitated both treatment engagement and real-world application of the skills learned during the sessions. The strategies mothers learned to engage in more positive communication with their children and others in their social network were the most notable of these skills. Moreover, discussion of parenting concerns increased mothers' motivation to reduce alcohol- and drug-related harms. In addition, although we originally conceived of the FF intervention as an intervention for problem drinking, facilitators did not impose individual treatment goals on mothers but instead assisted each of them in constructing a hierarchy of needs reflecting her most urgent concerns (Denning, 2000; Rotgers, 1999). Thus, mothers set goals for reducing the risk about the substance that seemed to be causing the most harm, and as our interviews indicated, some mothers set goals related to alcohol or its associated risks, whereas others

worked on reducing the risks associated with other drugs, such as marijuana and cocaine. Examples of these goals included changing patterns of substance use (e.g., not drinking or using drugs in front of children), substituting more harmful substances for those that entailed less physical or emotional risk (e.g., using marijuana instead of cocaine), or changing the social contexts that triggered substance abuse, as well as reducing or eliminating alcohol and/or drug use. Results of the present study appear to endorse these strategies for women who are not seeking treatment, as they expand the concept of what substance use behavior change can entail and might serve as a motivator for change. Moreover, the use of these individualized harm reduction strategies might be an additional key ingredient of the FF intervention. The development of both qualitative and quantitative instruments to measure substance use–related outcomes in harm reduction–focused treatment more accurately is another crucial area for future research.

The therapeutic relationship was instrumental to all aspects of the FF intervention, from undermining isolation to supporting behavior change. Other researchers have found the therapeutic alliance to be a predictor of engagement and retention in alcohol and drug abuse treatment, and it might relate to treatment outcome for problem drinkers (Connors, Carroll, DiClemente, Longabaugh, & Donovan, 1997; Meier, Barrowclough, & Donmall, 2005). Mothers in our study uniformly found the FF facilitators caring and helpful, two qualities other researchers have found to predict substance abuse treatment engagement, particularly for women (Fiorentine, Nakashima, & Anglin, 1999). Therapeutic techniques of acceptance, such as empathy and validation, are consistent with the major theoretical underpinnings of the FF intervention, and the use of these techniques by facilitators might have served as a model of interpersonal interaction that mothers' used in their relationships with others in their social networks (Linehan, 1993). In fact, our findings indicate that the improvement of relationships with adolescent children was a highly salient aspect of the intervention for mothers and might be another active ingredient of the intervention. Future qualitative work should involve adolescents' perspectives on changes in their relationship with mothers.

Qualitative interviews are also useful in identifying unanticipated phenomena (Maxwell, 1996). In some interviews, mothers recalled very directive interactions with facilitators, particularly in the application of harm reduction principles and other skills to mothers' individual circumstances. Although the intervention manual clearly articulated a collaborative, guided discovery approach to the real-world application of skills, mothers interviewed for this qualitative study appeared to remember, with some detail, specific advice from their facilitators, which they perceived as extremely helpful and not coercive. Cognitive-behavioral therapists are typically directive with clients, and positive treatment outcomes have been associated with clients' perception of cognitive-behavioral therapists' being active, skillful, and self-confident in sessions (Keijsers, Schaap, & Hoogduin, 2000). Although we did not analyze the sessions that were recorded for supervision, this unexpected finding is an avenue for future research.

Although mothers' HIV status was not a primary focus of the present study, we anticipated that there might be differences in how the two groups experienced the intervention. We conceptualized HIV status as one potential motivator to reduce substance use and designed sessions to discuss HIV-related issues. However, the majority of women did not report that HIV infection was as a primary stressor. The absence of a specific question concerning HIV/AIDS in the interview guide might have contributed to the lack of sustained discussion on HIV-related issues, although it might also reflect that HIV is only one of multiple stressors that participants face. Among HIV-infected women, other researchers have found poverty, violence, and substance abuse to be far more disruptive than HIV/AIDS (Ciambrone, 2001; Siegel, Karus, & Dean, 2004). Furthermore, it is possible that the HIV-infected participants in our study had adapted fairly successfully to their serostatus, although still struggling with their

problem drinking and drug use. In this context, HIV infection might make little independent contribution to behavior change.

Finally, the high rates of attendance to the intervention were due in large measure to the persistent, intensive outreach by the facilitators and study team. Many mothers received the 14-session intervention over several months as substance use, housing and financial problems, and responsibilities for children and others in their social network prevented them from weekly attendance. Although mothers did not specifically mention this intensive outreach in their interviews, it is an aspect of the therapeutic, client-centered approach that conveyed to mothers the facilitators' availability, responsiveness, and nonjudgmental attitude regarding the many missed and canceled sessions. Guided by the theoretical model, facilitators' stated and practiced attitude of "meeting clients where they are" both in the sessions regarding their goals and behaviors and in the ongoing process of engagement was a crucial aspect of the intervention design and delivery that fostered the therapeutic alliances that emerged as a dominant theme in these interviews.

CONCLUSION

This qualitative analysis of a behavioral intervention for urban mothers illuminated a number of mechanisms by which participants made changes in their substance use patterns and in their parenting practices. Participants identified a number of features of the intervention that contributed to their process of behavior change, including a strong therapeutic alliance, a focus on reducing the harms associated with alcohol and drug use, the development of coping strategies, and attention to participants' roles as mothers and the challenges they face parenting adolescent children in disadvantaged urban areas. These features might be considered some of the active ingredients of the intervention and warrant future examination with women challenged by alcohol and drug use problems. Recognition and attention to the ways in which substance abuse is embedded in women's primary relationships is vital for effective treatment. In particular, for mothers who are not seeking substance abuse treatment, facilitators might increase mothers' motivation for behavior change by capitalizing on their desire to improve relationships with their children.

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