

Rowan University

Rowan Digital Works

Theses and Dissertations

7-24-2006

Drug addiction and mothers: does parenting get better with treatment?

Concetta Arabia
Rowan University

Follow this and additional works at: <https://rdw.rowan.edu/etd>



Part of the [Psychology Commons](#)

Recommended Citation

Arabia, Concetta, "Drug addiction and mothers: does parenting get better with treatment?" (2006). *Theses and Dissertations*. 880.

<https://rdw.rowan.edu/etd/880>

This Thesis is brought to you for free and open access by Rowan Digital Works. It has been accepted for inclusion in Theses and Dissertations by an authorized administrator of Rowan Digital Works. For more information, please contact graduateresearch@rowan.edu.

DRUG ADDICTION AND MOTHERS: DOES PARENTING GET BETTER WITH
TREATMENT?

by
Concetta Arabia

A Thesis

Submitted for partial fulfillment of the requirements of the
Master of Arts Degree
of
The Graduate School
at
Rowan University
July 24, 2006

Approved by _____
Advisor

Date Approved July 24, 2006

© 2006 Concetta Arabia

ABSTRACT

Concetta Arabia

**DRUG ADDICTION AND MOTHERS: DOES PARENTING GET BETTER WITH
TREATMENT**

2005/06

Dr. Mary Louise E. Kerwin

Master of Arts in Mental Health Counseling and Applied Psychology

Objective: To examine the parenting skills and attitudes of substance abusing mothers in a comprehensive drug treatment facility in Camden, NJ. **Methods:** Giving three self-report measures and urine analysis to 14 mothers at intake, 2-months, and 6-months.

Participants were reimbursed for their time and travel. **Results:** Mothers parenting skills and attitudes at intake were found to lack the confidence and enjoyment in their parenting and to have high levels of perceived stress. Bigger sample sizes are needed. **Discussion:** Progress towards incorporating parenting skills training in in-patient and out-patient treatment facilities has been made. However, a distinction between bad parenting and drug abuse needs to be investigated further.

ACKNOWLEDGEMENT

I first would like to acknowledge my thesis advisor, Dr. Mary Louise Kerwin for her endless support and guidance through this process. I would like to thank my fellow classmates for being rational at a time when I was not and for their immeasurable support and advice. Lastly, I would like thank Sikora Center for changing my life forever by allowing me to come into the world of drug and alcohol addiction.

Table of Contents

Acknowledgments	iii
Table of Contents	iv
Chapter 1 - Introduction	1
Chapter 2 - Methodology	12
Chapter 3 - Results	17
Chapter 4 - Discussion	25
Chapter 5 - References	29
Appendices	
Table 1 - Demographic Characteristics of Participants	37
Table 2 - Number of children in each category	39
Table 3 - Participant Treatment History	41
Table 4 - Means and SD on Parenting Measures	42
Table 5 - Drug Abstinence	43
Table 6 - Attendance at the Treatment Center	45

CHAPTER 1

INTRODUCTION

Drug abuse and addiction is a major public health problem that affects many people and has social consequences. In 2001, the National Household Survey on Drug Abuse (NHSDA) estimated that almost 6 million children younger than 18 years of age lived with at least one parent who abused or was dependent on alcohol or an illicit drug (Substance and Mental Health Services Administration, 2003). The National Institute on Drug Abuse (NIDA) conducted a survey in 1992 and 1993 and found that 221,000 women used illegal drugs during their pregnancies in those given years (NIDA, 2005). This is troubling because research has documented that children with substance abusing parents are more at risk for alcohol and drug use, delinquency and depression (SAMHSA, 2003; Huang, Cerbone, & Gfroerer, 1996). Furthermore, substance abuse has a tendency to occur across generations in families (McLellan, 2002; McLellan, Lewis, O'Brien, & Kleber, 2000; McLellan, McKay, Forman, Cacciola, & Kemp, 2005; NIDA, 2005).

Parental substance abuse continues to be a serious issue in the child welfare system. Maltreated children of substance abusing parents often remain in the child welfare system longer and experience poorer outcomes in life (National Clearinghouse on Child Abuse and Neglect Information (NCCAN), 2003). Approximately 50 to 80 percent of all child abuse and neglect cases substantiated by Child Protective Services (CPS) involve some degree of substance abuse by the child's parents (NIDA, 2005). Since the passage of the Adoption and Safe Families Act of 1997 (ASFA), these children may be

less likely to reunify with parents and are subject to alternative permanency decisions in greater numbers than children from non-substance abusing families (NCCAN, 2003).

The lack of parenting knowledge and the abuse of substances usually lead to the removal of children in a home, mainly for neglect. To support this, Besinger, Garland, Litrownik, and Landsverk (1999) found that children placed out of home came from substance abusing homes approximately eight out of ten times, and were more often removed due to neglect, but less often removed for physical or sexual abuse. Further research indicates that in substance-abusing families, many different adults may be caring for the children (Mayes & Bornstein, 1995). Most times, children of addicted mothers are placed with relatives or foster care to protect them from a disruptive, drug using life style (Knis-Matthews, 2003; Luthar & Walsh, 1995; Suchman & Luthar, 2000; Uziel-Miller & Lyons, 2000; Rittner & Dozier, 2000).

Because these children are often removed from the home of their biological parent(s), usually their mother, CPS will take a more active role in designing and managing the care plan for the family. For example, mothers often are referred to substance abuse treatment through CPS as a requirement for retaining or regaining custody of their children (SAMHSA, 1996). What is often overlooked by CPS is the chronic nature of substance abuse, and how often a person will relapse after treatment (Kelly, Finney, & Moos, 2005; McLellan et al., 2005). Recovery can be a life-long process (McMellan et al., 2005) and should be a factor when CPS designs a care plan for a parent. According to Rittner and Dozier (2000), once these women complete a drug treatment program, CPS does little to continue to supervise these families and to arrange services needed by the recovering mother. Frequently, substance abuse is treated as an

acute disorder (McMellan, 2003; McLellan et al., 2005) and the length of recovery is too brief to assist parents in a full recovery, which will lead to relapse time and time again (Terling, 1999).

Although drug treatment works (Peterson, Tremblay, Ewigman, & Saldana, 2003), its effects on parenting have not been investigated thoroughly. Smith (2003) found that despite ongoing drug use and the perceived parenting benefits resulting from the completion of drug treatment substantially increased the rate of child reunification. In addition, Rittner and Dozier (2000) found that compliance with treatment recommendations was used to evaluate whether or not the parent should be reunified with their child(ren) without regard to whether or not parenting skills improved. These observations of service practices are significant because state agencies often assume that parenting skills improve as a function of substance abuse treatment. This is a problem because there is a high correlation between substance abuse and child maltreatment, but we do not know what skills these women have as parents, and we are not sure that parenting skills training are being addressed in drug treatment.

In more recent years, there has been a focus on comprehensive, community-wide prevention programs that incorporate prevention strategies within each of the human service systems (Held, 1998). Smith and Marsh (2002) found that within any given treatment program, the most typical practice is to provide a standard protocol of services to each client in the program. However, the practice of conducting a thorough assessment of each client individually that could permit shaping or matching services to needs of the client is not standard practice. Interestingly enough, there is no data suggesting that CPS has a protocol or procedure to follow the mother's progress (Karoll,

& Poertner, 2002; Smith & Marsh, 2002) and evaluate for changes in risk (Mullins, Bard, & Ondersma, 2005).

Similarly, Mullins, Bard, and Ondersma (2005) studied participants in a nine-month treatment program. The program's goals were to treat the mother's substance abuse and to reduce child maltreatment. Parents were involved with CPS and were required to participate in random urine drug screens. They found that simply attending the program was not sufficient to avoid future child maltreatment; there needed to be some motivation on the part of the parent to want to change. Also, there was no difference in those participants attending the program solely to meet CPS requirements and those who were motivated to change in regards to being reunified with their children. Although there were no differences in drug abstinence as measured through urine screenings, the study did not utilize any measures assessing risk for child maltreatment or parenting strengths or weaknesses.

In order to get a better understanding of the parenting skills of substance abusing mothers, mental health professionals need to address the issue of substance abuse itself as a chronic disorder (Kelly et al., 2005; McLellan et al., 2000). Relapse rates among this population are high and recovery takes a long time (McLellan et al., 2005). On the one hand, CPS identifies women as needing treatment; however, there are limited resources for these women (National Adoption Information Clearinghouse, 2003). CPS caseworkers are under pressure to close cases and to reunify children with their biological parents (Hohman & Butt, 2001). Recovery time and a mother's support system need to be considered when discussing a client's treatment needs (Zlotnick, Franchino, St. Claire, Cox, & St. John, 1996). Terling (1999) found that 50% of CPS cases reentering the

system involved substance abuse. These cases could be differentiated into two groups: those families in which there was the presence of a substance abusing partner who had not gone through treatment, and those cases in which not enough time was allowed for substance abuse recovery. It seems that very little emphasis by CPS is given to whether the perpetrator's partner is complying with the treatment plan since many cases were closed with this risk factor present. Startling, time is not given ample importance in decision-making. For example, a mother with a history with CPS, a serious addiction to heroin, crack, and alcohol, and prior relapses following periods of recovery, was given her children back after three months of abstinence (Terling, 1999). The mother subsequently relapsed and the children returned to foster care. Unfortunately, this type of sad occurrence happens more often than not.

There are many variables independent of drug abuse that can have a direct effect on parenting in general (McMurtrie, Roberts, Rosenberg, & Graham, 1998). It has been shown that life stressors such as low socio-economic status (Ondersman, 2002; Suchman & Luthar, 2001), single parenthood, lack of social supports and resources (Davis, 1997), and inadequate or unstable housing (Uziel-Miller & Lyons, 2000) can form the basis to which mothers abuse drugs. Davis (1997) suggested that the ineffective parenting techniques utilized by many chemically dependent women might be a result of pre-existing conditions, such as traumatic childhood experiences, negative affective states, and ineffective social support networks, as well as actual substance abuse (Locke & Newcomb, 2004). She found that high levels of stress caused by ineffective support networks and poor coping skills can lead women deeper into drug use, which will interfere with parenting effectiveness. Similarly, Ondersma (2002) found that families

that were of a low socioeconomic status, had a history of substance abuse, and a history of negative life events appeared as significant predictors of neglect of the children in the home.

Deficiencies in parenting skills might be an outcome of poor role models provided by the parents of the substance abusers themselves (Barnard, 1999; McMurtrie, Roberts, Rosenberg, & Graham, 1998; Camp & Finkelstein, 1997). Within the literature, many of these women had been victims of childhood trauma (Coyer, 2001; Luthar & Walsh, 1995; Zlotnick, Tam, & Roberts, 2004) such as being physically abused, sexually abused (Millar & Stermac, 2000), and neglected. Huebner (2002) found that over sixty percent of the parents studied reported childhood experiences of maltreatment, such as sexual abuse, neglect, physical abuse or emotional abuse. They also witnessed drug abuse in the home and violence in the home (Camp & Finkelstein, 1997). When experiences are adverse, the consequences can interfere with adult functioning in multiple domains (Miller-Perrin & Perrin, 1999).

Gaining some insight as to how these women perceive parenting is an important factor as well. If mothers use drugs, they may not have the ability to integrate their own adverse early experiences and may become poor parents themselves (Newcomb & Locke, 2005). Subsequently, maternal drug addiction has been clearly linked with parenting deficits (Luthar & Walsh, 1995; Suchman & Luthar, 2000). Such deficits include punitive punishments (Di Lauro, 2004), unrealistic expectations in expecting their children to take on responsibility (Spieker, Gillmore, Lewis, Morrison, & Lohr, 2001), limited cognitive ability (Terling, 1999), deficiencies in basic parenting skills (Coyer, 2003), lack of empathy, and no or little attachment to their children (Di Lauro, 2004).

Schuler, Nair, and Black (2002) found that ongoing maternal drug use and poor parenting attitudes were associated with less favorable maternal behavior during mother-child interaction.

Often times chemical dependent mothers lack basic parenting knowledge, do not recognize cues in their newborns (Coyer, 2003; Luthar & Walsh, 1995), and how to play with their children, discipline, or communicate with their child (Knis-Matthews, 2003). It has been found that mothers who abuse drugs have an inability to read infant gestures as well as a difficulty in maintaining interactions with their infants (Thurman & Berry, 1992) and have unrealistic expectations of child behavior (Spieker et al., 2001). Mothers who are substance users report higher levels of parenting distress.

As stated earlier, feelings of isolation and lack of social supports can be stressful to a parent in recovery. When a mother is experiencing distress, she may use drugs to escape the distress and/or abuse and neglect her children. Suchman & Luthar (2001) investigated the role of parenting stress in the drug treatment process. When addicted mothers viewed their children's temperaments and behaviors as a source of parenting stress, mothers were more likely to report parenting problems involving verbal and physical aggression, ineffective discipline, and excessive control (restriction of children's autonomy). Parenting problems involving neglect and withdrawal were more prevalent when mothers were stressed and dissatisfied about their relationships with their children. Parenting problems involving aggression and poor discipline were more likely to arise when mothers were stressed by their children's characteristics and behaviors. These results are consistent with the evidence that abusive mothers tend to view their children as having significant behavioral and temperament problems and as being difficult to rear

(Coyer, 2001; Davis, 1997; Suchman & Luthar, 2001; Velez, Jansson, Montoya, Schweitzer, Golden, & Svikis, 2004), adding stress to the recovery mother.

Professionals need a better understanding of the parenting skills and deficits within this population of women. Fortunately, some recent studies have begun to investigate the parenting skills of this population. Huebner (2002) studied 199 mothers of children one through thirty-six months of age who were at risk for parenting problems and child maltreatment. The purpose of this study was to evaluate whether a brief and inexpensive clinic-based education program could benefit parents by alleviating parental stress and improving parent-child interaction. Huebner studied three groups: a health department group (HD), a children's clinic group (CC), and a residential drug treatment group (DT). Each group was given sixteen hours of parenting classes based on the Systematic Training for Effective Parenting (STEP) program. Outcome measures used were the Parenting Stress Index/Short Form (PSI/SF; Abidin, 1995), the Home Observation for Measurement of the Environment (HOME) Inventory, and the NCAST scale (NCAST Caregiver/Parent-Child Interaction Teaching Manual, 1994). Results from the study revealed that parents in both the HD and CC groups reported significant improvement due to decreased stress in the parent-child relationship. Mothers in the DT group reported a significant decline in parenting stress due to their feelings about themselves and about themselves as parents. They also attended more of the parenting class sessions. For the group as a whole, parents reported a significant decline in parenting stress, especially stress coming from the parent-child relationship. It is important to note that mothers in the drug treatment group commented that they

appreciated the parenting program because it helped them realize that other parents were struggling too.

The parent with inadequate knowledge of child development does not see the absurdity between her demands of the child and the child's developmental level. The parent eventually avoids contact with the child, which can result in neglect or abuse (Spieker et al., 2001). Velez et al. (2004) found that drug dependent women entering substance abuse treatment lacked knowledge about basic parenting and this knowledge improved with parenting training as a component of a comprehensive drug treatment. They investigated seventy-three pregnant women attending the Center for Addiction and Pregnancy, which provided specialized care to pregnant and postpartum substance abusing women and their children. Results suggested that the women sampled lacked important parenting knowledge and held misconceptions about basic parenting practices, and that this knowledge showed short-term improvements after comprehensive substance abuse treatment that included a parent training component. Limitations to this study were the lack of a non-treatment control group, the use of self-report instruments, and a wide range of time between pre- and post-test.

Peterson, Trembley, Ewigman, and Saldana (2003) implemented a seven level model of successful parenting on high risk, substance-abusing mothers. This program included modeling, role-playing, Socratic dialogue, home practice, and home visits. Results showed that there was a reduction in the mother's use of spanking and other types of harsh discipline and was an increase in their use of more gentle disciplines. Their knowledge of developmentally relevant skills increased and their unrealistic and dangerous beliefs about children decreased, less child-directed anger was seen and

mothers showed more acceptance of the role of the parent in determining answers to resource-limited problems, more nurturance was shown by the treated mothers in the observation tasks, and lastly, their sense of effectiveness as parents increased.

Kelley and Fals-Stewart (2002) studied the effects of three treatment approaches to couples where at least one parent was using drugs. The three different treatment approaches were: Behavioral Couples Therapy (BCT), Individual Based Therapy (IBT) and Psychoeducational Attention Control Treatment (PACT). Sixty-four couples (22 BCT, 21 IBT, and 21 PACT) were assigned to a drug treatment condition; 71 couples (25 BCT, 22 IBT, and 24 PACT) were assigned to an alcohol treatment condition. Results show that BCT resulted in reduced substance use and partner's improved dyadic adjustment compared to parents who participated in IBT or PACT during the follow up period. The benefits of BCT allowed couples to address conflict more constructively. This, in turn, improved children psychosocial functioning after treatment completion and at 6 and 12 months post-treatment.

In summary, many researchers have studied mothers who abuse substances, and how the abuse of the drugs impacted their parenting. Without refuting this claim, other conditions may influence why these mothers started to abuse substances in the first place. It is important to know what kind of parenting skills a mother who abuses substances has and to separate it from the substance abuse. All too often society and state agencies claim that the substance abuse is the cause for poor parenting (VanBremen & Chasnoff, 1994). Again, without refuting this claim, it is presumptuous to allot all of the blame on substance abuse. Parenting skills by themselves need to be taken more seriously when formulating treatment plans for mothers who abuse substances. The idea of a mother

having poor parenting skills independent of her substance abuse problem needs to be investigated further.

The aim of this study is to investigate the parenting views and skills of women in a comprehensive, outpatient drug treatment center. It is imperative for researchers to investigate long-term abstinence and parenting skills at the same time. Few studies have measured a range of parenting skills. Even fewer studies have done any kind of direct observation of parenting skills (Kerwin, 2005). Up until now, most studies relied solely on self-report measures to identify the parenting skills of substance abusing mothers. With this study, trained investigators will directly observe the parenting skills of substance abusing women in conjunction with self-report measures while receiving treatment over time. If drug treatment is related to parenting, there will be room to explore the policy implications of that outcome.

CHAPTER 2

METHOD

Participants

Throughout the course of the study, participants were enrolled in an intensive outpatient drug treatment center for women. Participants were 18 years of age or older, met the criteria for substance dependence or abuse of at least one substance other than nicotine, were mothers and/or legal guardians of at least one child under the age of 15 years of age, and lived with their child(ren) or saw their child(ren) at least one hour/every other week for the past 6 months. Women experiencing episodes of psychosis, expressing suicidal or homicidal thoughts and/or who reported that they know they would be moving out of the area or would be unavailable for the 2 month or 6 month assessment were removed from the study. This study was approved by Rowan University's Institutional Review Board and all participants provided informed consent.

Potential participants were identified by the treatment center staff and the research staff then approached potential participants individually or in small groups and briefly described the study. If a woman stated she was interested, she was screened for eligibility. Over the course of 5 months, 36 women were screened for eligibility. Of these 36 women, 25 were eligible to participate and 14 provided informed consent for the study. The number of women who completed the intake and were enrolled in the study was 12; two women consented to participate in the study but then never returned to the drug treatment center to complete the intake assessments. Of the 14 participants that provided informed consent, 6 women consented to the videotape portion of the study in

conjunction with the questionnaires. Of these 6 women, 2 completed the videotape portion.

Setting

The center chosen to conduct this investigation is Sikora Center, located in Camden, NJ. Sikora Center is a comprehensive outpatient drug treatment center that provides up to 20 hours of service each week. Included in these 20 hours are nine hours committed to drug treatment specifically. The center offers individual and group counseling, relapse prevention and continuing care. It also has a case management and mental health counseling components to help women address individual concerns. Women who live within the city limits of Camden are provided transportation to and from the program. Women are enrolled in intensive outpatient programs (Monday through Friday), or outpatient programs (1 to 4 days/week for 3 hours/day).

Experimental Design

This study used a within-subjects design. Assessments were scheduled at intake (within 2 weeks of admission to Sikora Center), 2 months and then again in 6 months. The scope of this thesis project will be primarily the intake data with a preliminary exploratory analysis of change over time.

Measures

Parenting Stress Index-Short Form (PSI-SF; Abidin, 1990). The Parenting Stress Index-Short Form consists of a 36-item questionnaire. It assesses dysfunctional parenting and predicts the potential for parental behavior problems and child adjustment difficulties within the family system. It yields a Total Stress score from three scales: Parental Distress, Parent-Child Dysfunctional Interaction, and Difficult Child. The participant

responds to each item using a 5-point Likert scale. Alpha reliabilities for the three scales are .87, .80, and .85, respectively and .91 for the 36-item Total Stress score.

Parenting Sense of Competence Scale (Gibaud-Wallston & Wandersman, 1978; Johnston & Mash, 1989) is a 17-item scale consisting of two empirically derived subscales, Parenting Satisfaction (9 items) and Parenting Efficacy (8 items). Each item is answered on a 6-point scale ranging from strongly disagree (6) to strongly agree (1). The total score shows a satisfactory level of internal consistency ($\alpha = .79$).

Parenting Scale (Arnold, O'Leary, Wolff, & Acker, 1993) is a 30-item questionnaire measuring discipline styles in parents. It consists of three factors: Laxness, Overreactivity, and Verbosity. Parents are asked to respond to each item on a scale from 1-7. The scale is anchored by a "parenting mistake" at one end and an adaptive "parenting response" at the other end. The total score has adequate internal consistency ($\alpha = .84$), and good test-retest reliability ($r = .84$).

Dyadic Parent-Child Interaction Coding System II (Eyberg, Bessmer, Newcomb, Edwards, & Robinson, 1994). The Dyadic Parent-Child Interaction Coding System II is a behavioral coding system designed to assess the quality of parent-child social interaction. It provides an observational measure of parent and child behavior during three 5-minute standard situations that vary in the degree of parental control required (5 minutes of child directed play, 5 minutes of parent directed play, and 5 minutes of clean up). Identical categories may be coded for both parent and child. These categories include verbalizations, vocalizations, and physical behavior. Scores for each behavior are determined using a sum of the frequency counts of each occurrence across all three 5-

minute situations. Adequate reliability and construct validity have been demonstrated for this system.

Drug Abstinence

Drug abstinence was assessed in two different ways. Research staff tested for cocaine, amphetamines, marijuana, opiates and PCP at the three assessment points using an integrated urine testing cup. The other way in which drug abstinence was assessed was through Urine Drug Screens (UDS) taken randomly each week by the drug and alcohol counselor at Sikora Center. A release form was signed by the participant to release the UDS outcomes. Some UDS were taken at the Center and then shipped to a lab for analysis all depending on the participant's referral source into the program. Participants that abused alcohol or receiving methadone had their samples sent to a lab for analysis.

Attendance at the Treatment Center

Attendance was taken daily at Sikora Center by the drug and alcohol counselors. Women attending the program were assigned days in which to attend. The number of days a woman attended treatment per week was dependent upon the referral source, prior drug treatment history and completion of treatment. A release form was signed by the participants to release their attendance record to investigators.

Procedure

At intake, investigators met with participants to discuss their participation in the study and to obtain informed consent. Intake is operationally defined as within two weeks after initial intake. This allows the participants to detoxify and stabilize. The participants had the option to consent to the self-report measures alone or the self-report measures and the video taped observation of parent-child play.

Participants who consented provided demographic information and a locator form to be used in case the woman graduates or drops out of treatment before the 2-month or 6-month visit. An appointment was made for the self-report measures. At this appointment, one of the investigators provided instructions on how to complete the forms and answer any questions the woman had. The measures were administered via audiotape and earphones through which she heard each question read aloud to her. The investigator recording the questions gave 15 seconds in between in each question before reading the next question. If the women agreed to allow the videotaping, an appointment was made for her to bring a child of her choice to the appointment. The woman was encouraged to bring the child with whom she was having the most difficulty. At the time of the appointment, the woman and child were greeted and the study was explained to the child to ask for their assent. If the child was older than six year of age, the child was asked to sign a written assent form. The mother and child were then escorted to a private playroom where the recording took place. The videotape observation took about 15 minutes to complete. The measures were repeated at 2 months after admission and at 6 months after admission.

Data Analysis Plan

The data collected was going to be analyzed using repeated measures on abstinence and parenting skills. However, due to the small number of data collected at Time 2, a paired T-test was used to analyze the data. Drug abstinence will predict better parenting skills and attitudes of mothers receiving drug treatment over time.

CHAPTER 3

RESULTS

Demographics of Sample

The mean age of participants was 32 years (SD= 6.2), and the majority of the sample self-reported being Black. Most participants were single, unemployed, had an education level of “some high school”, were not pregnant at the time of treatment, and had a mean of four children (SD= 2.2). The mean age of the children was 9 years of age (SD= 3.8). Most participants stated that they had no income; however, there were two participants that had stated they had an income of more than \$5,000. The reason for this is because one participant stated that she was receiving TANF and the other participant was married and using her husband’s salary as a basis for her yearly income. More information regarding the age, race, marital status, yearly income, education level, and employment status is shown in Table 1.

Most participants did not have child protective services involved (64 %), however, when participants were asked about child protective services involvement the women seemed unsure if there was a case open on one child and not another in the same family. Some of the children that were in placement were living with relatives, which made visitation easier for the mother in treatment. However, there were some children that were in foster care for whom visitation was not permitted at the time of the study. Information regarding CPS involvement, the number of children, the number of children

that are 15 years and above, number of children in the mother's care, and the number of children in placement is shown in Table 2.

According to the data collected, five women (36%) were incarcerated immediately prior to being admitted into Sikora Center. As shown in Table 3, most of the women were referred from Drug Court and Work First – Substance Abuse Initiative (SAI). Drug Court is a service provided by probation/parole. Usually a person coming out of incarceration will be set up with Drug Court to initiate treatment. Women referred by Work First – SAI are coming from the welfare system and this is a way for the women to receive treatment and find employment. Information regarding placement before treatment, the referral source, and if the participant was ever incarcerated is shown in Table 3.

Parenting Stress Index/ Short Form (PSI/SF)

The means and standard deviations of each dependent measure were calculated and compared to the normative data provided in the test manual. The mean testing child age was 9 years and 50 % of the children were male. Table 4 presents the means and standard deviations for intake (n=12) and Month 2 (n=2) assessments on the three self-report parenting measures and subscales.

As a whole, the mean Total Stress score at intake (mean = 77.3, SD = 25.8) was not clinically significant, which means that the Total Stress Score was within the normal range (between the 70th and 75th percentile). The mean total scores for each subscale fell within normal range as well. However, there seemed to be some flux among the scores.

Defensive Responding. The Defensive Responding scale assesses the extent to which the respondent approaches the questionnaire with a strong bias to present the most

favorable impression of him or herself and to minimize indication of problems or stress in the parent-child relationship. A defensive responding score of 10 or less indicates that the individual may be responding in a defensive manner, and caution should be exercised in interpreting the remainder of the scores. A low Defensive Responding scores indicate high levels of defensive responding. The group mean score for Defensive Responding was 16.8 (SD = 4.7) at intake. At the 2-month follow-up the mean score was 23.0 (SD = 1.4), however with only two participants. Three participants scored under 15 and two of these scored 12 and under at intake.

Two of the participants who had relatively low Defensive Responding scores (12 and 11) had similar scores across subscales. Their Parenting Distress score was relatively low (29 and 17 respectively) and their Difficult Child and Parent-Child Dysfunctional Interaction scores were in the clinical range.

Four participants had relatively high Parent Distress scores and their scores for Parent-Child Distress Interaction and Difficult Child were relatively lower. Their overall Total Stress scores were not in the clinical range.

Four participant's subscale scores fell above the 50th percentile range, however, they had a high Defensive Responding score, a relatively low Parent Distress score, a relatively high Parent-Child Dysfunctional Interaction score and a relatively low Difficult Child score.

Parental Distress. The Parental Distress (PD) subscale determines the distress a parent is experiencing in his or her role as a parent as a function of personal factors that are directly related to parenting stresses. Associated with the PD subscale are impaired sense of parenting competence, stresses associated with the restrictions placed on other

life roles, conflict with the child's other parent, lack of social support, and presence of depression, which is known correlate of dysfunctional parenting. When the PD subscale is the highest elevation among the three subscales, it is recommended that further exploration of the parent's personal adjustment be conducted.

The mean score for Parental Distress was 27.6 (SD = 8.8) at intake. At the 2-month follow-up the mean score was 36.0 (SD = 4.2).

Parent-Child Dysfunctional Interaction. The Parent-Child Dysfunctional Interaction (P-CDI) subscale focuses on the parent's perception that his or her child does not meet the parent's expectations, and the interactions with his or her child are not reinforcing to her as a parent. The parent projects the feeling that her child is a negative element in the parent's life. Commonly, her description of the parent-child relationship suggests that the parent either sees herself as abused by or rejected by the child, or she is disappointed in and feels alienated from the child. High scores suggest that the parent-child bond is wither threatened or has never been adequately established.

The mean score for the Parent-Child Dysfunctional Interaction scale was 23.7 (SD = 9.9) at intake. At the 2-month follow-up the mean score was 34.0 (SD = 8.5). A trend showed among seven of the participants who tended to have higher P-CDI scores and lower Difficult Child scores.

Difficult Child. The Difficult Child (DC) subscale focuses on some of the basic behavioral characteristics of children that make them either easy or difficult to manage. These characteristics are often rooted in the temperament of the child, but they also include learned patterns of defiant, noncompliant, and demanding behavior.

High scores produced by parents of children below 18 months of age suggest that the child may have significant problems in self-regulatory processes. In most instances, these difficulties are considered to be temperamentally or physiologically related. High scores produced by parents of children 2 years of age or older are related to measures of child-behavioral adjustment and to behavioral-symptom checklists. In these families, the parents are typically experiencing difficulty in managing the child's behavior in terms of setting limits and gaining the child's cooperation. Regardless of the cause of the problem, parents who produce high scores on the DC subscale usually need professional assistance.

The mean score for the DC scale was 26.0 (SD = 9.5) at intake. At the 2-month follow-up the mean score was 39.0 (SD = 11.3). DC mean scores were low at intake and at the 2-month follow-up with low scores on PD and high scores on P-CDI and TS.

Parent Sense of Competence (PSOC)

Scoring for some items is reversed so that, for all items, higher scores indicate greater parenting self-esteem. Scores were compared to a study done by Ohan, Leung, and Johnston (2000) in which scores were separated by the testing child's gender and age and by subscale in the Ohan et al. study. Looking at the differences of scores by gender at intake, the total score for mothers who had boys was 71.3 and who had girls was 73.1. This is consistent with Ohan et al.'s scores of 65.7 and 67.9 respectively. Ohan et al. found significantly higher Efficacy scores for parents reporting on girls compared to parents reporting on boys. The authors speculate that parents of boys perceive their sons' behavior as more challenging than their daughters.

Satisfaction. The Satisfaction subscale measures a parent's contentment or the parent's liking of the parenting role. In this study, participants scored 40.5 for boys and 39.7 for girls at intake. Scores differed slightly at the 2-month follow-up where the Satisfaction score for boys went up (41.0) and for girls went down (38.0). These scores compared to Ohan et al., were once again similar, 38.8 for boys and 39.3 for girls respectively.

Efficacy. The Efficacy subscale measures a parent's perceived effectiveness or perceived competence in the parenting role. In this study, participants scored lower on this scale than the Satisfaction Scale for boys (30.8) and for girls (33.5) at intake. Interestingly, the Efficacy scale scores reduced for boys (23.0) at the 2-month follow-up and increased for the girls (36.0). These scores are comparable to Ohan et al. scores of 26.9 and 28.6 respectively.

Parenting Scale (PS)

The PS was designed to identify discipline "mistakes" among parents of 2- to 4-year old children. The scale is behaviorally focused and consistent with the premise that discipline practices play a fundamental role in the development and improvement of the child behavior problems. The PS also distinguished between mothers of clinic-referred and non-clinic referred children.

The PS total scores at intake were 3.1 (SD = .64) and 3.2 (SD = .12) at 2-month follow-up were clinically significant according to O'Leary, Arnold, Wolff and Acker (1993). According to O'Leary, et al., a score of 3.1 is clinically significant.

Laxness. The Laxness subscale measures the extent to which parents notice but do not discipline misbehavior. The Laxness total score at intake was 3.0 (SD = .86) and 2.8

(SD = .77) at the 2-month follow-up. These findings are consistent with O’Leary, et al. clinically significant score of 2.8 (SD = 1.0)

Overreactivity. The Overreactivity subscale measures emotional reactivity in the context of discipline encounters. The Overreactivity total score at intake was 2.4 (SD = .92) and 2.4 (SD = .78) at the 2-month follow-up. These findings are consistent with the control group score of 2.4 (SD = .7) in O’Leary, et al.’s study.

Verbosity. The Verbosity Scale measures the extent to which parents respond to misbehavior with coaxing, begging, or lengthy explanations. The Verbosity total score at intake was 4.0 (SD = .82) and 5.6 (SD = .61) at the 2-month follow-up. These findings are not consistent with either the clinic or control group found in O’Leary, et al.’s study.

Urinalysis

Most participants have remained drug-free for the duration of their treatment. Information on the percentage of clean urines for each drug tested at the treatment center is represented in the Table 5. In addition to the random urinalysis results from the treatment center, urinalysis data was taken as part of the assessment battery. Results from the urinalysis collected as part of the research measures was that one participant tested positive for one drug which was PCP. Further results from the intake urinalysis can be seen in Table 5.

Treatment Attendance

Information on the participant’s attendance and disposition is shown in Table 6.

Parenting Over Time

A paired t-test analysis was conducted as a preliminary analysis on the parenting measures to address the hypothesis of parenting skills and attitudes will get better over

time with drug treatment. Using a paired t-test, there was not a statistical significance in parenting scores with individuals receiving drug treatment and parenting skills training. However, the paired t-test analysis did show a decrease in means for each of the dependent variables. To interpret the Parenting Scale and the Parenting Stress Index/Short Form a high mean means that there is clinical significance to the scores. The Parenting Scale mean at Time 1 was 102.5 (SD = 3.5) and at Time 2 was 100.5 (SD = 17.7). The means decreased which translates as parenting “mistakes” went down. However, it seems that perceived parenting stress increased when examining the results of the paired t-test at Time 1 (m = 98.5, SD = 38.9) and at Time 2 (m = 111.5, SD = 16.3). The Parenting Sense of Competence takes a reversed interpretation, where a higher mean signifies higher satisfaction and efficacy a parents feels about their parenting. At Time 1 the mean was 57.5 (SD = 2.1) and at Time 2 was 59.0 (SD = 11.3). There was an increase in means which signifies a higher sense of satisfaction and efficacy.

CHAPTER 4

DISCUSSION

More often than not, mothers use the same parenting techniques their parents used (Harmer, Sanderson & Mertin, 1999). Substance abuse is a factor in poor parenting, however, it is not the sole reason for the parenting difficulties that mothers in drug treatment may experience. The combination of mental health issues, low cognitive ability, and a lack of social support may compromise these mothers' ability to parent, therefore placing their children at risk of abuse and neglect (Kerwin, 2005). This study attempts to look at parenting change over time, but more importantly what are the parenting skills of substance abusing mothers at intake. Results from this study show that mothers going into a comprehensive, outpatient drug treatment center have high levels of perceived stress in their lives, have difficulties in knowing how to appropriately discipline their children, and do not feel like they are effective parents nor are they satisfied with their parenting going into treatment.

These results seem to be consistent with the results from other studies regarding the parenting skills and attitudes of substance abusing mothers (McMahon, Winkel, Suchman, & Luthar, 2002; Nair, Schular, Black, Kettinger, & Harrington, 2003). Unfortunately, most of the women in the study scored significantly high in one or more of the subscales when completing the *Parenting Stress Index/Short Form*, showing that they were having one or more perceived stressors in their lives. In contrast, a study done by Harmer, Sanderson, and Mertin (1999), parental stress went down with drug treatment and parenting skills training. Huebner (2002) found similar results with women in a drug

treatment group having more significant results than women in the other two groups.

Some argue that recovery itself is stressful. It was shown by Suchman and Luther (2001) and Kelley (2003) that perceived stress can and will effect a mother's parenting. It is important to realize that even though these mothers are in recovery and may or may not have their children in their custody, they are still mothers and want to be good parents (Hanlon, O'Grady, Bennett-Sears, & Callaman, 2005).

It has been shown that parenting skills training (Gross, Fogg, Webster-Stratton, Garvey, Julion & Grady, 2003; Kerwin, 2005) has been effective in helping mothers improve their parenting skills. However, long term follow up needs to occur in order to observe any real effects. One of the most critical issues programs must address is how to explain the relationship between addiction and parenting (VanBremen & Chasnoff, 1994).

Implications

Many women who abuse substances seek drug treatment because they have lost custody of their children or are in danger of doing so. Drug treatment was mandated by the legal system for many of the women in this study and thus became a part of the treatment process. Strengthening parenting skills is perceived as aiding recovery and recovery as resulting in improved parenting. Because most treatment agencies believe that achieving sobriety through traditional addiction treatment takes precedence over all other objectives, parenting interventions may not be a high priority. Since programs are based on the traditional models of addiction treatment they do not integrate a parenting skills component. Efforts to provide more comprehensive services to address of a woman's needs, including education, housing, and job training, in addition to treatment

should be developed to help a woman transition from actively using drugs to coping without using drugs.

Designing parenting interventions for women in recovery

The first step for any program intending to integrate intervention approaches for women who are addicted and their children is to address differences between treatment and parenting interventions. The weight that an agency gives to parenting interventions will influence the implementation of those interventions and the hiring and training of the staff as a whole. According to VanBremen and Chasnoff (1994), there are several approaches that can be taken to ensure the successful integration of maternal and child services in the context of a substance abuse treatment program for women.

Limitations

The largest limitation of this study was that there was not enough time to collect repeated measures over time on more women leading to a small sample size. Another limitation is the measures used were all self-report measures. Many of the women had a hard time understanding and/or completing some of the self-report measures, especially the Parenting Scale and Parenting Sense of Competence Scale. Most of the women in this study found the questions hard to comprehend and had asked an investigator to clarify some questions. There is still a fair amount of uncertainty that the participants understood the questions and answered them appropriately. There needs to be a simpler measure, one that is easier to read and understand. A final limitation is the lack of a true experimental design with random assignment and a control group. Given this limitation is unclear if changes observed over time can be attributed to maturation and/or history versus the intervention.

Future Directions

More research is needed to separate parenting skills from substance abuse. There needs to be more done on the parenting skills substance abusing women have when they first enter treatment. We need to know what skills they have when they enter treatment as well as what parenting skills they have when they are discharged from treatment. A study using women entering drug treatment for the first time that never had any kind of parenting skills training should be investigated. A control group of women with an open case with CPS with no history of substance abuse should be looked into further. This will allow us to filter out the parenting skills of substance abusing women and the parenting skills of abusive and neglectful mothers and to see the similarities and the differences among the two groups. Parenting skills and substance abuse need to be seen as two entities on their own. Of course, substance abuse does not help the parenting skills, but surely it can not be the only reason that many of these women are neglectful towards their children.

More mental health counselors are needed to address the past abuse these women usually experience. Huebner (2002) have found that women who abuse substances have been physically, emotionally, and sexually abused themselves. Most of these women came from parents who abused drugs as well. Many times, treatment facilities will only address the substance use attributing that as the reason why clients do their wrong doings. However, I am not refuting that. Treatment programs need to address the mental health needs of this population in conjunction with the substance abuse. These women are not without mental illness. We need to address both issues simultaneously to achieve the results that will ultimately prevent relapse with this population.

CHAPTER 5

REFERENCES

- Besinger, B.A., Garland, A.F., Litrownik, A.J., & Landsverk, J.A. (1999). Caregiver substance abuse among maltreated children placed in out-of-home care. *Child Welfare League of America, 78*, 221-239.
- Camp, J.M., & Finkelstein, N. (1997). Parenting training for women in residential substance abuse treatment. *Journal of Substance Abuse Treatment, 14*, 411-422.
- Coyer, S. M. (2001). Mothers recovering from cocaine addiction: factors affecting parenting skills. *JOGNN: Journal of Obstetric, Gynecologic, and Neonatal Nursing, 30*, 71-79.
- Coyer, S. M. (2003). Women in recovery discuss parenting while addicted to cocaine. *MCN: The American Journal of Maternal Child Nursing, 28*, 45-49.
- Davis, S.K. (1997). Comprehensive interventions for affecting the parenting effectiveness of chemically dependent women. *JOGNN: Journal of Obstetric, Gynecologic, and Neonatal Nursing, 26*, 604-605.
- DiLauro, M.D. (2004). Psychosocial factors associated with types of child maltreatment. *Child Welfare League of America, 83*, 69-99
- Gross, D., Fogg, L., Webster-Stratton, C., Garvey, C., Julion, W., Grady, J. (2003) Parent training of toddlers in day care in low-income urban communities. *Journal of Consulting and Clinical Psychology, 71*, 261-278.
- Hanlon, T.E., O'Grady, K.E., Bennett-Sears, T., Callaman, J.M. (2005) Incarcerated

- drug-abusing mothers: Their characteristics and vulnerability. *The American Journal of Drug and Alcohol Abuse*, 1, 59-77.
- Harmer, A.L.M., Sanderson, J., & Mertin, P. (1999). Influence of negative childhood experiences on psychological functioning, social support, and parenting for mothers recovering from addiction. *Child Abuse & Neglect*, 23, 421-433.
- Held, G. (1998). Linkages between substance abuse prevention and other human services – Part A. Retrieved November 4, 2005, from <http://www.drugabuse.gov/about/organization/despr/hsr/dapre/HeldLinkagesPartA.html>
- Hohman, M.M., & Butt, R.L. (2001). How soon is too soon? Addiction Recovery and family reunification. *Child Welfare League of America*, 80, 53-67.
- Huang, L.X., Cerbone, F.G., & Gfroerer, J.C. (n.d.). Office of Applied Studies. *Children at Risk Because of Parental Substance Abuse*. Retrieved November 12, 2005, from <http://oas.samhsa.gov/NHSDA/Treatan/treana08.htm>.
- Huebner, C.E. (2002). Evaluation of a clinic-based parent education program to reduce the risk of infant and toddler maltreatment. *Public Health Nursing*, 19, 377-389.
- Karoll, B.R., & Poertner, J. (2002). Judges', caseworkers', and substance abuse counselors' indicators of family reunification with substance-affected parents. *Child Welfare League of America*, 81, 249-269.
- Kelley, S.J. (2003). Invited commentary - Cumulative environmental risk in substance abusing women: early intervention, parenting stress, child abuse potential and child development. *Child Abuse & Neglect*, 27, 993-995.
- Kelly, J.F., Finney, J.W., & Moos, R. (2005). Substance use disorder patients who are

- mandated to treatment: Characteristics, treatment process, and 1- and 5-year outcomes. *Journal of Substance Abuse Treatment*, 28, 213-223.
- Kelly, M.L., & Fals-Stewart, W. (2002). Couples-versus individual-based therapy for alcohol and drug abuse: effects on children's psychosocial functioning. *Journal of Counseling and Clinical Psychology*, 70, 417-427.
- Kerwin, M.L. E. (2005) Collaboration between child welfare and substance-abuse fields: Combined treatment programs for mothers. *Journal of Pediatric Psychology*, 30, 1-17.
- Knis-Matthews, L. (2003). A parenting program for women who are substance dependent. *Mental Health Special Interest Section Quarterly*, 26, 1-4.
- Locke, T.F., & Newcomb, M.D. (2004). Child maltreatment, parent alcohol- and drug-related problems, polydrug problems, and parenting practices: a test of gender differences and four theoretical perspectives. *Journal of Family Psychology*, 18, 120-134.
- Luthar, S.S., & Walsh, K.G. (1995). Treatment needs of drug-addicted mothers: Integrated parenting psychotherapy interventions. *Journal of Substance Abuse Treatment*, 12, 341-348.
- McLellan, A.T. (2002). Have we evaluated addiction treatment correctly? Implications from a chronic care perspective. *Addiction*, 97, 249-252.
- McLellan, A.T., Lewis, D.C., O'Brien, C.P., & Kleber, H.D. (2000). Drug dependence, a chronic medical illness. Implications for treatment, insurance, and outcomes evaluation. *Journal of American Medicine Association*, 284, 1693.
- McLellan, A.T., McKay, J.R., Forman, R., Cacciola, J., & Kemp, J. (2005).

- Reconsidering the evaluation of addiction treatment: From a retrospective follow-up to concurrent recovery monitoring. *Addiction, 100*, 447-458.
- McMahon, T.J., Winkel, J.D., Suchman, N.E., & Luthar, S.S. (2002). Drug dependence parenting responsibilities and treatment history: Why doesn't mom go for help? *Drug & Alcohol Dependence, 65*, 105-114.
- McMurtrie, C., Roberts, P., Rosenberg, K.D., & Graham, E.H. (1998) Child care and parenting education within drug treatment programs for pregnant and parenting women. *Women's Health Issues, 8*, 246-253.
- Millar, G.M. & Stermac, L. (2000). Substance abuse and childhood maltreatment. Conceptualizing the recovery process. *Journal of Substance Abuse Treatment, 19*, 175-182.
- Miller-Perrin, C.L. & Perrin, R.D. (1999). *Child maltreatment: An Introduction*. Newbury Park, California: Sage
- Mullins, S.M., Bard, D.E., & Ondersma, S.J. (2005). Comprehensive services for mothers of drug-exposed infants: relations between program participation and subsequent child protective services reports. *Child Maltreatment, 10*, 72-81.
- Nair, P., Schuler, M.E., Black, M.M., Kettinger, L., & Harrington, D. (2003). Cumulative environmental risk in substance abusing women: early intervention, parenting stress, child abuse potential and child development. *Child Abuse & Neglect, 27*, 997-1017.
- National Clearinghouse on Child Abuse and Neglect Information. (December 2003). Substance Abuse and Child Maltreatment. Retrieved, November 12, 2005, from <http://nccanch.acf.hhs.gov>.

National Clearinghouse on Child Abuse and Neglect Information. (2004). State Statutes Series. *Parental Drug Use as Child Abuse*. Retrieved November 12, 2005, from <http://nccanch.acf.hhs.gov>.

National Institute on Drug Abuse (NIDA). (n.d.). Drug Abuse and Addiction: One of America's Most Challenging Public Health Problems. *Magnitude*. Retrieved November 12, 2005, from <http://www.drugabuse.gov/about/welcome/aboutdrugabuse/magnitude/>.

National Institute on Drug Abuse (NIDA). (n.d.). NIDA InfoFacts. *NIDA InfoFacts: Pregnancy and Drug Use Trends*. Retrieved November 12, 2005, from <http://www.nida.nih.gov/infofacts/pregnancytrends.html>.

National Institute on Drug Abuse (NIDA). (n.d.). NIDA InfoFacts. *NIDA InfoFacts: Treatment Methods for Women*. Retrieved November 12, 2005, from <http://www.drugabuse.gov/infofacts/treatwomen.html>.

National Institute on Drug Abuse (NIDA). (n.d.). NIDA InfoFacts. *NIDA InfoFacts: Understanding Drug Abuse and Addiction*. Retrieved November 12, 2005, from <http://www.drugabuse.gov/infofacts/understand.html>.

National Institute on Drug Abuse (NIDA). (February 2002). NIDA NOTES. *Risk and Protective Factors in Drug Abuse Prevention*. Retrieved November 12, 2005, from http://www.drugabuse.gov/NIDA_Notes/NNVol16N6/Risk.html.

Newcomb, M. & Locke, T. (2005). Childhood adversity and poor mothering: consequences of polydrug abuse use as a moderator. *Addictive Behaviors*, 30, 1061-1064.

Ohan, J.L., Leung, D.W., & Johnston, C. (2000). The parenting sense of competence

- scale: Evidence of a stable factor structure and validity. *Canadian Journal of Behavioural Science*, 32, 251-261.
- Ondersma, S.J. (2002). Predictors of neglect within low-ses families: the importance of substance abuse. *American Journal of Orthopsychiatry*, 72, 383-391.
- Peterson, L, Tremblay, G., Ewigman, B., & Saldana, L. (2003). Multilevel selected primary prevention of child maltreatment. *Journal of Consulting and Clinical Psychology*, 71, 601-612
- Rittner, B., and Dozier, C.D. (2000). Effects of court-ordered substance abuse treatment in child protective services cases. *Social Work*, 45, 132-140.
- Schuler, M.E., Nair, P., & Black, M.M. (2002). Ongoing maternal drug use, parenting attitudes, and a home intervention: effects on mother-child interaction at 18 months. *Journal of Developmental and Behavioral Pediatrics*, 23, 87-94.
- Smith, B. (2003). How parental drug use and drug treatment compliance relate to family reunification. *Child Welfare League of America*, 82, 335-365.
- Spieker, S.J., Gillmore, M.R., Lewis, S.M., Morrison, D.M., & Lohr, M.J. (2001). Psychological distress and substance use by adolescent mothers: Associations with parenting attitudes and the quality of mother-child interaction. *Journal of Psychoactive Drugs*, 33, 83-93.
- Suchman, N.E., & Luthar, S.S. (2000). Maternal addiction child maladjustment and socio-demographic risks: Implications for parenting behaviors. *Addiction*, 95, 1417-1428.
- Suchman, N.E. & Luthar, S.S. (2001). The mediating role of parenting stress in

- methadone-maintained mothers' parenting. *Parenting: Science and Practice*, 1, 285-315.
- Terling, T. (1999). The efficacy of family reunification practices: reentry rates and correlates of reentry for abused and neglected children reunited with their families. *Child Abuse & Neglect*, 23, 1359-1370.
- Thurman, S.K., & Berry, B.E. (1992). Cocaine use: Implications for intervention with childbearing women and their infants. *Children's Health Care*, 21, 31-38.
- U.S. Department of Health and Human Services. Substance Abuse and Mental Health Services Administration (SAMHSA). National Household Survey on Drug Abuse. (2003, June 2). *Children Living with Substance-Abusing or Substance-Dependent Parents*. Retrieved November 12, 2005, from <http://oas.samhsa.gov/2k3/children/children.htm>.
- U.S. Department of Health and Human Services. Substance Abuse and Mental Health Services Administration (SAMHSA). National Survey on Drug Use and Health. (2004, August 20). The NSDUH Report. *Women with Co-Occurring Serious Mental Illness and a Substance Use Disorder*. Retrieved November 12, 2005, from <http://oas.samhsa.gov/2k4/femDual/femDual.htm>.
- Uziel-Miller, N.D. & Lyons, J.S. (2000). Specialized substance abuse treatment for women and their children. An analysis of program design. *Journal of Substance Abuse Treatment*, 19, 355-367.
- VanBremen, J.R., & Chasnoff, I.J. (1994). Policy issues for integrating parenting interventions and addiction treatment for women. *Topics in Early Childhood Special Education*, 14, 254-274.

Velez, M.L., Jansson, L.M., Montoya, I.D., Schweitzer, W., Golder, A., & Svikis, D.

(2004). Parenting knowledge among substance abusing women in treatment.

Journal of Substance Abuse Treatment, 27, 215-222.

Zlotnick, C., Tam, T., & Robertson, M.J. (2004). Adverse childhood events, substance

abuse, and measures of affiliation. *Addictive Behaviors, 29*, 1177-1181.

Zlotnick, C., Franchino, K., St. Clair, N., Cox, K., and St. John, M. (1996). The impact of

outpatient drug services on abstinence among pregnant and parenting women.

Journal of Substance Abuse Treatment, 13, 195-202.

Table 1

Demographic Characteristics of Participants

Demographics	n = 14	% of sample
Race		
Black/African American	9	64%
White	2	1%
Hispanic	3	2%
Marital Status		
Single	11	79%
Married	1	0.7%
Divorce	2	1%
Yearly Income		
Below 5000	11	79%
5000-7999	1	0.7%
30000-39999	1	0.7%
Education level		
Elementary	1	0.7%
Some high school	7	50%
Graduated high school	5	36%
Some college	1	0.7%
Employment status		
Not employed	14	100%

Employed	0	0%
Pregnant	1	0.7%

Table 2

Number of children in each category

Category	Number
Sample of mothers (n = 14)	
Number of children 15yrs & older	18
0	7
1	3
2	1
3	1
4	1
6	1
Number of children in mother's care	12
0	8
2	3
3	2
4	1
Number of children in placement	27
0	4
1	3
2	3
3	2
5	1

7	1
Number of children for total sample	57
1	2
2	2
3	2
4	2
5	3
7	2
8	1

Table 3

Participant Treatment History

Demographics	Number	% of sample
Placement before current treatment		
Incarceration	5	36%
Inpatient/Residential	4	29%
Outpatient	2	14%
No treatment/ don't know	3	21%
Referral Source		
Probation/Parole	3	21%
Drug Court	4	29%
Work First – SAI	4	29%
DYFS	1	7%
Self-referred	1	7%
DYFS & Probation	1	7%
Incarcerated Ever		
Yes	6	43%
No	4	29%
Do Not Know	4	29%

Table 4

Means and Standard Deviations on Parenting Measures

Measures and Subscales	Intake (n=12)		Month 2 (n=2)	
	Mean	Standard Deviation	Mean	Standard Deviation
Parenting Stress Index: Total Score	77.2	25.8	109.0	15.6
Parental Distress (PD)	27.6	8.8	36.0	4.2
Parent-Child Dysfunctional Interactions (PCDI)	23.7	9.9	34.0	8.5
Difficult Child (DC)	26.0	9.5	39.0	11.3
Defensive Response	16.8	4.7	23.0	1.4
Parenting Scale: Total Score	3.1	.64	3.2	.12
Laxness	2.3	.86	2.8	.77
Overreactivity	2.4	.92	2.4	.78
Verbosity	4.0	.82	5.9	.61
Parenting Sense of Competence: Total Score	72.3	11.7	69.0	7.1
Satisfaction	40.0	8.0	39.5	2.1
Efficacy	32.2	6.9	29.5	9.2

Table 5

Drug Abstinence

Parti- cipant	PCP	AMP	BAR	BZO	COC	OPI	THC	ALC	METH
1	100% (n=5)-	100% (n=10)-	100% (n=10)-	100% (n=5)-	100% (n=10)-	100% (n=10)-	100% (n=10)-	100% (n=9)-	100% (n=9)-
2	100% (n=5)-	100% (n=8)-	100% (n=8)-	100% (n=5)-	100% (n=8)-	100% (n=8)-	100% (n=8)-	100% (n=3)-	100% (n=3)-
3	100% (n=2)-	100% (n=2)-	100% (n=2)-	100% (n=2)-	0% (n=2)-	100% (n=2)-	100% (n=2)-	N/A	N/A
4	100% (n=2)-	100% (n=2)-	100% (n=2)-	100% (n=2)-	100% (n=2)-	100% (n=2)-	100% (n=2)-	N/A	N/A
5	100% (n=3)-	100% (n=5)-	100% (n=5)-	100% (n=3)-	100% (n=5)-	100% (n=5)-	100% (n=5)-	100% (n=3)-	100% (n=3)-
6	100% (n=4)-	100% (n=4)-	100% (n=4)-	100% (n=4)-	100% (n=4)-	100% (n=4)-	100% (n=4)-	100% (n=1)-	100% (n=1)-
7	a	a	a	a	a	a	a	a	a
8	100% (n=2)-	100% (n=2)-	100% (n=2)-	100% (n=2)-	100% (n=2)-	100% (n=2)-	100% (n=2)-	N/A	N/A
9	a	a	a	a	a	a	a	a	a
10	100% (n=3)-	100% (n=6)-	100% (n=6)-	100% (n=3)-	100% (n=6)-	100% (n=6)-	100% (n=6)-	100% (n=3)-	100% (n=3)-

11	0%	100%	100%	100%	100%	100%	100%	100%	100%
	(n=2)+	(n=3)-	(n=3)-	(n=2)-	(n=3)-	(n=3)-	(n=3)-	(n=1)	(n=1)
12	a	a	a	a	a	a	a	a	a
13	a	a	a	a	a	a	a	a	a
14	a	a	a	a	a	a	a	a	a

Note. The number inside the parentheses indicates the number of urine drug screens completed. The “+” or “-” indicate the results from the urine drug screen taken at intake.

^aNo urine drug screens were taken on the participant.

Table 6

Attendance at the Treatment Center

Participant	No. of days of tx	No. of days attended	% of days attended	Disposition
1	63	63	100%	discharged – completed tx
2	63	63	100%	discharged – completed tx
3	33	18	55% ^a	discharged - incarceration
4	32	32	100%	discharged – completed treatment
5	51	51	100%	active
6	47	47	100%	active
7	49	49	100%	active ^b
8	25	18	72% ^a	discharged – incarceration
9	23	23	100%	active
10	47	47	100%	active
11	42	41	98%	active
12	23	8	35%	discharged – too many unexcused absences
13	21	21	100%	active
14	19	1	1%	discharged – too many unexcused absences

^aParticipant was discharged in the middle of the month.

^bParticipant has been hospitalized and not formally discharged from the program.