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**An Evaluation of a Psychoeducational Group for Parents  
in Substance Abuse Treatment**

**by**

**Beatrice Rogoff Plasse**

**A dissertation submitted to the Graduate Faculty in Social Welfare in partial fulfillment of the requirements for the degree of Doctor of Social Welfare. The City University of New York.**

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This manuscript has been read and accepted for the Graduate Faculty in Social Welfare in satisfaction of the dissertation requirement for the degree of Doctor of Social Welfare.

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## Abstract

### An Evaluation of a Psychoeducational Group for Parents in Substance Abuse Treatment

By Beatrice R. Plasse

Advisor: Professor Michael Smith

The dissertation is an evaluation of a structured psychoeducational group for parents in alcohol and substance abuse treatment, known as Parenting in Recovery. The parents in the study completed a 15 week group program which was conducted in two women's residences, a men's residence, a day treatment program and an outpatient mental health clinic. The study reports on 52 subjects who were primarily low income, minority adults living in the metropolitan New York area. The study contains data gathered from pre and post program questionnaires, a behavioral survey, the journal work of participants and interviews with parents who completed the program. The program used a structured curriculum with a guide for group workers which presents cognitive learning material and group activities.

The study presents data on changes in parents' perceptions of their

attitudes, and their behaviors in parenting tasks and roles. The findings from the questionnaires and behavioral survey show that parental visitation, telephone contact and letter writing increased significantly after the program .

There were statistically significant improvements in parents' perceptions of their social isolation and in the parents' sense of trust with their families and their children . Statistically significant changes were also recorded for parental satisfaction in play with children and efficacy in providing mental stimulation .There were also statistically significant positive changes in parental use of encouragement and praise , reduction of verbal abuse, and increased communication with children about the parent's drug history .

The study provides a view of the anxieties and problems facing this group of parents. Parents had high scores on stress over fear of relapse , children's demands and the damaging effects of addiction on the children. Parents responses showed that they believed that their children were fearful of being abandoned by them. They reported that their children had developmental delays , school problems , and problems with socialization and impulse control .

Using the Group Engagement Measurement , the study presents data that demonstrates how subjects met the criteria for engagement on all seven dimensions of the scale for engagement in a social work group.

*To my husband Jon for his love and support.  
and to my children Leah and Jacob for inspiring my own parent education.*

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## CHAPTER 1

### Introduction to the Dissertation

Parental addiction is the single most frequently cited cause for out of home placement of children. Social work professionals and others in the field of child welfare have devoted a great deal of effort to developing programs and strategies that preserve the family and at the same time protect children from abusive and neglectful addicted parents (Child Welfare League of America, 1992) .

The topic of this dissertation is an evaluation of a group program that was developed in 1988 for parents in substance abuse treatment. The program became known as Parenting in Recovery (PIR) . In my work as a group worker in several substance abuse treatment agencies the PIR curriculum and program design gradually took shape. Over the years I have trained social service professionals working in a variety of addictions agencies and training institutes using this model . Currently the PIR training has been approved by New York State Office of Alcoholism and Substance Abuse Services (OASAS) for credits toward New York State certification in substance abuse counseling.

The Parenting in Recovery program has specific features which set it apart from other social work group programs. These features make comparisons with other program evaluation studies somewhat problematic. One essential characteristic of the program is the population : parents who attend the group while in recovery from alcohol and substance abuse . Another important feature is the structural model that is used . This is a time-limited, structured group that incorporates learning and social work group dynamics.

The literature on evaluations of parent psychoeducational groups in substance abuse treatment is very limited. Although there is a great deal of research literature in the area of addictions and parent education groups , literature that specializes in evaluations of *parent education groups in*

*addictions treatment* is significantly harder to find.

One of the primary reasons for the scarcity of applicable literature to review is that there simply are not very many group programs in existence for *parents* as a separate client group within the addictions field. The policy of substance abuse treatment agencies for dealing with parents is to refer them to community or family service agencies. However, since the trend in substance abuse treatment is to shorten length of treatment and reduce services, these referrals are less likely to be made. In addition, parents may be reluctant to go to a family or child welfare agency fearing that it is connected to the foster care system which removed their children. Parents need a safe haven for treatment. Frequently, the most that addictions agencies do is to provide crisis interventions for parents with children and some family therapy sessions. (Smyth, 1995) The lack of trained mental health professionals also accounts for the policy of referring parents to outside agencies.

There is very little in the literature that describes the types of curricula that are used at substance abuse treatment centers with parenting skills groups. There is also difficulty in finding descriptions of programs in parenting skills. This may be due to the fact that group workers at addictions treatment facilities are not accustomed to doing evaluations of their programs or writing for publication.

I have found the quantitative research data coming out of studies in the area of addiction and treatment outcomes to be of very limited value. Because of complex variables in parent populations, particularities of program design, and narrowness of outcomes it is difficult to generalize, compare or otherwise use findings from the literature.

Some of the most credible and relevant studies I found used qualitative data such as anecdotal reports from parents. These studies offer a sense of authenticity from empirical experience. One recent example comes from a

study of a group of drug involved parents that was done in 1997 by Geoffrey Greif for the book he edited called Group Work with High Risk Populations. His chapter describes a parenting group in a methadone maintenance program. Grief's evaluation and summary consists of brief self-reports from three group participants. Writing about the need for scholarly work from empirical group practice Garvin wrote -

"there have been very few recent doctoral dissertations in social work primarily devoted to analysis of groups variables. Nevertheless we believe that a recent increase in the amount of attention devoted to the use of groups in social work will again lead to research efforts. There are clearly many areas in which research is needed such as the effects of different approaches to group composition, of different strategies of intervention, of structured and /or time-limited as opposed to less structured groups, of different ways of facilitating transfer of learning, and of different worker styles." (P . 293 , Garvin)

The drive for evaluation and accountability in group work has also been articulated by Feldman (Feldman,1975, 1984, 1986 ). Feldman has called for clarity and verifiability of group work terms as well as measurements of group outcomes . Feldman holds that group workers have much to do before they can claim that their practice is well-grounded in scientific research. To this end , Macgowan has done some scholarly work to define and measure the elements that comprise group engagement . Macgowan's Measurement of Engagement Scale for social work groups is a framework that I have used in this dissertation to examine specific PIR components of engagement .

Despite the call by Garvin , Feldman and Macgowan for evaluation and empirical studies, much of the literature on social work groups for addicts remains theoretical , and speculative . There are so many acknowledged flaws in the research on group and individual addictions treatment that very few statements about the effectiveness of any one method can be made. It is my hope that this dissertation will begin to fill the knowledge gap that exists in regard to short term , time-limited, structured groups for parents in recovery.

## **Introduction to Parenting in Recovery : Theory, Methods and Goals**

The Parenting in Recovery program is a psychoeducational social work group that combines two helping methods, one found in social work groups and the other found in educational settings .

The social work group models that most closely approximate the theoretical frames of reference in the PIR program are the remedial and reciprocal models of groups (Papell and Rothman, 1966) . The remedial group model is one that is directed toward the rehabilitation and restoration of the individual . Remedial groups are often situated in hospitals , substance abuse agencies and other rehabilitative institutions. Diagnostic similarities and a psychological orientation characterize the remedial group. Treatment plans for the individual must interface with the treatment goals for the group.

The PIR program also incorporates ideas from the reciprocal model of group work. This model emphasizes engagement between group members and the role of the group worker as mediator . The mediation role of the group worker was based on ideas first articulated by Schwartz (1971). The group worker acts as a mediator between the individual and the group .The group worker provides opportunities for group members to support and confront each other . Group members often will provide suggestions and ideas drawn from personal experience. As members help each other they simultaneously help themselves . Their ability to use the group as a helping resource may extend to improved ways for mediating the environment beyond the group (Shulman & Gitterman, 1994) .

The typology of social work groups presented in the work of Hartford is recognized as the definitive catalog of social work groups. Hartford appreciates a broad spectrum of methods and means used in a variety of populations and contexts . Hers is an encompassing vision of the group and group worker where the role of the group worker is sometimes one of management and direction

(Hartford, 1971). Like some of the models Hartford presents, the PIR program has many formal structures, rules and requirements. These structures initially grew out of my practice experience working with parents who had problems with organization and management of their sometimes chaotic lives.

Parents have found clarity and reassurance in the predictability and consistency of the PIR program's structural elements. La Salvia (1993) found that the format of psychoeducational groups benefitted the addicts he worked with due to serious deficits in their basic ego functioning. The structures of the group enabled group members to use the higher ego functions of insight and integration. In an analysis of group characteristics that measured more-structured versus less-structured therapy groups, the research supported better outcomes in programs which had a high degree of structure for non-psychotic patients. Those patients with greater problems valued more highly structured groups than patients who had fewer problems. Some of the literature reports that members' interactions were more harmonious in groups with more developed structures. (Leszcz, 1986; Gruen, 1977)

There are two overarching goals for parents in the PIR group that use two methods. The first is a cognitive goal for learning that uses instructional methods and the second is a therapeutic goal for improved functioning and self-awareness that uses group interaction and written journal work. A brief description of the format of a typical PIR session will illustrate the interplay of instructional methods and social group dynamics.

The session begins with the group worker taking attendance and returning to group members their previous journal assignments with the worker's written comments. The workers' written remarks often praise parents for their efforts but also are a way for the group worker to monitor the parents' learning. Then what can be called the work phase begins. Group members will read aloud from their journal assignments to the rest of the group. Journal

reading provides an opportunity for group members to discuss each other's ideas and to practice what they eventually learn about attentive listening . After the journals are read they are collected by the group leader . Then , there will be a lecture or an activity that relates to a topic or skill from the curriculum. Lectures are brief and often take the form of a presentation of discussion points . Expanding on lecture concepts , the worker encourages members to make the content relevant and personal . Discussions may be enhanced through brainstorming ideas , composing lists , practicing communication skills , doing a role play or creating documents. Group workers direct comments between members so that the exchanges occur among group members and not through the group worker . The journal assignment for the next session is then given out and questions about it may be answered. This marks the ending phase of the session .

Mainstream social work group theory speaks of the power of social work groups to take advantage of contextual and environmental opportunities for growth experiences ( Klein, 1985, Garvin, 1997). Under the group work principle of using environment for growth parents in substance abuse programs should be given the opportunity to learn healthier ways of parenting .

A psychoeducational group has been defined as a form of learning that is required to master a major life transition (Brown 1997: La Salvia 1993). When parents enter treatment, the stage has been set for transformation. The PIR program has been a part of the transition and transformation of parents from addiction and crisis to reconciliation and healing.

## **Parental Addiction and Child Welfare. A Complex Social Problem**

The dissertation subject touches upon addiction and child maltreatment, two problems that are interwoven and have far-reaching consequences. Despite their connection, addiction treatment and child welfare are frequently treated as separate entities of social service. (Tracy & Farkas, 1994; Finkelstein 1993) There are several reasons for the lack of coordination between these two social services. Substance abuse treatment agencies focus their energies on the alleviation of the symptoms of chemical dependency. The child welfare system views its primary role as being the protection of children from abusive or neglectful parents. Moreover, it is often the case that the parent is in an adversarial position to the child welfare system.

Parents with substance abuse problems who have been reported for child maltreatment come to be viewed by the child welfare system as endangering the welfare of their children. The resources of most child placement agencies then are directed toward the provision of safe foster homes or group residences and not toward the rehabilitation of the addicted parent. This lack of coordination of services to children and their addicted families has, in many instances, led to the dissolution of the parent child relationship (Tracy, 1994; Lawson & Wilson 1980). The question of what is in the best interests of children who may suffer maltreatment with addicted parents can be a rationale to justify the poor linkages in social services.

State and federal laws have attempted to bring together the needs of children in placement and their parents. In 1989, in response to the sudden increase in foster care placements largely attributable to the influx of crack cocaine, New York City developed the Family Rehabilitation Program. This program offered intensive casework services to families where children were considered at risk for placement due to the parent's substance abuse. The program directed case planners to provide an array of services including drug

treatment, group , individual and family counseling and parenting skills training (Carten, 1996).

The legal framework in which the child welfare system operates is based on the Adoption Assistance and Child Welfare Act of 1980 which calls for prevention of placement through intense casework services, speedy reunification where placement has occurred or termination of parental rights when reunification does not meet time limits (Segal, 1991 ).

The time-table for reunification as set by legal mandates poses special problems for many addicted parents. In particular for single, unskilled and unemployed mothers, substance abuse can be a chronic or relapsing condition (Azzi-Lessing & Olsen, 1996) .The needs of these parents therefore require different strategies, interventions and supports. Until the past decade, the structure of services in substance abuse treatment agencies tended to favor the needs of single alcoholic men. ( Reed , 1987). As the numbers of women with chemical dependency problems has grown, and the nature of their problems has become better understood, agencies are becoming more responsive . Today most agencies include treatment and referrals for a wider range of services . Despite this expansion of services there are still very few SA treatment centers that provide parenting skills groups on their premises. Instead agencies may refer families to self -help groups such as Al-Anon for spouses of substance abusers , COA for children of alcoholics or substance abusers, and Alateen for teenagers with an addicted parent. Family therapy is also offered at some substance abuse agencies. (Kaufman, 1994:Smyth, 1995) . )

There is a body of literature that has focused on the issues of parenting and child welfare which consistently recommends that the various services for addicted parents be integrated with services to children . (Tracy, 1994:Yaffe, Jenson & Howard, 1995: Goldberg, 1995: Carten, 1996 : Finkelstein, 1993) Studies of outcomes for chemically dependent mothers who received intensive

, child-centered and comprehensive substance abuse treatment showed improvements in parenting and in the mother's mental health (Wobie, et al, 1997 ;Saunders, 1993)

Parent education and supportive groups for parents are services that link substance abuse treatment with child welfare. This study provides further evidence that parents who are receiving treatment for their addiction can make a commitment to changing their relationships with their children (Mejta & Lavin 1996 : Gustavsson & Rycraft , 1993: Leif, 1985 ) . A holistic perspective on the addict would provide comprehensive and integrated treatment of addiction with family and child-centered services rather than keeping them separate . The PIR program has been part of this approach to the complex problem of drug dependent mothers and fathers

## **Overview of the Response to the Problem of Parental Addiction**

The consequences of parental addiction in terms of financial costs and individual suffering are hard to quantify, but to get an idea of the scope of the problem we can look at data from the Child Welfare League of America on the causes of foster care placement of children . CWLA found that in some localities between 60% and 80% of the child welfare cases involved substance abusing parents . (Olsen, 1995: ). In addition, there is ample documentation on parental substance abuse or dependence as a primary risk factor for serious physical problems for the developing fetus and the newborn.( Zuckerman, Frank, & Brown , 1995). The effects of parental drug addiction on older children are framed in terms of chronic illnesses, poor socialization, and learning problems . (Carten, 1996: Mejta & Lavin, 1996: Segal, 1991).

According to a National Institute on Drug Abuse study , in 1989 over 5 million women of childbearing age used illicit drugs. Statistics on men's drug abuse and alcoholism are more difficult to compare because the status of fatherhood is not identified among alcoholic and chemically dependent men. The National Association for Perinatal Addiction Research and Education (NAPARE) estimated that as many as 375,000 infants are exposed to drugs each year. Of that number NAPARE estimates that 300,000 children have suffered some damage due to intrauterine exposure to cocaine (Hawk, 1994). From 1982 to 1989, in New York City's poorest neighborhoods, the introduction of crack cocaine coincided with a two fold increase in substance-abuse related reports to the Administration for Children's Services .

The problem of drug abuse for the addicted parent is often only one amid a host of disadvantages involving poverty, violence, family dysfunction and poor coping skills .These problems contribute to dysfunctional patterns of child rearing .

In their article on facilitating healthy parenting , Mejta and Lavin (1996) cite

research that reports on the needs of mothers after they have received treatment for drug abuse.

Often the assumption is made that if a woman enters treatment for her substance abuse, she automatically will become a better parent. Treating the addiction alone is insufficient to correct parental deficits and dysfunction (Mondanarao, 1989) Early studies (Black ,1979) reported that family health and parental functioning did not always improve with sobriety. Lacking past and present role models of healthy parenting, some maternal substance abusers are unable to differentiate healthy from harmful parenting practices. Being in recovery does nothing to ameliorate the effects of these lackings. Although children often supply the impetus for a mother to seek and complete treatment (Wells & Jackson, 1992; Koski-Jannes,1991) the mother continues to show impairments in her parenting skills. In fact, the mother may tend to overcompensate for her past inadequate parenting by overprotecting, over disciplining and over controlling the lives of her children (Kilpatrick,1986; Scott, 19889 ; White, 1990). In some cases, it takes years for recovering mothers to become healthy parents (Mejta and Lavin p. 35).

The Parenting in Recovery program recognizes that even comprehensive substance abuse treatment programs do not necessarily help parents better understand the needs of their children or change destructive parenting behaviors . Traditional parent education curricula do not specialize in helping parents with a history of drug abuse communicate about the traumas in the lives of their children . Later in this paper I present sessions from the PIR curriculum which illustrate how the groups address issues that are specific to the lives of families with addiction problems.

### Description of the Population

According to a 1984 study by Frieze and Schafer, male partners of substance using women are the most likely to abuse children with or without the mothers' knowledge. Nevertheless, most of the research literature on parental drug abuse focuses on pregnant and parenting women rather than on men. Perhaps this is because men in treatment do not identify with their roles as fathers or assert parental claims for custody in court proceedings.

The descriptive statistics on parental addiction, therefore, offer a great deal more information on drug abusing pregnant, postpartum and parenting women than on men with children. A rather detailed portrait of the addicted woman has emerged from my reading of the social work literature, particularly on crack cocaine and heroin using women with children. In this light, addiction can be viewed as but the signal symptom of serious social and emotional impairments resulting from acute or chronic trauma.

In a clinical and national epidemiologic sample of women who received treatment for a substance abuse disorder more than 80% had histories of sexual assault, physical assault or death of a family member due to a homicide. These factors have been identified as predisposing for individuals who later become addicted (Goldberg, 1995)

A study based on interviews of 146 crack cocaine-using mothers from New York City aimed at reaching a diverse group. The women were currently or recently addicted and were either pregnant or mothers of children under 5 years of age. They were recruited from both treatment and non-treatment sites. The authors looked at their psychiatric histories and found a high prevalence of self-reported psychiatric hospitalizations and a high incidence of sexual abuse in childhood. The women also spoke of involvement with men who exerted pressure on them to use drugs. (Chavkin, Paone, Friedmann & Willets, 1993)

Several studies of women and crack cocaine have presented accounts

that temper some of the hyperbolic reports in the media which depict the crack addicted mother as totally lacking in maternal feelings. (Irwin, 1995; Kearney, 1995; Beckett, 1995; Rosenbaum & Murphy, 1990) . Irwin's ethnographic study reported that pregnant crack addicts do make attempts to reduce harm to the fetus . But they may avoid prenatal care out of fear of loss of custody of their babies and older children. The negative attitudes and contempt of medical personnel was another reason why these women did not follow up on regular prenatal visits.

Crack-addicted mothers have reason to fear incarceration as well . Over 167 women in 24 states were prosecuted for drug use while pregnant in 1992 . Beckett (1995) writes that "Although criminal prosecutions of pregnant drug users have been largely unsuccessful, thousands of women have had their children removed from their custody as a result of their prenatal use of drugs and most family courts have upheld these decisions."( p.588 )

Heroin was one of the first drugs to receive attention in the research literature . As a result, there exists an extensive literature from the 1970s on heroin-addicted pregnant and parenting women. In it there is a consensus that methadone maintained mothers and their developing babies fare better during and after pregnancy than heroin -using mothers. (Elred, Grier & Berliner, 1974)

The largest and most well-documented descriptive study on heroin-addicted mothers was done by the Jewish Child Care Association of New York between 1966 and 1971 . ( Lawson & Wilson, 1980) One of the study's findings showed that of all children in placement with the agency, the children of heroin- addicted mothers did most poorly in terms of time spent in placement . About 70% of the children of heroin- addicted mothers were still in foster care after 5 years . The women received intensive casework services and referrals for SA treatment. The most important predictive factor for improvement in child outcome was whether the women made the effort to enter methadone

maintenance treatment programs. This finding supports the assumption that , in terms of child-centered outcomes, parent education groups could be best utilized by heroin addicted women when they are in methadone maintenance treatment.

A five year study of methadone-maintained mothers with infants done through Columbia University College of Physicians and Surgeons Pediatrics department compared 57 methadone-maintained mothers and 31 drug-free controls to assess the adequacy of infant and child care (Fiks,Johnson & Rosen, 1985). Despite the finding that the parenting values and attitudes of both groups of mothers were the same, the results indicate that the methadone maintained mothers were more socially isolated and needed a variety of concrete and psychiatric supports. The authors conclude that the mothers' reduced capacity to stimulate and interact with their infants put the infants at risk for school and social failure. Characteristics of the methadone-maintained mothers were lack of family support , failure to utilize social services offered through the study, low levels of education, and social isolation.

Another similar study done by Bauman and Dougherty (1983) compared methadone-maintained mothers with preschool children to non-addicted mothers with preschoolers. This study showed that the methadone-using mothers performed less adaptively in measures of parenting ability. Consequently children of the mothers on methadone performed more poorly than the children of non-addicted mothers on measures of intelligence, development and socially adaptive behavior.

## Obstacles to Treatment

In articles which analyze obstacles to treatment and factors in early termination there is a significant correlation for women with histories of sexual abuse, childhood rape or incest and exposure to violence (Brown, Huba, & Melchior, 1995; Zlupco, Kauffman & Dore 1995; Ingersoll, Li, & Haller, 1995). Research studies on resistance to treatment have found significance in the prevalence of women's addiction and traumatic life events that result in the symptomatology of PTSD. (Brown, Recupero & Stout, 1995; Dansky, Saladin, Brady, Kilpatrick, & Dean, 1996).

As previously mentioned, the risks of legal prosecution or loss of custody that addicted pregnant women and mothers face are additional barriers to treatment. Therefore mothers risk much more than fathers when they decide to enter treatment for substance abuse.

The most frequently mentioned obstacle to treatment which has deterred many addicted mothers of infants or young children has been the lack of pediatric services and child care at the substance abuse treatment centers. Zlupco, Kauffman and Dore (1995), summarize these problems for mothers.

For many women, particularly those of lower socioeconomic backgrounds, alternative child care is unaffordable or unavailable. Very few drug treatment programs offer on-site child care or provide help in making child care arrangements. And most residential treatment facilities do not allow parents to bring their children with them into treatment. (Zlupco, Kauffman & Dore p.48)

Some studies have noted that pressures from children to enter treatment as well as parents' concern for children are the primary motivations for women who do enter treatment (Yaffe, Jensions & Howard, 1995). Programs where mothers and children can live together while the mother obtains drug treatment show positive outcomes in the mother's self-esteem (Wobie, Eyler, Conlon,

Clarke & Behnke, 1997). Unfortunately there are very few residences where mothers can live with children while they receive substance abuse treatment (Coletti, Schinka , Hughes & Hamilton ,1995 ).

## **CHAPTER II**

### **HISTORY AND LITERATURE REVIEW**

#### **Organization of the Review**

The subject of the dissertation is a complex program that is comprised of several strands of theoretical and practiced-based literature. The major components or content areas of the history and literature review are parent education , group work interventions and substance abuse treatment . The literature review was organized in the following manner : First , I looked at the history of the parent education movement and the content of parent education programs which influenced or contributed to the PIR curriculum. This is followed by a section on specialized parent education groups for high risk parents and for special populations of children. I then looked at definitions and models of psychoeducational groups and proceeded to a survey of group work interventions in substance abuse treatment . The major types of groups in substance abuse treatment mentioned are psychotherapy groups , self-help 12-step groups and psychoeducational groups. Finally , I reviewed the literature on parenting skills groups with substance abusing parents in treatment programs. In each section of the literature I commented on some of the limitations and weaknesses in the research designs and methodology .

## Early History of Parent Education and Training

The direction of the first parent educational groups reflects the overlapping agendas of religious and secular concerns in American family life. The first recorded meeting of a group of parents in America dates from 1815 . This group, known as a "maternal association" , gathered in Maine and was dedicated to reinforcing the moral and religious child rearing practices embedded in New England Calvinist beliefs. (Croake & Glover, 1977) . The next significant movement in parent group education came in 1888 when the Society for the Study of Child Nature was founded; it is known today as The Child Study Association of America. This organization has had an on-going parent education program whose emphasis is on the psychology of the child-parent relationship.

In 1909 the U.S. Public Health Service took an initiative begun at the first White House Conference on Child Welfare and created parent education groups oriented toward child health needs in America. An empirical and scientifically rigorous method of understanding child rearing was developed in 1919 at the Iowa Child Welfare Research Station . In the 1920's and 1930's, pediatricians Arnold Gesell and Frances Ilg published a series of widely acclaimed guidebooks for parents with performance and measurement norms for child development using observational methods.

American parent education reached it's peak of popularity and influence during the 1920's. In large measure this flowering was due to a well-organized social movement financed by the Laura Spelman Rockefeller Memorial and its chief architect, Lawrence Frank. The Rockefeller organization and its workers were instrumental in creating government agencies, universities such as Bank St. and the New School for Social Research, foundations, and publishing houses devoted to parent education . Fine ( 1989) writes that in the 1920s "Parent education received more systematic and sustained attention than

at any time until the 1970s.”

A survey conducted in the 1930's by the U.S. Office of Education found that a total of 378 organizations reported work recognized as parent education as defined by the National Society for the Study of Education. One outcome of the 1930 White House Conference on Child Health and Protection was a publication that included categories, content and methods of parent education programs. Cloake and Glover (1977), in their evaluation of parent education programs, report that studies done in the 1930's reported significant improvement in parent knowledge.

During the early 1930's the Works Progress Administration of the Roosevelt era helped to expand parent education programs tremendously by providing teachers, group workers and other trained personnel to conduct parent groups. A study of this government program found that mothers' child rearing practices were more positive and encouraging after parent education. Universities, including Columbia and Cornell, began programs that did research and training on parent education. In the mid-1930's, there was a shift away from parent education as some universities began to question the viability of the traditional family as opposed to institutional child rearing. A shift away from parent education was also a result of the country focusing its energies on World War II. At this time the National Council of Parent Education was disbanded. (Cloake & Glover, 1977)

After World War II, parent education efforts were resumed and expanded under the auspices of the National Institutes of Mental Health. The post war scholarship in child psychoanalysis, led by the attachment theorists, John Bowlby, Rene Spitz, D.W. Winnicott and Anna Freud, brought about the swing of the pendulum back onto the importance of parents and family and away from institutionalization of children. The identification and recognition of failure-to-thrive syndrome among orphans and young children separated from their

parents in England during the war may have contributed to the expansion of parent education as well. The parental guidance field in the post war period offered parents information, clarification, advice, support, directives, psychotherapy and social services . (Fine, 1989)

In the 1950's, participants in parent education were largely drawn from middle and upper level economic groups and information was geared to parents of younger children. A popular literature of advice and self-help oriented books flooded the book market in the post war period and has continued through the to the present.

In an article intriguingly titled "Is group parent education worthwhile? A research report " the author, I.S. Shapiro (1956), answered yes, parent education was worthwhile . His own research and his review of the research of others showed improvements in parent and child behaviors . Other studies of parent education groups done prior to 1960 report outcomes where there was improvement in parent attitudes toward discipline and greater tolerance for child behaviors ( Hedrick, 1934; Davis & McGinnis, 1939 ; Chandler, 1955) .

Cloake and Glover wrote an evaluation of parent education research in 1977 in which they criticized modern research studies for lacking stringency in design. They said that most studies did not have control groups and were susceptible to researcher bias .

## Parent Education Groups - 1960s to the Present

The content of many parent education programs from the 1960s to the present covers a broad spectrum of topics. Fine in the Second Handbook on Parent Education ( 1989 ) examined programs and found a focus on one or more of the following areas : information sharing, skill building, improving self-awareness and problem solving. These are also areas of content that are included in the PIR program.

Information sharing involves learning about child health care, developmental tasks and milestones, peer interaction, disciplinary techniques. Skills building helps parents practice what they learn through role-playing, modeling and behavioral rehearsals . Parents have been taught communication skills such as "I " messages, reflective and genuine listening, praising and encouragement and how to hold family meetings, negotiate conflict, set limits and use time out . (Faber & Mazlish, 1980:Larson, 1972)

A review of thirty-four studies which involved training parents in behavior modification techniques was conducted by Berkowitz and Graziano (1972) and they concluded that training parents "has important implications for a systematic preventive program of mental health. " Again in 1974, a review of seventy behavioral modification parent groups reached a similar conclusion. (O'dell, 1974)

The PIR program is in general agreement with the ideas of Alfred Adler and Rudolf Dreikurs. The Adlerian approach to parent education was based on the premise that the American family was moving away from an autocratic structure and toward social equality between parents and children. Rudolf Dreikurs , a student of Adler, emphasized the importance of a child's strivings for status in the family. He analyzed children's misbehavior in terms of the child's wish and need to belong and contribute to the family. Two separate studies of Alderian groups using control groups reported to have helped

parents make significantly higher scores on tests measuring changes in accord with the Adlerian attitudes and parental behaviors. (Freeman, 1975 : Dreikurs & Soltz, 1964)

In the 1970's , popular parent education groups included Active Parenting (Poplin, 1983) , and Responsive Parenting Program , both of which had a supportive perspective on parents and a democratic approach . Parent Effectiveness Training, PET (Gordon,1970) and the Systematic Training of Effective Parenting, or STEP program (Dinkelmeyer & Mckay ,1976) were two programs with wide-spread popularity. The PET approach was derived from the client-centered group therapy of Carl Rogers where the values of empathy, unconditional positive regard and non judgmental attitudes were encouraged. The PIR program has incorporated some concepts of the PET program. Specifically , parents are taught the communication skills of silence, active listening, open-ended questions and "I" messages.

The hallmark of the STEP program was to help parents understand the meaning of problem behaviors and instill discipline using the concepts of natural and logical consequences over punishment .Some of these ideas have been used in the PIR group to help parents replace methods of control which are harsh and punitive . The Achievement Motivation Program (AMP) and a Discussion-Encounter Group (DEG) were two other well-known programs . In the AMP program parents discussed personal goals and values and identified strengths in themselves and their children. In the DEG program parents learned to directly and accurately express their emotions. In a comparison study PET and AMP groups were found to be superior for the parents involved. Other research studies of PET include one done by Gordon in 1980 that found significant improvements in the behaviors of parents and children. (Fine,1989)

The research on outcomes of parent education groups has historically been very inadequate both in amount and quality. A 10 year (1975-1985)

literature survey drawn from 13 prominent social work journals with 83 articles on parent training programs illustrates some of the problems in the state of knowledge about parent training programs. The review states that the articles generally lacked operational descriptions of interventions, empirical rigor and reliably demonstrated results. (Polster, Dangel & Rasp. 1987) Part of the problem of researching parent education interventions comes from the complexity of parent educational groups. The literature often does not specify what comprises the content of the group curriculum, the orientation of the group workers and the setting of the group, which may vary greatly. Some groups may be led by parents themselves whereas other groups are facilitated by professionals. The group workers may come from different fields of study and disciplines . Parenting groups have been led by social workers, teachers, guidance counselors, nurses and psychologists. Each professional brings to the group his or her own curriculum and orientation to group process. For some groups the emphasis is on behavioral changes in the parent or the child ; for others the focus is on changing the attitudes of parents toward the child and the family as a whole.

### **Specialized Parent Education Groups**

Much of the literature on specialized parent education groups contains descriptions of groups for parents where the focus is on the special needs of the children. These include groups for parents of delinquent and handicapped children (Armstrong, H. Raymond, M. Amerongen, M. & Kernaghan, 1983). Studies of parent training groups for children with disruptive and delinquent behaviors indicate that parents are able to become effective in reducing difficult behaviors (Patterson, Chamberlain and Reid, 1982).

In 1968, the federal government enacted a policy under the Education of the Handicapped Law in which it promoted parental training to support instruction and educational goals for handicapped children. In her doctoral dissertation, Watson presented research that showed the importance and efficacy of education for parents in the handling of their handicapped children (Watson, 1997).

Specialized groups often must be situated in comprehensive treatment settings that include ancillary social services. Teen parent education groups require a general education, vocational or career environment. The curriculum of one teen parenting group ranges from learning about human reproduction and heredity to skill building and effective communication with children. (Lebow, 1978) Services for the infants of teens such as child care, pediatric care and social services to support the teenager help to enhance the acquisition of competencies necessary to carry out the goals of the parenting skills group.

Another group of high risk parents with special needs are emotionally disturbed parents. Groups for these parents may take place in either inpatient or outpatient mental health facilities. (Anthony & McGinnis 1978)

Abusive parents are another special needs group. The book Preventing Child Abuse and Neglect through Parent Education (Reppucci, Britner & Woolard, 1997) is devoted exclusively to describing a variety of parent

education programs for abusive parents . Given the strong correlation between child abuse and addiction , it is striking to find a book for abusive parents, published as recently as 1997, that has no program or curriculum for abusive *and* addicted parents. There is only one paragraph in the entire book on substance abusing parents and it minimizes the connection between child maltreatment and addiction. The authors do acknowledge the lack of parent education programs and curricula which specifically deal with the substance abusing parent . Their solution to this program gap is to tack on a component for the addicted parent . However, they offer no information regarding what the content of such a component would be.

Most parent education curricula fail to address the issue of substance abuse. Because substance abuse is known to affect *some* of the clients served and can interfere severely with good parenting some human service projects cover this topic or augment in their parenting classes with occasional seminars focusing on substance abuse; other programs make referrals to appropriate agencies . The absence of a strong substance abuse component may limit a program's ability to reach its intended clientele or effect long-term change in those clients with abuse abuse problems. (Reppucci,Britner & Woolard,1997)

Some of the literature on educational and insight- promoting groups for populations of high risk parents and special needs children has been favorable both in terms of research findings and as sound social policy . ( Eliasons, 1995; Fiks, Johnsons & Rosen, 1985 ; Webster -Stratton ,1997 ) Other researchers conclude that no one particular program is more effective than another (Schofield,1979 ; Anchor & Thomason, 1977) What is more important than the actual program is parental participation in a program aimed at improving parenting. (Powell,1986) The problem with studies on special populations is that they have limited application or generalizability because they have focused on only a few learning outcomes with narrowly conceptualized measures (First & Way ,1995).

## **Psychoeducational Groups**

The form that best defines the Parenting in Recovery program is the psychoeducational group . As its name implies , a psychoeducational group combines two areas of human functioning: the cognitive and the emotional . A variety of disciplines including, social work , educational guidance, medicine and psychology, have forms of group experience that combine therapeutic group process with the process of learning.

In their chapter on the historical roots of group psychotherapy Addie Fuhrman and Gary Burlingame describe the earliest psychoeducational groups. Although these groups were run by psychiatrists and physicians they can be seen as being very much in the spirit of the empowerment orientation that is associated with social work groups. One of the first psychoeducational groups was devised for tuberculosis patients by the physician Joseph Pratt in 1905. Pratt sent his patients to classes in order to enlist their cooperation in medical procedures and to instill in them optimism and faith in being cured. In the 1920's ,Marsh brought groups of mental patients together in a classroom format to stimulate group involvement in planning their own treatment strategies . Marsh believed that the dignity of the individual was better maintained in a class than in the doctor-patient relationship. Also in the 1920's, E.W. Lazell began treating hospitalized schizophrenics in a group setting using lectures and other psychoeducational methods. ( Fuhrman & Bulingame, 1994)

In her book Psychoeducational Groups , Brown (1998) offers a definition of psychoeducational groups that comes from the Association of Specialists in Group Work (ASGW) which states that psychoeducational groups are similar to guidance groups and primarily teach and emphasize skills training. The goal of psychoeducational groups, as defined by the ASGW, is "to prevent an array of educational and psychological disturbances from occurring." Brown asserts that psychoeducational groups are a kind of treatment that can contribute

significantly to group counseling, therapy and group psychotherapy. Brown adds " I use the term psychoeducational group in this book to include a broad spectrum of groups that have a significant educational component: such groups are used with children, adolescents, and adults in all kinds of settings.(p.9) "

In his 1995 edition of the encyclopedic text The Theory and Practice of Group Psychotherapy, Yalom lists various ways that psychoeducational groups have been used. One is for pre-group preparations to teach prospective members about group therapy. Yalom lists psychoeducational groups for cancer and heart patients, as well as self-help psychoeducational groups for victims of rape and violence. Self-help educational groups for parents include Parents Anonymous for abusive parents and Parents without Partners, a support group for single parents.

Brown and Yalom concur on two goals for a psychoeducational group . The first is to foster personal insight for amelioration of a critical life problem and the second is to teach skills and impart ideas based on a body of knowledge. Brown presents a list of groups that have been created to meet specific developmental challenges, such as an adolescent group about choosing to go to college and a group for older adults concerned with restructuring of life around retirement. In her typology of groups the following categories are found : educational or task groups , guidance groups , groups for training in interpersonal relations, and social skills groups . These may be remedial or preventive and include parenting skills groups where communication and listening skills are learned. Brown lists drug and alcohol education under guidance groups. These are groups for education and prevention of addiction whose members would be adolescents and parents of adolescents. Overall, Brown describes groups that are more didactic than therapeutic.

## Substance Abuse Treatment Groups

There are two basic paradigms of group treatment in the field of substance abuse that will be discussed in this literature review. One is based on the classical psychotherapeutic approach where the therapist is a trained professional and plays a central role. The other comes from the self-help or mutual support movement where groups are facilitated by trained ex-addicts.

The earliest classical psychotherapeutic group for alcoholics can be credited to Alfred Adler. Adler was also the first European and classically trained psychiatrist to use group methods in the United States. (Rosenbaum and Berger, 1963) He and Rudolf Dreikurs were the first to use group psychotherapy with alcoholics. Between 1900 and 1930, Dreikurs developed a group method that could be seen as a precursor to group therapy. It was called "collective counseling". As previously mentioned in this paper, both Adler and Dreikurs also did acclaimed work in parent group education.

Traditional or classic group psychotherapy has often been described as the treatment of choice in substance abuse and therapeutic groups can be found in every type of SA treatment facility (Marsh & Miller, 1985; Smyth 1995; Lowinson & Zwerling, 1971). Two surveys done in the U.S. and the United Kingdom indicate that group therapy is the predominant treatment form in substance abuse treatment programs. (Stinchfield, Owen & Winters, 1994)

One of the most powerful reasons why group psychotherapy is so beneficial for addicted people is that the group experience offers a kind of antidote to the addict's core problems: denial and isolation. The group therapy experience offers a method that is curative in a way that individual therapy cannot be. Flores, in Group Psychotherapy with Addicted Populations (1997) cites studies that have shown that the treatment of choice for addiction, in most treatment settings, is group psychotherapy. Citing the research of Yalom and

Kanas, Flores writes

In some cases , the estimation is that the recovery rate for patients in group psychotherapy is two to three times higher than for patients who only receive individual psychotherapy. (Kanas,1982; Yalom, 1985) . In a review of the treatment outcome literature on group psychotherapy and addiction, Kanas (1982) found most studies supported the claims made in the anecdotal literature regarding the effectiveness of group psychotherapy as a substance abuse treatment modality. Groups also provide support, safety and instill hope by providing new members with access to longer-term members who are examples of successful coping. In addition, they offer members the opportunity to model ways of communicating and interacting. (Flores, p.492)

There are a variety of types of professionally run treatment groups found in substance abuse treatment in the 1990's. One commonly found in residential and day treatment settings is the relapse prevention group. In this group members learn to identify triggers for relapse and preventive coping strategies. Similar to relapse groups are assertiveness training groups . There can also be socialization groups that center around recreational activities. In the treatment center where the PIR is held , one staff member has devised a 12 session group known as the Stress and Anger Management Group. There are also professionally run life skills groups which focus on the world of work and personal money management.

## Self-help and Mutual Support Groups In Substance Abuse

The self-help movement began with the creation of Alcoholics Anonymous groups . The rapid proliferation of AA groups was due in large part to the limited numbers of available professionals with an expertise in treating the condition of alcohol addiction. Moreover, AA attracted large groups of people who could not afford the services of professionals .

One of the ways in which self-help groups can be distinguished from psychotherapy groups is through the exclusive use in the former type , of recovered members as group workers. The power of peers , and social identity through group affiliation ,are usually mentioned when discussing the appeal and success of self-help groups. Other self-help groups within the field of substance abuse include NA, for narcotics addiction, Al-Anon , a self-help group to support family members of alcoholics , and Alateen for teenage children of addicts and alcoholics.

Research into the importance of the peer group during childhood and adolescence helps to explain the impact of self-help groups. Flores ,in his discussion of the self-help movement, mentions the research of Emrick ,whose data is cited repeatedly in the literature :

While peers powerfully affect individuals, peer groups do even more so. Research presented by Emrick (1977) points to the influence of groups in providing individuals with social support, social identity, and social reality. Peer groups represent even more influence than groups not made up of peers. By definition there is more of a basis for similarity in peer groups . In psychotherapy groups with peers, the similarity lies in the problem or issue which was the reason for the person joining the group. Common experiences and attitudes about alcohol and drugs yield more interpersonal attraction than when these commonalities are absent. Homogeneity of group members, as Yalom has clearly demonstrated, leads to more cohesiveness. (Flores, p. 207)

An offshoot of AA known as SOS Secular Organization for Sobriety , was created by a group of people with alcohol problems . They differentiate

themselves from AA on the basis of their rejection of the central idea in AA of a concept of God or higher power .

In the 1950's , groups in residences for narcotic addicts were often led by trained ex-addicts. These became well-known for their unique styles of treatment. Their work with street-hardened heroin addicts was characterized by aggressive and confrontational methods within a structured hierarchical community. Residential treatment centers developed their own style of groups such as the encounter group and the marathon group in which members sometimes exchanged roles of leadership . In the 60's and 70's these kinds of groups were developed at Synanon, Daytop Village, Odyssey House and Phoenix house. Drug addiction is viewed by these programs as symptomatic of an underlying character disorder. Lowinson & Zwerling (1971) , in their work on group therapy with narcotics addicts , caution that charismatic workers can emerge in power struggles and that the level of verbal hostility can be harmful to some borderline clients. Feminist social workers point out the tendency of self-help groups to re-victimize female substance abusers and call for treatment that empowers women with children to view their addiction in less stigmatizing terms . (Nelson-Zlupco, Kauffman & Dore, 1995.;Ettorre, 1992)

In her summary of the research on the effectiveness of self-help groups as compared to psychotherapeutic groups , Smyth (1995) in the Encyclopedia of Social Work states that to date there are no studies which conclude that one method is better than the other and that all the studies have serious methodological problems.

The weaknesses in the research on traditional group psychotherapy were characterized in one literature review as being "limited, anecdotal or equivocal " (Flores, 1994) and lacking a systematic, well-organized or clearly defined method of research design . Another survey found that programs which studied themselves consistently found positive results over programs other than

their own. Often in research on groups in substance abuse a study sample is too small, and fails to measure post-treatment substance use. The conclusions reached in literature reviews about the effectiveness of group psychotherapy have, at times, been contradictory .According to Solomon (1983) numerous studies that led to the conclusion that group therapy was indisputably more effective than individual therapy were contradicted by another extensive review which concluded that there was little difference in outcomes between individual and group treatment methods. (Solomon, 1983)

## **Psychoeducational Groups in Substance Abuse Treatment**

In an article entitled "Enhancing Addiction Treatment Through Psychoeducational Groups" , La Salvia (1993) describes a psychoeducational "self-care group" . His description of the group comes close to capturing the flavor of the PIR parenting skills group in that there is a psychodynamic emphasis as well as the orientation of skill development .

Clients with an addiction disorder generally present with an ego deficit in the area of self-care. This deficiency manifests itself in an inability to suffer and struggle with day-to day problem solving... To address both issues of ego and life skills deficits, the use of a psychoeducational group is presented. This specialized, task-oriented didactic group is a necessary component of a comprehensive addiction treatment program. A psychoeducational group in the treatment of addictions can serve as a synthesis for problem-solving skills training used in mental health and the psychodynamic theory of addictive behavior. (La Salvia, p.440)

The ego deficits that are mentioned above ,combined with traumatic events and social disadvantages, are characteristic of the clientele who come to substance abuse treatment and to the PIR parenting skills groups. In addition to economic privation and the struggle with addiction most of the parents that have attended the PIR groups have a history of poor parenting, family violence and psychiatric vulnerabilities.

In the 1995 edition of The Encyclopedia of Social Work types of psychoeducational groups in substance abuse and the research on them are described. Their concentration on understanding the symptoms of addiction and relapse is reminiscent of the earliest psychoeducational groups for schizophrenics and tuberculosis patients.

Psychoeducational groups provide information on the signs and symptoms of addiction, pharmacology and the effects of alcohol and other drugs, and behavioral changes that strengthen recovery from addiction. Despite the frequent use of psychoeducational groups as part of treatment , no study has rigorously evaluated their effectiveness. (Smyth p.2332)

Outcome studies of psychoeducational group treatment in addiction recovery programs are hampered by the same problems as research into substance abuse treatment groups in general. Solomon (1983), in a review of studies comparing the efficacy of individual versus group treatment of alcoholism, addresses two of the key problems in the research: the lack of knowledge about the subjects and the paucity of adequate studies using randomized control trials. Solomon writes in her conclusion the following:

There may be characteristics of various client groups - women, youth, blacks, etc.- which tend to suit them better to one context or the other. More attention should be paid to the interplay between client needs and/or life-style on the one hand and therapy properties on the other, as a basis of generating testable predictions. (Solomon, p. 84)

### Treatment Programs for Addicted Parents

Interventions or programs for addicted parenting women did not receive federal funding until the mid -1970's. This period was marked by the activism of the women's health movement , and by media attention to the problems of women and substance abuse. (Abbott, 1994) Before this, models of treatment were based on the profile of the alcoholic male (Reed,1987) and interest in studying women's addiction was almost nonexistent . A review prior to 1974 that covered 271 treatment outcome studies found that only 110 included women and only 4 focused on women alone. (Emrick,1976 cited by Finkelstein, 1995) Programming for mothers that was undertaken in the 1970's by NIDA and the National Institute on Alcohol Abuse and Addiction (NIAAA) did not grow. When the Nixon administration redirected federal dollars to the war on drugs and away from substance abuse treatment in the 1980's many new women's programs were retrenched, and the literature reflects this loss. Despite over ten years of legislation , in 1987, only one percent of the Federal allotment for drug treatment went to programs for parenting women .

A review of the literature on treatment groups for addicted parents leads to the conclusion that programs directed at , or developed for , the addicted parent in substance abuse treatment are very few in number . The paucity of such programs is striking given the well-researched evidence that upwards of two thirds of children reported for neglect or abuse come from families where one or both parents have a drug abuse issue. However, it may be misleading to conclude from the literature alone that so few programs actually exist. Parenting skills groups in substance abuse agencies may be in existence , but the workers of these groups are not geared toward writing or publishing articles on their programs .

In the 1997 report on substance abuse programs and research, put out by the Center for Substance Abuse Treatment , U.S. Dept. of Health and Human

Services entitled 50 Strategies for Substance Abuse Treatment the only intervention for parent training they report is a family therapy program entitled Training in Parenting Skills (TIPS) . The focus of this 12-session instructionally based program is not , however, the addicted parent. TIPS is a program for families with an adolescent who has been identified as having abused drugs.

One of the pioneering programs for addicted parents was begun in 1975 at the New York Medical College. The program, known as the Pregnant and Addicted Mothers Program (PAAM), provided a broad range of services in a coordinated manner . Each mother and child remained in the program for three years at which time the child was enrolled in a preschool program. PAAM engaged addicted young women early in their pregnancies . The young mother was followed throughout her pregnancy for prenatal care and delivered by a member of the staff . The program offered home visits ,and case management with direct services. Mothers received medical care , infants were tested periodically, and psychiatric services provided to the mother and her family . An important component of the PAAM program were the two year parenting classes which mothers were required to attend with their children. In a discussion of the results of the program this is what the author Dr. Nina Leif (1985) had to say about the parent education component:

In the context of a program offering comprehensive care to high-risk families, what is contributed by adding a parent education component? Conceivably, the result of the larger program would be no worse without the investment of time and effort that the parenting course demands. Yet it may be at the other extreme, that such a course can be made to be not only beneficial in itself but also a means of integrating and potentiating the other program elements. We are greatly encouraged by the progress we have seen in the parents and children who attend our program . We believe that the long and intensive investment of care in each family that an overall program is designed to make is appropriate to the types of problems that are involved. We consider that parent education can and should play a leading part in any program for families both normal and at high risk. ( Lief, p.91)

In 1996 , Alma Carten published the findings of a qualitative exploratory study that examined outcomes for 20 women who had successfully completed a court-ordered program , the Family Rehabilitation Program , aimed at poor women of color whose children were at risk of foster care placement. Parent education was a part of the Family Rehabilitation Program. Because there are no uniform standards or curriculum prescribed by New York city or state , the parent education component of the Family Rehabilitation Program was not described in the article ; however, the outcomes for the mothers were positive in terms of prevention of foster care and improvements in overall parenting. The most successful mothers were women with low severity and chronicity of drug use, identification with the parenting role, family supports, and educational or vocational achievements.

A public child welfare program known as SAFE (Substance Abuse Free Environment) offered parent education groups and customized services to address multiple problems . The study obtained data on the mothers and suggests the need for coordinated services including parenting skills groups. (Gustavsson & Rycraft, 1993).

The Project Connect program is another project that provides a model for coordinated services for addicted parents which included a parent education group . The personnel involved in Project Connect, which was funded by a grant from the National Center on Child Abuse and Neglect , U.S. Department of Health and Human Services, coordinated personnel from a school of social work, a private non-profit agency and a number of substance abuse and health care agencies. The goals of the project were to reduce the risk of child maltreatment, to keep families together and to increase the capacity of the local service system to respond to the needs of the families. In addition to parent education services ( which were not described), home-based substance abuse assessment and counseling, individual and family counseling, pediatric care,

formal substance abuse treatment and other community resources were provided. The average length of service was 10 months . The project worked with 66 primarily single parents and 176 children receiving AFDC. One of the more striking findings in the study of the program was that for parents who were successfully involved in the project services the rate of foster care placement of children was only 17% ,in contrast to an 83% foster care placement rate for families whose parents had not been successfully engaged at the end of the tracking period. (Olsen, 1995)

A comprehensive parenting education model which recognizes the complexity of the problem of parental addiction is proposed by Mejta and Lavin (1996) . This article, unlike others, describes some of the elements of the parenting program which includes educating maternal substance abusers about child care , developing supports, resources and coping skills, repairing and developing the mother-child relationship and involving family members .

A consortium of researchers at the 57th Annual National Institute of Drug Abuse Scientific Meeting presented the following recommendations regarding parenting among drug dependent women .

The need to include parenting services has been based on 1) the risk of developmental and behavioral problems for children born to substance abusing mothers and 2) an attempt to reduce barriers to women's participation in treatment related to the presence of dependent children. Parenting services may take many different forms and combinations, such as dyadic prevention/intervention, developmental day care/child care, parent support groups, parent-child activity , parent education and parenting curriculums. Whatever form is used , parenting services should reflect a developmental model which assesses mothers' and infants' behavioral strengths and weaknesses and emphasizes sensitive, responsive parent-child interaction as an essential element to both the child's and parent's development. (Finnegan, Kaltenback ,Kandall,Lester, Mayes and Paltrow .)

## **A Culturally Specific Parent Education Program in Substance**

### **Abuse Treatment**

The Strengthening Families Program ( Kumpfer and Demarch ,1985 ) was developed specifically for children of alcohol and drug-abusing parents. The program has children's groups that meet simultaneously but separately from the parent's groups. (The authors state that there is no research showing that working with children and parents together or separately is more effective than having parents groups alone.) This curriculum focuses on communication skill development, and teaches parents to use "differential attention " where parents ignore behaviors that are negative or unwanted. The curriculum teaches parents ways to give attention and praise to desirable behavior.

This program has a curriculum with separate material for Black and Asian families which supplements their regular curriculum. The Strengthening Families Program offers some guidelines to improve effectiveness with ethnic families. These include providing programs of sufficient intensity that provide at least 30-40 hours of contact. Also recommended are the following : matching the program to the families' needs through accurate assessment of typical problems, screening for parental dysfunction , providing transportation, matching indigenous group workers to ethnic groups, providing comprehensive family services to address poverty and stress, review of program materials for cultural relevance and doing follow-up studies on program effectiveness.

The black family curriculum contains a section which defines and distinguishes the goals and objectives of traditional black discipline from contemporary black discipline. Corporal punishment and an authoritarian approach were the legacy of the black family from the time of slavery. Until recently , the orientation to discipline was to perpetuate a weakened and subservient character in children in order to protect the child from a hostile world . A fear of authority figures was required for survival in a de facto

segregated and racially divided society . In order to protect black children from conflict with police and other figures of authority subservience was cultivated in the relationship of the child to the parent.(Comer, 1980)The goals of contemporary black discipline, however, are based on the premise that the black child has a chance for achievement ,success and upward mobility . The building of the child's confidence and self discipline is emphasized as a means of attaining success. The authors of the Strengthening Families Program report that there is little research to support the need for culturally based parenting and family programs. Studies aimed at isolating the variables and etiology of drug abuse and family disruption point to educational and economic factors rather than cultural differences. (Dela Rosa & Rodriguez ,1988; Jones & Demarkee, 1995) .

The research cited puts in question the role of culture in parenting .Family functioning , and the roles modeled within the family, as well as education and economics seem to play a greater part in predicting health than race , ethnicity or religion.

## **CHAPTER III**

### **History and Description of the Project - Parenting In Recovery**

The Parenting Skills groups known as *Parenting in Recovery* (PIR) have been held since 1990 at a large multi-service substance abuse agency in the Bronx to be known as Bronx Substance Abuse Services (BSAS). The groups serve many parents, some coming to the program voluntarily and many because they were mandated to obtain some form of parent training. Before coming to BSAS I had been working as a group worker and developing the PIR curriculum at various agencies in the metropolitan area. The BSAS agency had been referring clients to these PIR groups. In 1990 BSAS asked me to run the groups at their facilities. Due to the increase in requests for the program from clients, the administration decided that PIR groups should be run at all their sites and they asked me to train and supervise a select group of counselors to run the groups. For the past five years the groups have been conducted at the BSAS men's residence, two residences for women, a day treatment center, and a methadone maintenance facility. The most difficult to recruit parents came from the methadone maintenance program. Many efforts were made to have more MMTP parents enroll in the PIR program. Parents in MMTP are difficult to engage in programs. They come to the agency to receive their methadone and keep their appointments with caseworkers. Casework services are quite minimal. Most caseworkers in the MMTP program have 50 to 60 clients on their caseloads. Methadone using clients do not come to the agency expecting other social services. The program has also been held at an outpatient mental health clinic in Manhattan to which BSAS refers clients and a women's residence that is part of a hospital in Staten Island.

The *Parenting in Recovery* Program has a 15 session curriculum. The complete curriculum can be found in the appendix. In order to give an overview

of the program's content the following outline is provided.

**Session one - Contracting for a Working alliance : Goal setting**

**Session two -The First year of Life, Establishment of Basic Trust**

**Session three - Pregnancy and Planning: The Hopes and the Realities**

**Session four - Influences on Parent and Child, Creating An Eco-Map**

**Session Five - Essential Routines for Family Life**

**Session Six - Attachment and Individuation ( Years 1-3)**

**Session seven - Ingredients of Good Communication**

**Session eight - Communication Skills : Genuine Listening**

**Session nine-Children's sexuality and Protection from Sexual abuse**

**Session ten - Raising your child's self-esteem :Praise & Encouragement**

**Session eleven - Discipline and Punishment**

**Session twelve - Understanding Children's Behavior**

**Session thirteen - Preventing Isolation: Creation of a Resource List**

**Session fourteen - Helping Parents Talk to Children about Separation and Recovery**

**Session fifteen - Creation of the Group Position Paper**

In a screening interview the requirements of the program are presented. Parents sign a contract which sets forth requirements for earning a certificate of completion after the first session . Requisites center around attendance minimums , punctuality, and journal and homework assignments . A graduation ceremony marks the completion of the program . After the recruitment and pre-contracting phase is completed a written contract is signed by the parent and the group worker . Mutuality of expectations and responsibilities of the worker and the parent are presented. The contract spells out the responsibilities of the parents for journal assignments and attendance requirements . The worker's responsibilities include reading and commenting on the journals, keeping attendance records and awarding certificates of completion when requirements are satisfied.

Contracting also involves a discussion of the guarantee and conditions of confidentiality . This entails telling parents that they will be informed before

information is shared with outside authorities and this would occur only when the welfare of the parent or child may be in question.

Program administrators and family members have attended the graduations as have caseworkers from the city Administration for Children's Services. In 1996 Ruth Messinger spoke at a graduation ceremony .

The group worker training has been approved by OASAS for 6 CAS Certification credits. I have taught the curriculum to social workers and substance abuse counselors at National Development and Research Institutes and at the training institute of the Alcoholism Council of New York . I also taught the PIR program to caseworkers at the Children's Aid Society and Louise Wise Services.

### **Description of the Settings and Agencies**

Most of the subjects in the study were in treatment at the BSAS agency. The BSAS agency is a multi-service , comprehensive, community based social agency , formed in 1974 by community workers and residents of the South Bronx in response to the overwhelming deterioration of the East Tremont community. The causes of the devastation of the community were two fold; the epidemic of drugs and the effects of economic decline on an already marginalized local economy. The most intractable problems were loss of jobs, housing and homelessness. Especially pervasive and insidious was abuse of drugs and addiction leading to the disruption of families. The agency has three residences for women. Two are licensed by New York State OASAS and one other is a transitional housing unit where women receive diagnostic services and housing referrals. The men's residence houses 75 to 80 men and receives referrals from various city and state agencies. The day treatment center offers basic education classes, GED, college preparatory courses , and some college courses through Mercy College. The day treatment center has vocational training and job placement services specializing in computer technology, food services and health care services. The MMTP facility serves approximately 850 clients and has a primary care HIV health clinic. BSAS has low income and enhanced housing projects in the Fordham -Tremont area to which it refers clients in need of housing .

The BSAS agency has the unfortunate distinction of being located in the poorest district in the Bronx. The clientele served by the agency has almost twice as many people living below the poverty line as that of the entire Bronx County and more than 2.5 times that of New York City as a whole. The community tops the list of virtually every social indicator of poverty in New York City. The clients and tenants of agency housing are predominantly Latino and African-American. Many have not completed high school and have been

unemployed for long periods of time. There is a very high rate of children in foster care and single parent families in this community.

The program was also conducted at an outpatient substance abuse mental health clinic in mid-Manhattan. This agency offers a range of services including individual counseling, relapse prevention groups, marital counseling and acupuncture. Some of the parents who attended the PIR program at this site were employed and had been discharged from the Bronx agency's day treatment or residential programs.

The women's residence in Staten Island is part of a hospital complex . There are approximately 40 women in the residence and all are required to attend the PIR parenting groups . The women must have a minimum of 3 months in treatment before they can begin the program. This program allows some of the women to have their children spend the night with them over the weekend at the residence. The women in this residence attend various day treatment programs or have been placed in jobs.

### Discussion of the PIR Curriculum

There are content and topics in the curriculum that use activities done in the group to strengthen the learning process. The methods used to make the material on communication skills and attachment theory relevant and meaningful, can be discussion, role play or group writing projects. Homework assignments, done outside of group sessions, are another method for learning. The journal and homework assignments reinforce concepts and must be done without the involvement of the group. The learning that comes out of the homework reflects the individual's personal understanding of the concepts.

#### Journal and Creative Writing

One of the distinguishing features in the Parenting in Recovery group experience, as previously mentioned, is the use of creative writing activities. Written methods that incorporate journals and poetry are recognized by family and group therapists as being valuable treatment tools. (Penn & Frankfurt 1994; Epston and White, 1991; Leavitt & Pill 1995) The poet and writer Kenneth Koch has used poetry to help children express their feelings about unusual situations in their lives (Koch, 1970). The techniques Koch used with children inspired my work with addicted parents.

Reading and writing poems can unlock creative energies in groups. Some of the poems and letters I collected from the PIR groups have been published in the Journal of Poetry Therapy (Plasse, 1995). Part of the first session includes having the group write a poem. In the first session a group culture and climate are introduced. (Yalom, 1990) The first session is also when the group's mission takes shape. The group begins to form a working alliance and the poem becomes one of the first fruits of its labor. In addition, the group poem achieves the goal of establishing a common ground where members can meet and find similarities.

The poem is written in this way. Each person is given file card and

asked to write on it a line or phrase to complete the sentence - *The first time I held my child.* To reduce self-consciousness and encourage risk taking no names are put onto the cards. The group worker collects the cards ,shuffles them and then reads them. The following is an example of a poem that was composed in the first session of a parenting group.

*The first time I held my child  
I didn't know what it was  
to feel love for a child of my own.*

*The first time I held my child  
I didn't want to put her down  
some kind of rush of joy came inside of my body .*

*I first time I held my child  
I was scared  
What had all my drugging done to this tiny life?*

*The first time I held my child  
I was happy, and nervous  
I had to be there for someone else , not just me.*

*The first time I held my child  
I was afraid that I was hurting her  
Was I holding too tight  
or not tight enough?*

*The first time I held my child  
I couldn't believe  
that this was the little person who had been growing inside of me.*

Although the poem contains a range of feelings ,it is a collective expression of a universal experience. The images and tone of the poem confer a sense of the exalted to the group 's upcoming work. At the next session the

group worker , who has printed out the poem with the group's names , will distribute it . This will become the first entry in the journal. Other poems that parents have written in the groups were inspired by group discussions. Here is a poem that was written after a discussion about parental encouragement by a group of women from one of the residential facilities. A mother offered the opening line for a poem which began "*When you look into my eyes you will see* ." The name of the poem which appears below is Mother Mirror.

### **Mother Mirror**

When you look into my eyes you see

A picture of me so strong, so loving

you think "that's the person I would like to be".

When you look into my eyes you see

happiness and you will be all you can be.

When you look into my eyes you see

tenderness

you know how much you mean to me.

When you look into my eyes you see

the doubt

am I going to be able to take care of you

will I change and be the way I want to be?

When you look into my eyes you see

the happiness and joy you bring to my life

you'll see my love always

When you look into my eyes you see

a rising moon with shining stars

When you look into my eyes you see

no more pain.

When you look into my eyes you see  
a frightened person  
who is trying hard to be courageous.  
When you look into my eyes you see  
a face I can't despise  
and a burning love brighter  
than a sunrise.

Groups have also written letters to their parents and children as a group activity . Each line or thought in the letter would be discussed by the group before it was accepted and included. The following is a letter that was written by a group of parents in Day treatment in 1995.

*Dear Mom,*

*I found it very hard talking to you while growing up. You had very little time for me, you always seemed to be working so hard. I felt you weren't there. I never gave it a thought to talk to you. You weren't the kind of mother I could talk to. I miss the times we spent together, laughing , crying and arguing. I wish you were here now. I wish I could speak to you about the changes I'm going through. Mom, I wish you would talk to me and not at me. If you were here today I would make you listen to me. I've always wondered what it would be like to talk to you. Now I realize the pain you were going through. I wish you would have let me reach out to you. I know you loved me but I just didn't feel that you cared. I'll always love you.*

Creative and journal writing is required by everyone who has been part of the PIR program. No one who wishes to join the group has ever been turned away because they do not have sufficient reading or writing abilities. The parents in the PIR program typically have educational deficits and learning difficulties. Many parents have had no formal education beyond the

elementary school grades, while others might have had some college. The program has supports that have enabled parents to do the journal writing at whatever level they can achieve. During sessions most of what goes into the journals is copied from the a flip chart or black board directly into the parent's journals. Some group workers meet with parents before or after the groups to help with assignments. Parents may be also be assigned a journal sponsor who may be a member of the group . It has sometimes happened that parents with teenage children do the written assignments with their help and input . Another option is for the group member to do the assignment with their counselor or caseworker . In this way the group assignment can sometimes be integrated into the overall casework planning and treatment.

#### Dealing with Issues of Separation and Disclosure

The majority of parents who have gone through the PIR program over the years have been separated from their children either prior to treatment or upon coming into treatment . The children may have been placed in foster care by the New York City Administration for Children's Services or may be living with grandparents or relatives. More often than not, relationships between the parent in treatment and the caregiving family members are strained . Parents in the groups have an range of feelings from ambivalence to bitter resentment toward foster parents and family members who are caring for their children . Any parent surrogate can be viewed as a threat to the addicted parent who fears losing the child's love or having the child turn against them . The animus between the parents and caregivers of their children is ultimately destructive to the child and the parent.

There are two sessions which deal with special issues of separation and disclosure to the child of the parent's addiction and treatment . In the second PIR session entitled *The First Year of Life* , parents learn about attachment theory and the effects of separation on young children . In this session the group

worker presents the famous study by Dr. Rene Spitz of infants and toddlers at the Hampstead clinic outside London during World War II. These young children, separated from their parents, developed a cluster of symptoms which later became known as failure to thrive syndrome. The clinic, however, was a model of efficiency. The children were clean, well-fed and received the care of volunteers and nurses in around the clock shifts. After the group worker describes the symptoms: babies and toddlers who stopped crying for their parents, became listless and depressed, and failed to develop normally, the group is asked to think about what could have gone wrong. Parents invariably arrive at the correct reason: the children could not bond or attach to one consistent person due to the shift changes of nurses and volunteers. A discussion follows about foster care versus institutional care and the rationale behind foster care for very young children. The journal assignment in this session is to write about the importance of bonding and how the parent can help the child have meaningful attachments even when they are separated. The parents who believe their children's welfare might be at risk in placement are encouraged to take steps, with help from counselors or case managers, to make changes in the child's living arrangements.

I wrote session fourteen and included a role play for the parents to enact because I recognized that parents in treatment needed help in order to help their children make sense of the separations, disruptions and consequences that accompany the parent's entry into treatment. The session begins with a discussion of the sometimes traumatic circumstances surrounding separations of parents and children. Some children have witnessed the parent buying, using or selling drugs. Some children have been with parents when they were arrested. Some children have overheard family and friends talking about violent events and the parent's drug addiction. (See appendix for session fourteen, entitled Helping Parents Talk to Children About Separation)

### An Ecological and Systems Approach in the Curriculum

Ecological and systems theories are incorporated into the curriculum to help parents develop a greater awareness of their connection to a variety of biopsychosocial influences. There are two sessions that can be found in the addendum which address the isolation of the parent using a systemic perspective. One is session four, Influences on Parent and Child, and the other is in session thirteen, Creating a Resource List.

In session four, the group creates a kind of eco-map of the parent and child's world. During the session parents create a visual representation of all the positive and negative forces and influences that they can think of. Then they assess whether these forces have an impact on the child. Each group has fashioned different diagrams with a variety of influences. The drawing from the training manual is a guideline for group workers of what can come out of the session.

For people with poor writing skills, graphic depictions enable them to "see" themselves in the fullness of their environment and personal choices. As the parent-child eco map is drawn parents come to see the porousness of the boundaries between themselves and their children and the impact of some of their choices. Parents also can begin to discriminate between where choices do exist and where they do not exist.

The other session that incorporates a systems approach is the thirteenth session. At this point the group is beginning the ending phase. The session helps to prepare parents to separate from the group by having the group create a resource list and addressing the potential problem of isolation. The list will have neighborhood institutions and community services for children and parents. The list also would include the telephone numbers and addresses of the group members themselves. The goal is for group members to become part of each other's network of resources. Here parents create a resource list

that can become a tool that can prevent isolation and sustain the involvement of group members with each other after the group ends.

### The Parent Child Contact Form

Periodically during the PIR program parents would be asked to fill out a parent child contract report. (see appendix ) . The forms were given out in the second half of the program after parents had learned some of the communication skills that are included in the report. . Here are three samples , the first is of a child who lived in a kinship home, the second is of a child who lived in a foster home and the third is of a child who had been reunited and was living with his mother.

#### Example one:

Child is a 5 year old girl . The viist took place in the father's house. Parent is a mother living in the women's residence.

#### **Hygiene, appearance, mood and attttude**

Her hygiene was great. I gave her a bath with her duck sponge. Her appearance was colorful cause I let her dress herself. She was in a better mood than last visit and she had a postive attitude. I think she is adjusting to my being away and maybe she feels better because I am visiting more.

#### **Activities Between parent and Child**

We played with her dolls with her big sister and we played "guess who" and "fleas on fred".

#### **Communication Skills :Praise, encouragement, identification of a need or feeling , comfort, phsycial affection, limit setting**

I communicated with her by telling her how good she dressed her doll and how she draws so nice and also how she cut out some hearts. I said how proud I was of her cause she's doing so well in school.

#### **Concerns and Problems**

I see she gets sad when I have to go and she acts nasty to her sister when I give her sister attention . I know she misses me and that she needs more attention. I have trouble telling her to stop fighting with her brother because he is the youngest and he has his own needs for attention too.

Example 2:

13 year old boy in foster home , mother in methadone maintenance

**Hygiene, appearance, mood and attitude**

He's clean and he has new clothes that are too big because foster mother says he's growing. His mood is quiet, sad and angry at me sometimes. His voice is low so I have to ask him again and again what he just said.

**Activities Between parent and Child**

I took him to the play room and gave him some sandwiches. I looked into his eyes when he talked . I tried not to interrupt him. He had a lot to say. He wants to know when he's coming home and he says the foster mother isn't fair and makes him take care of the other kids. Then he showed me his school books. The foster mother sat down with me and him to help him get organized so I got some folders from the caseworker and we worked to get his stuff in better order. Then we played checkers and he beat me. I told him how smart he is and that he has to respect the foster mother just like me.

**Communication Skills :Praise, encouragement, identification of a need or feeling , comfort, physical affection, limit setting**

My son acts like he knows everything and he's a big man, but I know that inside he is scared . He has a lot of worries on his mind and I have to listen. I have so many concerns and worries about him.

Example 3

Boy age 14 reunited with his mother one month ago.

**Hygiene, appearance, mood and attitude**

My son don't care how he looks. He has an attitude because I yelled at him. He was playing and making noise. I didn't want to be here at that moment.

### **Activities between parent and child**

We played sega. He gets upset with me because I don't move fast enough for him.

### **Communication Skills :Praise, encouragement, identification of a need or feeling , comfort, phsyical affection, limit setting**

I told him I was sorry for yelling at him. He said he was sorry for the noise. We talked . I told him that he has a good imagination. I kissed him and he kissed me back.

### **Concerns and Problems**

I don't like to get upset with my kids. But now that we just getting back into each other's life , I don't want the fighting to spoil the new life we finally have together. I have to be more patient, understand how he feels about the past.

The parent child contact forms were a means of reinforcing the skills that were learned in the program and improve the quality of the parent's interaction with the child. The reports were read and discussed in the group. In discussions of their interactions parents deepened their understanding of separation reactions and other emotionally charged issues between them and their children. Parents made suggestions and supported the nurturing behaviors that the parent wrote about in the contract report . Group workers would assign the reports to parents whose visiting was sporadic. However,all the parents were encouraged to use the forms. The forms helped parents become more conscious of how to use skills of communication and practice nurturing behaviors in order to make the most of their visits.

### The Group Position Paper

In the final session the group writes a position paper. This is a statement of the group's values and ideals. The paper is a document that should be shared to help other parents in recovery. In the past the paper has been published in agency newsletters or included in the program at the graduation celebration. It sets forth the group's collective ideas about the rights and entitlements of parents and children who have been effected by substance abuse. In writing the position paper the group reaffirms its commitment to personal and collective goals and aspirations . Going public with a document that presents the group's values empowers the group and is a form of advocacy that clients can initiate for themselves. The following position paper was written by a group of parents at the BASA day treatment program.

A Position Paper for:

# Parents In Recovery

**We believe that the following guidelines should be observed by parents and parents-to-be who are in recovery from substance abuse.**

- 1. A man or women should be clean and sober for a minimum of 37 months before conceiving a child.**
- 2. Until children are returned to the mother and father from placement in foster care or kinship care the parents should refrain from having another child.**
- 3. A parent with a history of substance abuse should have no more than two (2) children.**
- 4. We believe that fathers are of great importance in raising their children on a day to day basis.**
- 5. We believe that safe and protected sexual practices are essential for all parents.**
- 6. We believe that it is every child's birthright to have the following:**
  - \*A drug and alcohol-free parent .**
  - \*Safe and Decent Housing.**
  - \*Attention and love from the parent.**
  - \*A positive and nurturing environment.**
  - \*Medical care.**
  - \*Acceptance and expression of the child's talents and individuality .**
  - \*Respect and understanding.**
  - \*A satisfactory education and caring teachers.**
  - \*Physical affection, hugs and kisses.**

## **Theoretical Foundations of PIR Group worker Training**

The centrality of importance accorded to the group worker has been well established in the literature (Schwartz & Zalba, 1971; Yalom et al, 1973; Shulman & Gitterman, 1994). The training of PIR group workers has been consistent in setting forth the essential values and norms of PIR program. Fortunately, I have had a voice in selecting, training and supervising the group leaders, most of whom have been good matches for the requirements of the program. The PIR group worker's role is a hybrid of group worker and teacher. Some people in the groups refer to the group worker as "My teacher", others refer to him or her as "My counselor". When I was running the groups I was always known, somewhat to my chagrin, as "Ms. Bea."

The theoretical framework that influenced the training that I give to group workers came from several sources. One influence is identified with the ideas of William Schwartz (1971) where the group worker is a mediator facilitating member to member exchanges. The mediator helps the group members stay focused on goals and topics while using a democratic approach and helping the group listen to each other's contributions.

Another model of leadership which influenced the training comes from Carl Rogers (1951, 1959, 1962, 1964, 1970) and his research on client-centered therapy. The respectful, caring attitude that Rogers brings to his groups exemplifies the qualities that are expected from the PIR group workers. His book, The Interpersonal Relationship: The Core of Guidance (1951) contains some of the ideas about aspects of learning that pertain to the group worker's role. Rogers presents conditions in which "significant learning" can take place. These findings are based on his research with client centered therapy.

Briefly summarized, the conditions for significant learning are when the group member perceives himself as faced by a serious and meaningful problem

and when the group worker is a *congruent* person . By congruent Rogers means that the group worker is empathic , accepting and able to understand the inner world of the client . But it is not enough for the group worker to have an accurate understanding of the inner world and experiences of the client ; the group worker should be able to communicate that understanding . Roger's writes of the need for the group worker to have an "unconditional positive regard" for the client . This unconditional regard does not preclude communicating real feelings and disagreements with clients . (Rogers, 1970)

Rogers puts the group worker very much at the center of the helping process whereas Schwartz positions the worker closer to the sidelines bringing the group members into center stage . Some group workers would say that the real power of the group resides in the group members' interactions with each other. Despite the differing perspectives , there is similarity in terms of human potential . Rogers calls for the "self-actualization" of the individual and Schwartz (1961) refers to the goal of "self-fulfillment" . The PIR group worker is trained to think about how to raise awareness of commonalities among group members and then to engage group members in a mutual helping process. This is a characteristic of the reciprocal model of social work groups . The reciprocal group was defined by Papell & Rothman (1966). They created a classification of theoretical models of social work group . In the reciprocal model the group worker facilitates interaction and involves group members in sharing solutions from personal experience.

The PIR leadership also has much in common with the social goals group model as well (Kurland & Salmon, 1998) . In the PIR group the contact and beginning phases of the group are devoted to the establishment of the social goal of learning to become a better parent . Within this goal are other goals such as the learning of skills and concepts from lectures and discussions.

In 1973 Yalom, Lieberman and Miles published a well-respected study on the effectiveness of group therapy. One major finding in the study was the importance of the group worker who was credited with being the most influential factor in the client's perceptions of the success or failure of the group. Study groups were created that met for 30 hours over a 12 week period. ( This time frame that is similar in time to the PIR program.) There were ten different ideological schools represented by the group workers. These included Gestalt, Transactional Analysis and psychodynamic. Yalom and his researchers found that the professed theoretical orientation of the group worker had no effect on the way that the group worker behaved in the group. Yalom derived a factor analysis of four basic functions and traits of successful leadership.

1. Emotional stimulation - challenging, personal risk-taking and high self-disclosure
2. Caring - offering support, affection, praise, protection, warmth, acceptance
3. Meaning attribution - explaining, clarifying, interpreting
4. Executive function - setting limits, rules, norms, goals.

The PIR group worker training emphasizes most of these functions, although some are stressed more than others. There is less emphasis on being challenging or confrontational because many parents in the groups have a history of being victims of violence and do not do well with this approach. The importance of caring and creating a supportive and affectionate climate is stressed in the training. One of the features of PIR program is that the group worker has a well-defined executive function in which the programmatic structures are clearly spelled out in the contract which the parent signs about rules, expectations and requirements. The feedback I have gotten from the staff I have trained has confirmed that having these structures is helpful to them as they conduct the groups.

## **CHAPTER IV**

### **Research Design and Methodology**

The dissertation is a study which examines a variety of dimensions in the lives of parents who have sought or were mandated to go into treatment for their drug and alcohol dependency. The study incorporates different kinds of information and therefore requires different strategies of data collection and different instruments for measuring change. There are several sources of data in the study. Quantitative data was collected in pre and post questionnaires that used a likert scale and a post program behavioral scale of 10 items that called for a yes or no response.

The main body of qualitative data came from interviews with 10 parents. The interview used a structured and open-ended guide of probes and questions. The journal work that participants completed during their program is presented in the study as another source of qualitative data. Finally, there is qualitative data from written responses to the pre and post questionnaires. The written questions asked parents about their needs in parenting, their concerns about their children and the impact of the program after completion.

Triangulation is the term used to describe the process of using different kinds of research methodologies and different types of data in the discussion and analysis of an evaluation. Studies which use several research strategies are said to be more robust. The benefit that accrues to studies using material generated from different methods is to create a more nuanced and multi-dimensional study (Babbie, 1994).

There are four basic types of triangulation (1) data triangulation (2) investigator triangulation (3) theory triangulation and (4) methodological triangulation (Patton, 1990). This study uses two out of the four kinds of triangulation. It uses different sources of data and different methods of data

collection from the qualitative and quantitative methodologies. Although the study may not use theory triangulation throughout for a comparative analysis, it presents a theoretical framework of engagement, the Macgowan Group Engagement Measurement (1997), and incorporates theories from the feminist perspective (Abbott, 1994), empowerment theory (Simon, 1994) and theories from work group on personal growth in groups. In an ideal study, all four kinds of triangulation would be used. But as Patton states triangulation is an expensive proposition in terms of time, money and personnel (Patton, 1990).

This is not an experimental study for the simple reason that the study does not have a control group. Instead the study uses a pre-post program questionnaire that measured change (Smith, 1990). The 52 people in the study all attended the program during summer and fall of 1999. The lack of a control group is partially explained by the context of the study which was within an agency setting. There would have been ethical problems in withholding treatment from clients who wished to enter the program and this would have created conflicts between the researcher and the agency where the research was being conducted. The study did, however, have baseline data that came from respondents in the pre program measurements and post program measures of the same variables. (Smith, 1990). The lack of a control group limits the ability to make statements of causality in relation to the program. In future studies randomly selected clients, including clients who received no other treatment than the PIR program, could be arranged. Another way to compare the outcomes of the program would be to utilize contrast groups which completed a different parenting intervention.

The primary value of a program evaluation such as this one, is that it provides empirical examples from social work practice for professionals to learn from and adapt in their work with similar populations.

### **Choices and Tradeoffs Between Methods**

Each method , quantitative and qualitative, has advantages and disadvantages and each method can provide data which have certain strengths and weaknesses. The choice of method should be determined by the nature of the information that is being sought. . The advantages of the data from quantitative methods are that it is succinct, parsimonious and generalizable. Information in this study that calls for this type of quantitative data would include such items as frequency of visitation, custody arrangements and treatment settings . Quantitative methods can provide this important type of precise and measurable data and have the advantage of being designed so as to allow replication, although within limits. The pre-post questionnaires and behavioral survey could be used again but only with this type of population in these types of substance abuse treatment settings .

Quantitative methods have certain disadvantages . They are not well-suited to studies that involve complex systems and vulnerable populations . Addicted parents are a varied and complex group. The PIR program is also a complex intervention. Quantitative methods do not allow for flexible exploration which is most useful in the early stages of program development . Without other methods , the scope of an inquiry would be limited exclusively to questions that are framed so that responses fit into a predetermined category or scale . The quantitative method is not well-suited to evaluating people and programs especially where there may be local variability and contextual influences. The data from qualitative methods, while less precise and generalizable, can be more nuanced and multi-dimensional.

When evaluating a study involving human subjects, interviews are an invaluable tool . The structured interview has the ability to capture the voice and story of the individual . The qualitative method of interviewing permits the

interviewer to follow up on compelling aspects of the subjects' story .

Human relationships are intrinsically dynamic and can often be volatile , passionate and irrational. This study asks parents to talk about the subculture of addiction and its turbulent impact on the relationships with their children and their families . It also looks at relationships between other parents in the PIR group and at the relationship with the PIR group worker. This study asks for respondents to talk about a program in terms of both its cognitive and emotional impact.

### **Sampling**

As Babbie (1990) notes “ The most carefully selected sample will almost never provide a perfect representation of the population from which it was selected. There will always be some degree of sampling error. p.227” This is especially true when the study is a small one such as this one . The study had 52 respondents who were matched by coded identification numbers from the pre and post questionnaires. They represent the total group of parents who completed the program . Smith (1990) draws the distinction between the sample of a program evaluation and samples used in other forms of research. “In program evaluation , sampling is a little different from that in basic research. In most cases, the population is defined as the total group of people in the program. p.16 “

The fact that a program evaluation uses only those who complete a program tends to limit the generalizability of the study. Little is known about those who dropped out. The attrition rate for participants in the program was between 10% and 15%. This is based on the attendance records of the group workers as well as their reports to me during supervision. Reasons that staff gave for parents dropping out of the program included parents who relapsed and parents who terminated treatment at the agency due to having been placed in jobs or referred out of the agency for vocational training programs due to the new welfare and work rules of the Guliani administration.

The behavioral survey has a sample size of 25 parents. The survey was created later in the study and reflects the total number of parents in the program at the time.

The sample group of 10 parents who were interviewed was a non-probability purposive sample based on the desire for maximum variability. Babbie (1990) lists this as the most important principal for sampling . “The chief

criterion of the quality of a sample is the degree to which it is representative -the extent to which the characteristics of the sample are the same as those of the population from which it was selected.p.226 “ The selection of interviewed parents was made with the involvement of the group workers . The criteria used were that parents would be selected from all the treatment settings and have a range of different demographic and personal characteristics . Two fathers from the men’s residence were interviewed , two mothers from the methadone maintenance program, two mothers from the day treatment center and four mothers from the two women’s residences. The parents were between 23 and 47 years old, had diverse ethnic backgrounds , their children ranged in age from infants to adolescents ,and they had divergent levels of education . One women relapsed but continued after a brief hospitalization and another woman was taking the program for the second time. Convenience was another criterion for the sample . Naturally there were limits on the schedules and availability of myself and the parents.

### Pre-post Questionnaires and Behavioral Survey

In searching for quantitative instruments with ordinal or nominal scales, I hoped to find a good fit for this inquiry . I was looking for questionnaires or surveys that would be relevant to the population and could match the specific areas of content in the curriculum. Ultimately, I decided that I should design the pre-post and behavioral questionnaires myself ( see appendix) . The instruments were designed to uncover parents' perceptions and attitudes toward the stresses of recovery and parenting. Examples of questions used in the measurement of stresses are , "I often feel nervous and worried that I will relapse" , "I often feel stressed by the demands of my children " and "I feel guilty about how my drug use has affected my children. "

The parent's sense of competence in child management is another area of inquiry that I included in the pre-post instrument and the behavioral survey . The pre-post interview asks about discipline in the following items , "Sometimes I do not understand why my children misbehave." , " I find that I yell and scream at my children more than I should " , " Often I can't say no to my children" and " I feel that I hit my children more than I should. " In the behavioral survey there are also items dealing with specific areas of limit-setting.

Another important topic in the pre and post instrument concerns family and social supports. Questions in this area include " I believe that my family does not trust me to stay in recovery" and " I feel alone and without friends most of the time." The related item in the behavioral survey states " I talk more with the people taking care of my children " .

The pre-post questionnaires include items that seek to understand changes in how parents see their children's well being and mental health. "My children are afraid that I will not be there for them " , "My children are not getting enough attention from me" and " At this point in my recovery my children do not trust me ". The related item in the survey states "My children seem calmer."

There are also two questions on the variable of disclosure . One question is “ My children are confused about my addiction “ and a second question is, “ I believe that it is important for me to talk to my children about my recovery “.

The items in the two instruments were selected on the basis of what I know about the characteristics and problems of the population as well as what is contained in the curriculum of the PIR program. The similarity of items from both the behavioral survey and the pre-post questionnaires strengthens the data and has the triangulation effect. The qualitative interview guide , which I discuss next, included many overlapping areas of inquiry and provides a more nuanced way to understanding some of the same phenomena. For example, the pre-post questionnaires ask parents how they see their ability to praise or encourage their children. The behavioral survey done after the program asks parents if they speak in a more encouraging way and the interviews ask parents about the changes in how parents communicate their affection and praise to their children.

### **Development of The interview Guide**

The guide for the qualitative interview is found in the appendix . It asks about how parents see themselves in their parenting role, the stresses on them during recovery, the impact of their addiction on their children and how the curriculum either met or did not meet their needs. The interviews also allowed me to inquire about elements of engagement using the dimensions of an instrument developed by Mark Macgowan (1997) known as the Group Engagement Measurement.

The interview questions and probes were developed with the following advice from the Patton text in mind. "The basic thrust of qualitative interviewing is to minimize the imposition of predetermined responses. This means that the questions should permit respondents to respond in their own terms."

( 1990.p.287 ) The information that I was able to gather in the interviews offered me a perspective on the program that could not have been achieved in any other way. When I developed the guide I was aware that I had two distinct aims . One was to ask about specific aspects of the program and the other was to be open to the possibility of discovery even when that may have come into conflict with my biases and preconceptions. Although there were limitations on the amount of interviewing time , I was able to hear parents talk about their lives during their addiction as well as how they experienced the program. The interview attempted to cover areas of learning , program and structural requirements, the relationships with group members and group worker and the changes parents felt they underwent with their children . The interview guide was developed through an examination of the curriculum topics and a review of the elements of engagement , motivation and participation which were defined in the Macgowan construct of engagement . Other questions in the interview

focused more directly on content areas of the curriculum.

Each person's account was like an odyssey into that person's recovery and this shaped the way that I used the guide. There were compelling issues in each parent's history, most particularly those touching upon the ways in which the parent's addiction affected their children. The responses led me to pursue some questions further and to skip over others entirely. Parents wanted very much to tell their stories, some in great detail, and so I listened.

## Reliability and Validity

Reliability refers to the capacity of a measurement to elicit responses that are consistent. The questionnaires and survey for this study met the criteria for common-sense reliability in that they addressed the topics of interest to the evaluation in clear language rather than in professional jargon. (Smith, 1990). Knowledge of the way that clients speak and read helped to make the questionnaires intelligible to the clients and therefore reliable. The questions in the pre-post questionnaire and the behavioral survey were worded in behavioral language and not clinical or psychiatric terminology. For example I used the term "nervous" instead of "anxious" in the question about relapse. In the interview guide, my questions matched the content of the interview and reflected the immediacy of the interview exchanges between myself and the subject rather than relying on a prepared script. For example to get to the question "how did you perceive your child's reactions to your addiction?" I asked the question "What do you think your child was going through when you were in and out of the house while you were using drugs?"

One way of testing the reliability of the instruments is to do a pre-test before using the instruments and then seeing if there is consistency among the responses in a post test. The results that were gotten from using the pre and post instruments did show a general consistency in responses. There weren't large discrepancies between how parents scored in the pre test and post test.

Validity is the quality of accuracy of a measuring instrument to measure that it is supposed to measure (Epstein & Tripodi, 1977). The pre and post questionnaires and behavioral survey have content or face validity based on the way they reflect the content in the curriculum and the known characteristics of the population.

Construct validity refers to the degree to which the questions in an instrument measure a theoretical concept. The theoretical framework in this study comes from several social work group models and theories, particularly the psychoeducational group. Other theoretical concepts that were part of the program come from feminist theory and empowerment theory particularly the contracting, recruitment and beginning phase of the program. A theoretical concept is based on a premise or hypothesis. In the PIR program the hypothesis can be stated this way. *While in substance abuse treatment addicted parents can learn more nurturing behaviors, develop more positive attitudes toward their children and feel more competent as parents through this psychoeducational group program.*

An additional test of validity is known as *empirical* validity. A test of empirical validity relates the findings of one measurement with another, external criterion. The behavioral survey provides this alternative way of testing the validity of the changes that were found in the analysis of the pre and post questionnaire items.

## **CHAPTER V**

### **Data Analysis Section**

This section will present the findings from both qualitative and quantitative data sources. The section begins with a presentation of the quantitative data which comes from the pre and post questionnaires and the behavioral survey. There are 25 tables and discussions of findings from the data in the tables. This is followed by the presentation of data from the in person interviews which I conducted at the various settings with parents . The qualitative section also includes some of the journal writings which illustrate concepts from the interviews and the content areas of the curriculum.

This section of the dissertation contains a presentation and discussion of the data from the pre and post PIR program questionnaires . The items are drawn from questions taken from the questionnaires and are organized into 25 separate tables. The data in each table has an analysis of the pre post scores for levels of statistically significant change. While each table can be read separately, for a more coherent discussion of findings ,the tables have been organized in clusters. The items were grouped together because they each represent a different aspect of a major parenting concept . The findings and discussions in this section of the data analysis deal with parents' self-perceptions about the stresses in their lives, the well being of their children, their efficacy in areas of child management and their outlook on their futures. There is also a survey of behavioral changes with 11 items . The behavioral survey was given at the end of the program to measure changes in parent activities and behaviors with children.

Table 25 presents data on parental contact and the living arrangements of children . The setting of treatment is an important variable in the analysis of the changes in frequency of contact and living arrangements of children.

## Parental Perceptions of Stress

### Pre-Post Changes

**Table 1**

1= Strongly agree    2= Agree    3=Disagree    4= Strongly Disagree

Ques.#3 "I often feel nervous and worried that I will relapse."  
(N= 50)

	Mean Score	STD. Deviation	t value	p level *
Pre	2.44	.87	-2.09	.021
Post	2.72	.86		* One tailed test

**Table 2**

1= Strongly agree    2= Agree    3=Disagree    4= Strongly Disagree

Ques.#4 "I often feel stressed by the demands of my children."  
(N=51)

	Mean Score	STD. Deviation	t value	p level *
Pre	2.55	.75	-.49	.30
Post	2.60	.85		* One Tailed Test.

**Table 3**

1= Strongly agree    2= Agree    3=Disagree    4= Strongly Disagree

Ques. #23 "I feel guilty about how my drug use has affected my children."  
(N= 48 ).

	Mean Score	STD. Deviation	t value	p level *
Pre	1.56	.71	-1.16	.12
Post	1.73	.89		* One tailed test.

## **Parental Perception of Stress**

Three variables that contribute to parental stress are presented in tables 1-3. The three areas of stress that were studied were 1) anxiety over relapse 2) feeling overwhelmed by the demands of children and 3) feeling guilty about the effects of the parents' addiction on the children. The level of psychological burden experienced by parents is shown in the data and can contribute to our understanding of the parent's self-image and world view. In the pre-program measurements the tables give a baseline on levels of stress. Post program data show how much change has taken place.

In order for the addicted parent to address the issues of parenting, the acute biological and psychological symptoms of drug and alcohol addiction need to be under control. Readiness for resuming the care of children should be based on some stability and commitment to the requirements of a drug-free daily life in substance abuse treatment. In table one the pre-program measurement showed a significant change in the level of anxiety regarding relapse. Parents were significantly less anxious about relapsing ( $p = .02$ ,  $t = -2.09$ ) after the PIR program than before. On an index from 1 to 4 where 1 was strongly agree, 2 was agree, 3 was disagree and 4 was strongly disagree program participants had a mean score of 2.44 on the pretest and 2.72 on the post-test. They moved from agreement that they were nervous (2.44) in the direction of disagreement (2.72) about being nervous about relapse.

Table 2 shows that there was almost no change in how parents felt about the demands of their children from the pretest to the post test measurement. On average, parents answered that they were only moderately stressed by the demands of their children (2.55 to 2.60). This could be due to the fact that when they began the PIR program they had already spent some time in a recovery program and arrangements for child care had been put into place. Many of the

children live with family members or are in foster care placement

Table three shows that parental feelings of guilt over the effects of their addiction on their children had lessened but was still high . Mean scores on this item both before and after the PIR program indicate that parents had strong feelings of guilt over how their addiction had affected their children .

On the pretest, parents had a mean score of 1.56 which is between strong agreement and agreement about guilt over how their drug use affected their children. The post-test mean was 1.73 which was a move in the direction of agreement rather than strong agreement. Although the change was not statistically significant ( $t=1.16$ ,  $p=.12$ ) the parents had slightly less guilty feelings.

When comparing three sources of stress ; relapse fears, children's demands and guilt , parents' responses show that guilty feelings are the most powerful source of stress that they experience.

## Parent's Perceptions of Interpersonal Relationships

### Pre - Post Changes

Table 4

1=Strongly Agree      2= Agree      3= Disagree      4= Strongly  
Disagree

Item # 17 " I feel alone and without friends most of the time."  
(N= 51)

	Mean Score	STD. Deviation	t value	p
level *				
Pre	2.61	.89	-1.91	.03
Post	2.82	.79	* one-tailed test	

Table 5

1=Strongly Agree      2= Agree      3= Disagree      4= Strongly  
Disagree

Item # 16 " I believe my family does not trust me to stay in recovery."  
(N=51)

	Mean Score	STD. Deviation	t value	p
level *				
Pre	2.57	1.02	-.81	.20
Post	2.70	1.01	*one tailed test	

## **Parents' Perceptions of Interpersonal Relationships**

Social isolation and disturbed family relationships have been identified as characteristic of substance abusing mothers (Fiks, Johnson & Rosen, 1985). The presence of supportive family members and/or social relationships is an important predictor of successful outcomes for people in recovery from substance abuse. Likewise the lack of family supports and abusive relationships in the family undermine the ability of the substance abusing person to remain drug free after treatment.

Tables four and five contain items that concern parents' perceptions about the quality of interpersonal social relationships and relationships within the parents' family. The means scores presented in these tables confirm the findings of other researchers about the isolation and alienation of the drug addicted person .

In table 4 the mean score on the item *I feel alone and without friends most of the time* in the preprogram measurement is 2.61 which indicates that parents scored between agree and disagree that they felt isolated and admitted to feeling that they had no friends. The post score for this item was 2.82 indicating that the parents scored closer to disagreement about feeling alone. This was a statistically significant reduction in loneliness (  $t=1.91$ ,  $p=.03$  ) . Parents did not see themselves as being quite so friendless and alone after the program . This finding indicates that the emphasis in the curriculum on mutual support in the group is necessary and suggests that the program has been effective in reducing some feelings of social isolation .

Table 5 contains the item *I believe my family does not trust me to stay in recovery*. Respondents felt that they lacked family support to a greater degree in the preprogram program measurement than in the post program score. While

there is not statistical significance in this item, there is a change in a positive direction. The pretest score of 2.57 is more in the direction of agreement that their families did not trust them to stay in treatment. The post-test score of 2.70 moved toward disagreement that their families did not trust them to complete treatment. The post scores indicate that the parents believe that their families are beginning to trust them.

The stronger finding of change in the item about friends does suggest that the group experience has created bonds of friendship among group members. For many parents, relationships with peers in recovery replace unhealthy family relationships.

Excerpts from interviews with participants that are presented in the qualitative data section indicate that parents have forged positive relationships with members of their groups. Parents' comments specifically refer to their ability to empathize with others in the group and feel the support of others for situations that were similar to their own. Triangulation of these two sources of data, one from the questionnaires and the other from the interviews, strengthens the findings about interpersonal relationships among group members.

My own observation and experience, which spans a longer period than that covered in the dissertation, is that often parents have maintained friendships that were created in the PIR group for years after the program had ended.

**Parental Interaction with Children**

**Pre-Post Changes**

**Table 6**

1=Strongly Agree    2= Agree    3= Disagree    4= Strongly Disagree

Item # 19 " I feel I am not able to develop my child's intelligence."  
(N= 50 )

Item # 19	Mean Score	STD Deviation	t value	p level *
Pre	2.75	.96	-3.30	.001
Post	3.30	.71		* one tailed test

**Table 7**

1=Strongly Agree    2= Agree    3= Disagree    4= Strongly Disagree

Item # 18 " I really don't enjoy playing with my children."  
(N=51)

	Mean Score	STD Deviation	t value	p level *
Pre	3.37	.63	-2.21	.016
Post	3.57	.57		* one tailed test

## **Parental Interaction with Children**

The relationship of the parent to the child is an important focus of curriculum areas in the PIR program. The pleasure that the parent takes in play with children promotes the child's ability to be successful in social situations while strengthening the parent child relationship. The parent's ability to provide mentally stimulating activities enhances the child's chances of success in school and problem solving. The PIR program has a parent child contact report form that parents are required to fill out which includes the communication skills, issues and areas of concern generated during visits with children. (see appendix. )

Studies on young children of substance abusing parents indicate that they are frequently at risk for school failure and have poorly developed social skills ( Bauman & Daugherty, 1983) . By engaging in enjoyable play experiences and being able to mentally stimulate children parents provide opportunities for children to learn how to get along with others and improve skills required for later learning. The parents' assessment of how well they mentally stimulate their children and feel about playing with their children were two areas that are evaluated in the tables.

The mean score of 2.75 in the preprogram program measurement in table 6 shows that parents had little confidence in their ability to develop intelligence in their children. Parents' perceptions of their own efficacy in this area confirm the previously mentioned research findings on substance abusing parents and children's problems with learning and socialization. The changes in the post scores on parents' perceptions of how well they can develop their children's intelligence were quite dramatic. In the post program score parents' responses were more positive; their mean score of 3.30 crossed over from agreement to disagreement with the statement that they could not develop their children's intelligence. The increase in confidence about

developing their child's intelligence was statistically significant (  $t=-3.30$ ,  $p=.001$ ).

In table 7 the item concerns the enjoyment that parents could feel when playing with their children . The parents' scores in their enjoyment of playing with their children increased to a significant degree from before the program to after the program ( $t=2.21$  ,  $p=.016$ ) . Before the program, parents tended to disagree that they did not enjoy playing with their children,( mean= 3.37). After the program, the parents moved toward strong disagreement (mean= 3.57) with the statement that they did not enjoy playing with their children.

## Parental Perception of Communication Skills

### Pre -Post Changes

**Table 8**

1= Strongly Agree 2=Agree 3=Disagree 4= Strongly Disagree  
 Item#6 " I think that I do not praise or encourage my children as much as I should." N= 51

	Mean Score	STD Deviation	t Value	P level *
Pre	2.39	.98	-1.90	.031
Post	2.65	.87	*one-tailed test	

**Table 9**

1= Strongly Agree 2=Agree 3=Disagree 4= Strongly Disagree  
 Item #7 "I find that I yell and scream more than I should." N=51 pairs

	Mean Score	STD Deviation	t Value	p level *
Pre	2.74	.86	-2.54	.007
Post	3.06	.68	*one tailed test	

**Table 10**

1= Strongly Agree 2=Agree 3=Disagree 4= Strongly Disagree  
 Item #14 "I believe it is important for me to talk to my children about my recovery." N=51 pairs

	Mean Score	STD Deviation	t Value	p level *
Pre	1.73	.73	2.04	.023
Post	1.53	.61	* one-tailed test	

## Parental Perception of Communication Skills

Parents in recovery often have not developed healthy ways of communicating with their children . The PIR program presents parents with ideas about the link between a child's self-esteem and the communication skills of listening and praising . Learning how and when to use praise and encouragement is a skill that is practiced by participants in the PIR program. Parents also learn to be aware of the ineffectiveness and destructiveness of yelling and screaming at children . Tables 8, 9 are concerned with how parents assess their communication skills in positive and negative ways. In table 10 the question of how parents feel about the importance of discussing addiction and recovery is posed. This is a topic that is specific to the needs of children whose parents are in recovery .

In table 8, the variable is the parent's assessment of how adequately they can praise and encourage their children. .In the preprogram scores parents felt more strongly that they did not praise or encourage their children adequately (mean score = 2.39). They scored significantly higher in the post program measurement indicating that they felt they were able to praise and encourage their children to a greater extent (mean score =2.65).

In Table 9 the parents responded to the question "I find that I yell and scream more than I should." Table 9 shows there was a statistically significant change in the parents' perceptions of how much they felt that they yelled and screamed at their children(  $t=-1.90$ ,  $p=.03$ ) . In the preprogram scores, parents agreed that they yelled too much (mean= 2.74) . In the post scores , parents reported that they felt they were not yelling as much at their children ( mean=3.06). This decrease in the perception that they were yelling and screaming less at the children was statistically significant ( $t=-2.54$  , $p= .007$ ).

Table 10 concerns disclosure to children about the parent's addiction.

While both preprogram scores 1.73 and post program scores 1.53 showed that parents felt it was important to talk to their children about their recovery, after the program parents felt more strongly that children needed them to talk about this topic ( $t=2.04, p=.02$ ) This may indicate that parents felt better about their ability to communicate effectively and , once having communicated , to finding more acceptance from their children. It also suggests that the program heightened parental sensitivity to their children's confusion and their need to understand the parent's addiction and treatment.

## Parents' Perceptions of their Children's Well-Being

### Pre and Post Changes

**Table 11**

1=Strongly Agree 2=Agree 3=Disagree 4=Strongly Disagree  
 Item #8 " My children are not getting enough attention from me." N=51

	Mean Score	STD Deviation	t value	p level*
Pre	2.08	.99	-.93	.17
Post	2.22	.92	* one tailed test	

**Table 12**

1=Strongly Agree 2=Agree 3=Disagree 4=Strongly Disagree  
 Item #10 " My children are afraid that I will not be there for them." N=51

	Mean Score	STD Deviation	t value	p level *
Pre	2.31	1.07	.67	.25
Post	2.21	1.03	* one tailed test	

**Table 13**

1=Strongly Agree 2=Agree 3=Disagree 4=Strongly Disagree  
 Item #11 "At this point in my recovery my children do not trust me." N=51

	Mean Score	STD Deviation	t value	p level *
Pre	2.76		.86	-.39
Post	2.82		.91	* one tailed test

**Table 14**

1=Strongly Agree 2=Agree 3=Disagree 4=Strongly Disagree  
 Item #13 " My children are confused about my addiction." N=50

	Mean Score	STD Deviation	T value	P level *
Pre	2.38		.90	-.10
Post	2.40		1.03	* one tailed test

## **Parents' Perceptions of their Children's Well-Being**

Parents in recovery have many concerns about the welfare of their children. One study that examined the motivation of parents as they entered treatment for substance abuse found that concern for the welfare of children was a primary factor ( Yaffe, Jensions & Howard, 1995) . Empirical and anecdotal evidence from participants in this program supports the notion that one of the most pressing motivations for entering treatment was concern for the children. Four variables related to the parents' feelings about their children's well being were examined before and after the program.

The preprogram and post scores in table 11 show that parents generally agree that they are not giving enough attention to their children. The post scores indicate that parents feel somewhat better about the amount of attention they are giving to their children although they still agree that their children need more attention from them. The change in the parents' perceptions in the amount of attention given to their children was not statistically significant from the pretest to the post- test (  $t=-.93$ ,  $p=.17$ ).

Parents' scores in the both pre and post measurements show their awareness and agreement that their children have fears of being abandoned (table 12) . The change in the post score shows a slightly greater acknowledgement of their children's fear of abandonment. This suggests that parents have developed greater empathy for the children's feelings . However the differences in pre and post test mean scores was not statistically significant ( $t=.67$ ,  $p=.25$ ) .

In table 13 parents' scores show they are in moderate agreement with the statement that their children do not trust their recovery efforts . A slight improvement is shown in the post program score indicating that parents believe their children are starting to trust them to succeed in recovery but the difference was not statistically significant (  $t=-.39$ ,  $p=.34$ ) .

In table 14 pre and post scores show that parents see their children as being confused about their addiction. There was no real change in the parents' perception of the children's confusion from the pretest to the post-test. ( $t = -.10$ ,  $p = .50$ ).

These items all share a common finding: parents felt that their children were in distress. They all reported feeling that their children needed more attention and therefore were neglected. They also felt that their children were afraid of being abandoned by them. They believed that their children lacked confidence in the parents' efforts to succeed in recovery and were confused about their addiction. Furthermore the parents' feelings of distress did not show any statistically significant changes from the beginning to the end of the program.

To understand this lack of significant change in parental perceptions of children's well-being, several speculations can be made. The first and it would seem most important, is that parents are aware that their children have undergone serious traumas and chronic maltreatment. These are concerns with depth and therefore would not change easily.

The next speculation is that the program has heightened the parents' concerns by teaching new concepts about healthy ways of giving attention, setting limits and the consequences of repeated losses. As a result of having more knowledge and the opportunity to discuss these concepts in the group, the parent may actually feel more worried about the child. In fact, this is confirmed in parent comments which are presented in the qualitative interview section of the dissertation.

Finally, a reason for the lack of change from pre to post scores may be that the time interval between measurements is not long enough to allow for changes to emerge.

# Parents' Perceptions on Limit Setting and Discipline

## Pre and post changes

**Table 15**

1=Strongly Agree 2=Agree 3=Disagree 4=Strongly Disagree  
 Item #5 Sometimes I do not understand why my children misbehave. N=51

	Mean Score	ST Deviation	t Value	p Level*
Pre	2.37	.56	-1.67	.05
Post	2.56	.72	* one tailed test	

**Table 16**

1=Strongly Agree 2=Agree 3=Disagree 4=Strongly Disagree  
 Item #7 I find that I yell and scream more than I should. N=51

	Mean Score	ST Deviation	t value	p Level *
Pre	2.74	.86	-2.54	.007
Post	3.06	.68	*one tailed test	

**Table 17**

1=Strongly Agree 2=Agree 3=Disagree 4=Strongly Disagree  
 Item # 9 Often I can't say no to my children. N=51 pairs

	Mean Score	ST Deviation	t Value	p Level *
Pre	2.37	.79	-.43	.33
Post	2.43	.78	*one tailed	

# Parents' Perceptions on Limit Setting and Discipline

## Pre and post changes

**Table 18**

1=Strongly Agree 2=Agree 3=Disagree 4=Strongly Disagree

Item #19 feel that I hit my children more than I should. N=51

	Mean Score	ST Deviation	t Value	p Level *
Pre	3.37	.89	.29	.38
Post	3.33	.82	*one tailed test	

**Table 19**

1=Strongly Agree 2=Agree 3=Disagree 4=Strongly Disagree

Item # 22 My children do not pay attention to me when I tell them what to do.

N=49

	Mean Score	ST Deviation	t Value	p level*
Pre	2.59	.97	.23	.41
Post	2.69	.96	*one tailed test	

## **Parents' Perceptions on Limit-setting and Discipline**

Parental efficacy in discipline , ways of setting limits and understanding of children's misbehavior were all important areas in the curriculum . Parents in recovery frequently have resorted to overly harsh punishments or do not set limits at all . Unhealthy role models for discipline can lead to abusive parental behaviors and guilt over addiction can result in a lack of discipline. Moreover, discipline is more problematic for parents in recovery where the child has been separated from the parent . When children have spent considerable time in the care of another family member or a foster parent they come to feel that their parents are not legitimate sources of authority. The PIR program devotes sessions to understanding why children misbehave and how to set limits in constructive ways. The program also explains to parents that it is in the best interests of their children that they support the rules that are set up for discipline in the kinship or foster home except where there are reasons to suspect abuse.

As shown in table 15, parents reported in both pre and post scores that they did not have an understanding of their children's problem behaviors. In the post scores ,however , there was a statistically significant change ( $t=-1.67$ ,  $p=.05$ ) in which parents came to feel they understood their children's misbehavior better. They moved from a mean score of 2.37 in the pre test to a mean of 2.56 in the post test more toward disagreeing that they did not understand why their children misbehaved

Table 16 contains the item concerning yelling and screaming at children that appeared in the group of variables on communication skills . Since this item also is a factor in discipline it is presented again with this group of tables. In the pre scores parents felt that they yelled too often . In the post scores parents reported that they disagreed that they yell or scream more than they should. The mean score changed from 2.74 to 3.06 which was a statistically

significant change in feeling that they yelled too often at their children ( $t=-2.54$ ,  $p=.007$ ) .

Table 17 reports on the parents' ability to set limits with children by saying no . Parents tended to agree in both pre and post scores that they had difficulty in saying no; however , there was some improvement in the post program responses of parents to being able to set limits. Yet the mean scores changed from 2.37 to 2.47 which was not statistically significant ( $t=-.43$ ,  $p=.33$ ) .

Parents reported in both pre and post scores that they did not agree that they hit their children more than they should (table 18) . The change in post scores is not statistically significant, indicating that there has been no real change for parents .

This suggests several possibilities : one is that parents may not use hitting as a means of discipline. Another is that it is not socially desirable to hit children and therefore parents would not report doing so, especially for parents who have been suspected of physical abuse and would fear having their children placed in the foster care system. Another explanation from the other end of the spectrum is that some parents may believe that hitting their children is acceptable . Finally, it may be that the parents' greater understanding of why their children misbehave , as shown in table 15 , has slightly increased their tolerance and empathy for their children's behaviors and deterred them from using hitting as a means of discipline.

Table 19 asks parents about how effective they felt they were in getting their children to obey them. The pre and post scores show that parents felt that they were not particularly successful in being able to get their children to listen to them . Only a slight improvement occurred after the program , from a mean score of 2.59 to 2.69 . The change in whether the parents felt their children do not pay attention to them , was not statistically significant ( $t=.23$ ,  $p=.41$ ) .

**Table 20****Average Pre-Post Changes In Visitation by  
Setting**

	<b>Women's Residence N</b>		<b>Men's Residence Day N</b>		<b>Outpatient Treatment/Methadone N</b>		<b>Total</b>
<b>Increased</b>	<b>8</b>	<b>40%</b>	<b>9</b>	<b>47.3%</b>	<b>2</b>	<b>22.2%</b>	<b>19</b>
<b>Same</b>	<b>11</b>	<b>55%</b>	<b>9</b>	<b>47.3%</b>	<b>10</b>	<b>66.7%</b>	<b>30</b>
<b>Decreased</b>	<b>1</b>	<b>5%</b>	<b>1</b>	<b>5.4%</b>	<b>1</b>	<b>11.1%</b>	<b>3</b>
	<b>20</b>	<b>100%</b>	<b>19</b>	<b>100%</b>	<b>13</b>	<b>100%</b>	<b>52</b>

### Changes in Visitation by Treatment Setting

In table 20 the average pre-post changes for each of the settings is presented. Tables 20 drew data from 52 participants on the pre and post from the questionnaire item "How often do you see your children?". The frequency of the changes in frequency and the setting where the PIR group was held are presented in this table.

The greatest percentage of increase in visitation occurred among the fathers in the men's residential treatment program. Of the 19 fathers who completed the program, nine, or 47.3%, saw their children more often. Two of these nine fathers reported that they had seen their young children for the first time either during or shortly after the program. The next largest increase in visitation occurred for the women in residential treatment. Out of 20 women, eight, or 40%, increased the frequency of visits with their children. When comparing the increases in contact between the men and women in residential treatment it needs to be noted that women had more frequent contact with their children in the pre program measurement.

A clear finding in Table 20 is that the greatest increases in visitation occurred in the residential treatment programs. This suggests that the residential settings, where there was a more intensive form of treatment, resulted in greater changes. Although the number of outpatient respondents was small, (n=13), there was a lower percentage of change. In this group, only 22% of the parents increased the frequency of their contacts with children.

Table 20 shows that a total of three parents decreased the frequency of their visits. In two of the cases the parents went from seeing their children once a week to seeing their children twice a month. Both parents, one a father and the other a mother, lived in residential treatment. While it is not known if the change in visitation was due to the requirements of the residence and the

parent's recovery plan, it is often the case that residential treatment has highly structured rules concerning off-site privileges.

It is important to note that the question does not ask about contact with children by telephone or mail. The third case in which visitation decreased was a father in the men's residence . He went from seeing his children on a daily basis to seeing his children on weekends. To better understand this case I looked at the final item on the questionnaire which asks for a written response to the question "What , if any changes, do you see in yourself as a parent since you took the parenting skills group?" This father wrote " ( I am) playing more of an active role in their lives by being there and being clean and sober. Learning from them, loving them , and helping them to grow. " It is quite possible that he and other parents called their children more frequently during and after they were in the PIR program than before the program.

**Table 21****Frequency of Visitation Pre Post by Setting**

	<b>Women's Res.</b>		<b>Men's Res.</b>		<b>Day treatment MMTP</b>	
	<b>pre</b>	<b>post</b>	<b>pre</b>	<b>post</b>	<b>pre</b>	<b>post</b>
<b>Daily</b>	<b>0</b>	<b>3</b>	<b>1</b>	<b>1</b>	<b>4</b>	<b>4</b>
<b>Weekly</b>	<b>7</b>	<b>8</b>	<b>4</b>	<b>7</b>	<b>3</b>	<b>3</b>
<b>2x month</b>	<b>7</b>	<b>6</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b>1x month</b>	<b>3</b>	<b>0</b>	<b>3</b>	<b>5</b>	<b>1</b>	<b>1</b>
<b>no Contact</b>	<b>3</b>	<b>3</b>	<b>9</b>	<b>3</b>	<b>1</b>	<b>0</b>
	<b>N=20</b>		<b>N=19</b>		<b>N=13</b>	

### **Frequency of Visitation Pre and Post by Setting**

One area of concern for parents in recovery is that during treatment for substance abuse they may not maintain adequate contact with their children. A goal of the PIR program is to both help parents stay connected to their children and also improve the quality of the parent's interaction and communication during time spent with children.

In table 21 figures are presented on various rates of visitation before and after the PIR program in the three settings. As could be expected, subjects in the women's and men's residences would not be able to see their children on a daily basis since the parents were not living in the same household as the children. Parents in the outpatient settings of day treatment and methadone, however, were more likely to be able to live with their children and therefore see them every day. Therefore although they are a smaller sample (13) outpatients have the highest number (4) with daily contact. The largest category for visits among women in residence (7 pre and 6 post) and outpatients (4 pre and 5 post) is twice a month. The policy for visitation when children are in public foster care is for visits to take place twice a month. Therefore this pattern of visitation reflects the placement status of the respondents' children.

Weekly and twice a month visitation are the most frequently reported patterns of parent-child visits pre and post program for all three settings. In the pre program measurement 14 women in residence saw their children either weekly or twice monthly. In the post program measurement 15 women saw their children weekly or twice monthly. The combined weekly and twice monthly visits for men in residence increased from 6 pre program to 10 post program. More than half the men (9) at the start of the program had no contact at all with their children. After the program only 3 fathers reported having no contact with their children. This change can be partially explained by the fact that many of the fathers had spent some time incarcerated before coming into treatment.

**Table 22**

**Average Changes in Visitation Frequency  
Women's Residence**

	<b>Pre</b>	<b>Post</b>	<b>%Change</b>
<b>Daily</b>	<b>0 %</b>	<b>15 %</b>	<b>+15 %</b>
<b>Weekly</b>	<b>35 %</b>	<b>40 %</b>	<b>+5 %</b>
<b>twice monthly</b>	<b>35 %</b>	<b>30 %</b>	<b>-5 %</b>
<b>monthly</b>	<b>15 %</b>	<b>0 %</b>	<b>-15 %</b>
<b>No contact</b>	<b>15 %</b>	<b>15 %</b>	<b>0 %</b>
<b>N=20</b>			

**Average Changes In Visitation Frequency for Women in Residential Treatment**

Table 22 presents the averages for various patterns of visiting between parent and child and the changes from pre to post program that took place. The first category of visitation is daily. Here there was an increase from 0% before the program to 15% who began to see their children every day in the measurement taken after the program. A smaller increase occurred for women seeing their children once a week. Before the program 35% saw their children weekly and after the program 40% saw children weekly. Twice monthly contact decreased slightly from 35% pre program to 30% after the program. The 15% or three women who had reported seeing their children monthly before the program was reduced to 0%. Since there was no change for the 15% who had no contact with their children the 15% with monthly visits pre program would have to have increased the frequency of their visitation.

The changes in visitation reflect the ability of women in residence to increase the time they spent with their children while in recovery. In the pre program data daily and weekly visitation combined were 35%. After the program 55% of the women reported that they saw their children either daily or weekly.

**Table 23**  
**Average Changes in Visitation Frequency**  
**Men's Residence**

	<b>Pre</b>	<b>Post</b>	<b>% Change</b>
<b>Daily</b>	<b>5.3%</b>	<b>5.3%</b>	<b>0%</b>
<b>Weekly</b>	<b>21%</b>	<b>36.8%</b>	<b>+15.8%</b>
<b>Twice Monthly</b>	<b>10.5%</b>	<b>15.8%</b>	<b>+5.3%</b>
<b>Monthly</b>	<b>15.8%</b>	<b>26.3%</b>	<b>-10.5%</b>
<b>No contact</b>	<b>47.4%</b>	<b>15.8%</b>	<b>-31.6%</b>
<b>N=19</b>			

**Average Changes in Visitation Frequency - Men's Residence**

Table 23 shows the averages for various patterns of visiting between fathers and their children and the changes from pre to post program that took place. The greatest change that occurred in visitation is found among fathers who reported they had no contact with their children in the pre program measurement. Before the program 47.4% had no contact with their children and after the program only 15.8% reported that they had no contact. It should be noted that within this group were fathers who had not seen their children in several years and fathers who saw their children for the first time. Although some of the men in the residence have had a history involving incarceration, they were required to have a minimum of 60 days in the residence before being allowed into the parenting program. As several of the fathers reported, they did not focus on parenting issues until the program was offered by the agency. Once they were in the program the men expressed strong feelings about seeing their children. (This will be presented in more detail in the qualitative section.)

A significant change from pre to post program was the percent of men who saw their children weekly. In the pre program measurement 21% of the men reported weekly visits and after the program weekly reported visits increased to 36.8%. Twice monthly visits increased from 10.5% to 15.8% and monthly visits increased from 15.8% to 26.3%. Pre program 15.8% of the men reported they had monthly visits and after the program monthly visits reported increased to 26.3%. Combined, the weekly, twice monthly and monthly visits increased from 47.3% pre program to 78.9% post program.

The increased visitation among fathers suggests that when men enter treatment for substance abuse they also can be helped to improve their ability to be parents and become engaged with their children.

**Table 24**

**Average Changes in Visitation Frequency  
Outpatient Day Treatment / Methadone  
Maintenance**

	<b>Pre</b>	<b>Post</b>	<b>% Change</b>
<b>Daily</b>	<b>30.8%</b>	<b>30.8%</b>	<b>0%</b>
<b>Weekly</b>	<b>23.1%</b>	<b>23.1%</b>	<b>0%</b>
<b>Twice Monthly</b>	<b>30.8%</b>	<b>38.5%</b>	<b>+7.7%</b>
<b>Monthly</b>	<b>7.7%</b>	<b>7.7%</b>	<b>0%</b>
<b>No contact</b>	<b>7.7%</b>	<b>0%</b>	<b>-7.7%</b>

**N=13**

## **Average Changes in Visitation Frequency - Outpatient**

Table 24 presents data on average visitation patterns between parents in outpatient treatment and their children. This group includes parents who attended methadone maintenance programs, out-patient clinics and day treatment programs. There are few changes in visitation between pre and post measurements in this group . Almost a third, or 30.8%, saw their children daily, suggesting that they were raising their children in their own households. This percentage did not change after the program.

Another third or 30.8% of parents saw their children twice a month prior to the program. After the program this increased to 38.5%. This change in twice monthly visits is one of the few changes in this group. As previously mentioned, twice weekly visitation suggests that children may be placed in non-kinship or court ordered foster care. The other change that occurred was that the one parent (7.7%) who reported having no contact began to see the children twice a month.

**Table 25****Living Arrangements of Children Pre Post by Setting**

	<b>Women's Res.</b>		<b>Men's Res.</b>		<b>Day treatment</b>	
	pre	Post	pre	post	pre	post
With Participant Parent	0 0%	0 0%	0 0%	0 0%	3 19%	3 19%
With other parent	3 16%	1 5%	15 79%	14 74%	2 13%	2 13%
With a relative	12 63.%	13 68%	4 21%	4 21%	4 25%	4 25%
In Foster care	4 21%	5 26%	0 0%	1 5%	7 45%	7 45%
	N=19		N=19		N=16	

## **Living Arrangements of Children**

Table 25 contains numbers and percentages for the living arrangements of children in the pre and post scores . The table shows that the overwhelming majority of children did not live with the parent who participated in the PIR program either before or after the program and that there were very few changes in the living arrangements of children before and after the program of all the settings.

A large portion of the children of men in residence however , lived with their mothers (15 pre and 14 post) but very few children whose mothers lived in residence lived with their fathers (3 pre and 1 post) . It is however possible that the higher number of relatives caring for the women's children (12 pre and 13 post) were members of the father's family or the fathers themselves.

Parental care and relative care combined for children of the women in residence was high, 79% pre and 73% post. For men in residence parental care and relative care for children was 100% pre and 95% post. For both populations the implication is that there is strong support of the extended family although men seem to have slightly more family support for their children than women.

The only participants who lived with their children were 3 parents from the outpatient group. Outpatients also had the highest number of children reported to be living in non-familial foster care. This implies that parents in the less intensive treatment settings at the MMTP and day treatment programs have less family supports.

The item on living arrangements for children was problematic for several reasons and therefore the conclusions that can be drawn from the data are limited. To begin with I did not offer the choice of the children living with a *parent* . I obtained that information by reading over the forms and seeing that some respondents added mother or father next to *relative* or *foster care* . In

addition there is the possibility that when *relative* was checked off without explanation , the relative could have been a parent . Another problem occurred with the choice *foster care* which did not distinguish between kinship foster care and non-kinship foster care . I did not ask about legal circumstances of placement and so it is not possible to know if placement were voluntary or court mandated for any of the children in foster or relative care.

The overall finding showed that parents and children were still living separately after the program. The program lasts approximately three months and treatment for drug abuse takes considerably longer which would explain why the living arrangements have not changed. The data here suggest that on-going and long term programs that reinforce visitation and positive parental behaviors need to continue.

## **Behavioral Survey - Post Program**

- 95.8% I speak in a more encouraging way to my children. N=25
- 95.8% I praise my children more. N= 24
- 89.5% I talk more with the people taking care of my children. N=19
- 88.9% My children seem to be doing better in school. N-18
- 87% I have made more phone calls to my children. N=23
- 83.3% I see my children more often. N=23
- 81% I have had less arguments with my children. N=21
- 77% I can say no to my children when I need to. N=22
- 72.2% My children seem calmer. N=18
- 62.5% I have taken my children out for a pleasant activity. N=24
- 52% I have written a letter to my children .N=25

## **Discussion of Behavioral Changes**

There are eleven items pertaining to parental behaviors in this chart. Parents answered yes or no to the statements listed in each item. Most of the parental behaviors are based on topics covered in the PIR curriculum .

The two most frequently reported behavioral changes had to do with positive verbal communication with children. Communication skill development is a goal of several sessions in the PIR curriculum. In response to the statements " I speak in a more encouraging way to my children" and "I praise my children more." over 95% of the parents answered yes.

The next most frequently reported change also involved communication. Here the communication was with the caregivers of the the parent's children. In the first session of the PIR curriculum there is material on the importance of the parents' support of kinship and foster caregivers. In most cases , a family member is caring for the parent's child. Often it is the mother , aunt or a sister of the parent who has custody of the children. The implication of the reported increase in communication with the caregiver is that the parent has a better relationship with members of the family.

The item on children's improvement in school performance was reported by 88.9% of the parents. The curriculum emphasizes helping parents mentally stimulate their children. It is also possible that once parents are in recovery , children are better able to focus on school rather than on the crisis of the parent's untreated addiction.

A high percentage of respondents (87%) reported that they make more phone calls to their children and 83.3% said that they saw their children more often. The PIR program encourages parents to have more contact with the children. Parents are given report forms and are asked to fill them out when they have visits and phone calls with their children.

The next two statements concern discipline and limit setting which is an

important topic covered by the PIR curriculum. To the statement "I have had less arguments with my children" 81% agreed and to the statement "I can say no to my children when I need to." 77% agreed. This indicates that parents are less punitive and contentious with their children but also more able to set limits .

The item about taking children out for a pleasant activity was less frequently reported ( 62.5%). This may be due to several restraints on the parents. Parents with ACS cases may be allowed only supervised visits with their children. When children are in foster care visits may take place only within the agency. Additionally, parents in residential treatment may only be able to see children on the premises of the residence.

In the final item ( 52%) of the parents reported that they wrote letters to their children. In some PIR groups parents who have limited contact with their children are assigned to write letters to their children. Parents who see their children may not initiate the writing of a letter.

## Qualitative Data Analysis

The qualitative data presented in this section is drawn from transcripts of interviews conducted with 10 parents who completed the PIR program , samples of journal work from the total sample , and written responses to the final questions on the pre and post questionnaires also from the total sample. The 10 interviews were conducted at the women's residences , the men's residence , the day treatment center and the methadone maintenance clinic. The focus of the interview guide was to examine how parents who completed the program became engaged in the learning and group work process of the PIR program. The guide is also an investigation of the components of the program that parents valued , found thought-provoking. and may have used to change parenting practices and attitudes .

### Organization of the Qualitative Data using the Group Engagement

#### Measurement

To better understand and organize the qualitative data on engagement in the PIR group I have used a theoretical construct that analyzes and measures the engagement process . The instrument entitled the Group Engagement Measurement (GEM) , was developed by Mark Macgowan and is described in a 1997 article published in the Journal of Social Science Research. The GEM is a 37 item instrument that Macgowan developed to measure engagement in groups . Macgowan's scholarly work brings together a wide range of ideas from group work theory about the elements and dynamics of member involvement in social work groups . Macgowan identified seven dimensions. (1) Contracting (2) Attendance (3) Contributing (4) Relating to the group worker (5) Relating to group members (6) Working on one's own problems (7) Working on the problems of others. Macgowan posits that for a person in a group to be

fully engaged all seven dimensions are called upon. He writes -

Engagement is a multidimensional construct which suggests that a member may be engaged in one dimension and not others. However, a group member is not fully engaged in social group work until there is minimal evidence of engagement in all seven dimensions. Thus, a member is engaged in social group work when there is evidence of attendance, verbal contribution and or participation in group activities, support for the work of the leader, interaction with members, adoption of the mutual contract, work on own problems and helping members in their work on their problems. (Macgowan, 1997, p.24)

Over the years the program has grappled with the problems of early termination and dropping out. As a result, much thought has gone into designing ways to motivate and engage participants. (It should be noted that even when a parent relapses by using drugs, they can continue in the group if the parent resumes substance abuse treatment shortly after the relapse.)

The elements of engagement in the PIR program closely parallel those presented by Macgowan. They are (1) processes of contracting and recruitment (2) attendance (3) verbal participation through journal reading and group activities (4) contributions to curriculum development and written work assignments (5) the relationship of the member to the group worker (6) the relationship of the member to the other group members.

The qualitative data concludes with a summary of comments from the interviews and written feedback from the questionnaires on what changes the parents felt took place as a result of participating in the group. This section not only tells us about the changes that the parents thought had taken place in themselves, but the qualities that parents saw as being within their grasp and potential. Perhaps some of their comments about the changes in themselves may seem too good to be true. If there is an element of idealization and wish fulfillment in the comments there may also be a glimpse of how parents visualize their better and future selves.

## **Contracting Phase**

Contracting is the first of the seven dimensions of engagement in the Macgowan construct .The dimensions of the pre-contracting and contracting phases of the PIR group are aimed at securing a real commitment based on being fully informed about the purposes and goals of the program. Whether parents join voluntarily or involuntarily , as is often the case, the process of contracting can foster engagement and commitment . In this excerpt the parent's resistance was lessened when her autonomy was respected and she felt she had something in common with other women.

*I have a case with family court so I knew that I really had no choice but to take parenting if I want to get my family together. But when I got to the orientation session they were willing to listen to me and the other mothers . I saw that we had a lot of the same issues and I started to think that I could learn something.*

This parent's comments reflect the complexity of the issue of voluntary versus involuntary participation .

*Did I feel I was given a choice? My caseworker said I had to get into the program. But I've always had a choice, to use what's offered to me for my recovery or to go AWOL and break my promise to my kids and myself.*

This mother spoke resentfully of the trauma her children suffered when she was arrested for selling drugs . While she felt she had to appease her caseworker , she came to feel she needed help for her drug dependency.

*When I signed up for the program it was first because I had to prove to my caseworker that I was taking a parenting skills class even though I know how to take care of my children. The certificate was one way to prove that to her. Now I feel that I need to prove to myself too that I can be the mother I used to be before my addiction got out of control.*

The motivation for joining the program was different for each parent depending upon the circumstances of the parent's entry into treatment and stage of recovery. One of the first areas of inquiry in the interview was to try to understand what motivated people to join the parenting skills group. The following are responses to the question "What did the chance of earning a certificate mean to you?" For some parents the certificate was a first in their lives. The proof that they could complete something that took effort. This proof was purely personal for some and for others it was evidence they needed to show caseworkers or court officials. For still others the certificate was like a gift they were giving to their children.

*When I heard that I could get a certificate I felt pleased . I never finished anything. I said my goal was to accept the decision I'd made to give my child to her father. Of course I have to do that myself but the group has helped me to stop beating myself up about this and the group helps me find ways to stay connected to my child.*

The anticipation of giving the certificate to her son helped motivate this mother :

*I wanted to get the certificate, it's the least I could do since I've never gotten any degree from school. But I'm going to give it to my son when I get it . He helps me do the assignments because, you know, my English is not too good. So he's earned it too.*

Beyond getting a certificate were more complex motivations . In the following excerpts are heard the conflicts and tensions behind the wish of the parent to become more involved and nurturing and the struggle to stay drug free. In this excerpt the ambivalence of one mother emerges around her fear that she could not cope with the stress of handling her five children.

*When I came here I said to myself, I'm going to get my kids. Well I haven't really had my kids in my life. I lived with my mother but basically she took care of them . I got to a point where I said that I've got to get into recovery, get my own apartment . I have five kids and I*

*can get my kids. Then when I heard about parenting I said that I have to get into that so that I can get my kids, There are a lot of things I've thought about since then and probably it's not right to try to get them all because there is so much stress on me. My recovery has to come first.*

Two single fathers discussed their wish to establish contact with children they had never seen and the tremendous odds they were up against. The difficulties mentioned by the fathers were as concrete as locating the child and as complex as their questioning whether they could assume the responsibilities of being a father. Another woman weighed her past struggles to stay drug free against the needs of her child. The comments of two parents who wanted to become more responsible but felt deprived of their own parents' attention and love is a frequent theme heard among addicted parents. Parents were also motivated by the situations in their children's lives and the pleas from children for the parent to get help.

The following comment comes from a father who, after 6 years of separation, saw his son for the first time since infancy during the process of being in the group. The father had been in the army when his child was born. The mother, also in the armed services, felt his alcoholism was out of control and with the help of her superior officers was reassigned to another post, taking the infant with her. The father stated in the interview that the loss of his wife and child soon led to his being dishonorably discharged. His alcoholism and drug use worsened. At his lowest point he slept on the subways and believed that he would die on the streets. This father saw the PIR group as the first real chance to find his son since he entered treatment.

*First of all I joined the group to reestablish contact with my son who I haven't seen in 6 years. I was very nervous when I heard the word parenting. I saw this as the opportunity of a lifetime to go ahead and learn. My family was concerned about me. They hadn't heard from my*

*son or his mother in 6 years. They were concerned about my life and me and my recovery. They knew that eventually those obstacles would have returned or surfaced. So my addiction had to be controlled first. Once they heard that I was taking a parenting class they said that was good and they hoped that I'd succeed .*

This father brought up the dilemma that parents in recovery have to face regarding their readiness for the responsibility of being a parent. This is an issue that has been echoed by others in the interviews . An important area of work in the PIR groups is to help parents make what are sometimes wrenching decisions about whether or not they are able to take on the responsibility of caring for their children.

The motivation of some parents for joining the program is undermined by the parent's own unmet developmental needs for love and attention. Roxanne, age 36, had never lived away from her mother who took over many of the responsibilities for raising her child . As one of seven children in a family with a working mother and an alcoholic father , Roxanne felt she never had the care she craved from her mother. While in the residence , Roxanne was able to have her daughter stay with her over the weekends . This was the first time she had cared for her daughter outside of her mother's home.

*I knew I should get into this group. When I started I didn't think I could handle my child. I just needed to stop using drugs and I thought that's how I'll become a better mother. But now I see how much I gave up my life to my mother and my child's father . They both took care of me . Now that my daughter has weekends here with me I see that she needs me and wants me to be her mother even though she loves my mother, she loves me and needs me more.*

Veronica , a meticulously groomed and poised woman , was a teenager when her daughter was born. She became addicted to heroin and would leave her

child with her parents. Until starting methadone several years ago , Veronica was more like an older sister than a mother to her daughter. When asked why she joined the group she said.

*I wasn't ready to be a mother before this. My parents were better to my child than I was. They could buy her anything she wanted and they spoiled her .What could I give her ? When I heard about the group I knew it was time. My family waited a long time to see me take over and be the mother and not just the bad child. The day of my graduation was the best day of my life .*

When I interviewed Ellen she showed me how she had had her certificate framed . According to Ellen she had been in six different recovery programs.

*I've never finished anything that I started . That 's the way we addicts are, we'll promise you whatever you ask for as long as we get what we want.*

What motivated Ellen to come into treatment this time was a crisis that threatened to unravel her troubled relationship with her 19 year daughter . Ellen had been an involved mother for the first five years of the child's life. Ellen and her husband owned a business and had enough money to send the child to a private parochial school. Ellen recalls how she took her daughter to the library and read books to her. But during these early parenting years Ellen was aware of destructive impulses that were just waiting to be unleashed. With easy access to the drug crack, Ellen's drug use spun out of control. When her child was five years old she brought her to her parent's home and for the next 14 years Ellen was in and out of her daughter's life.

*My daughter knew about my addiction and would come for money for her tuition and books. We got comfortable in a really terrible relationship. It would go like this, we would meet ahead of time , she would ask my husband for say \$35 and I'd get \$15 and she agreed to that in the beginning. And the tables turned on me. When I asked her*

*and she denied me and walked away she turned her back on me. I remember shouting to her "I'll never forgive you for this. " I realized that night that my daughter didn't turn her back on me, she turned her back on my addiction and I wanted to fight that truth but I sat in that hallway going through so much pain and the next morning I went into the hospital.*

The distress of the children was a powerful motivator for parents . This was the second time in three years that this mother took and completed the program.

*My first parenting class taught me so much , and basically my life has changed so much since then that I need to take it again. Okay, my reasons are that I just got back my daughter, The last time I took the group she was not living with me. She's been living with me now for 6 months and she's enrolled in school and she's in her first teenage years, she is 13 years old. She's experiencing peer pressure, the curiosities that teens normally go through ,and my purpose for taking the group again is to reinforce me and help me go through it with her whereas I can guide her through her trials and tribulations .*

Another mother spoke about her regrets and the need to come up with answers to her child about the history of her addiction.

*My personal reasons for joining is that I neglected my child and now that I started my recovery I found myself at a loss with my daughter , she asks questions that I can't answer . It felt good to have this group , because in my past parenting and everything of value I put on the back burner, in fact completely away from the stove, so it was extremely, in fact vitally important to me to pick up on this things.*

*To become a better parent. To understand a little more the job we have to carry out. It's not all about just buying clothes and food . It's about bonding. I want to be there for her emotionally, see how she feels.*

## Motivation

The engagement of group members depended on their motivation. In this section parents' remarks about their motivation are presented. They came from written responses to the question on the pre program questionnaire which asked " What do you hope to learn in order to help your children?" Most responses to this question expressed the wish that the program would help them improve the ways that they communicate with their children. Another theme was that parents wished to gain patience and understanding . Parents wrote about needing help in coping with children and this included the need to be more effective in setting limits.

*I want to learn how to communicate with her more nicely verbally .  
Learn how to have more patience.*

*To be patient , loving and understand . To have them depend on me a  
lot more and trust me again.*

*To get a better understanding on how to cope with teenagers, I just got  
my two girls back home again.*

*Well I want more information on how to help me to get through to  
my son. Sometimes I can't cope with him. I want to be there for him  
because he lost his father they were very close so he feels kind of alone  
and he doesn't open up with me.*

*How to better educate and be a role model for my son.*

*I need to learn to have tolerance for noise - sometimes its very easy to  
forget to listen.*

*To be consistent and strike a balance between honesty and discretion in  
sharing with them. To be patient.*

*Self-discipline and trust. How to communicate with my child since he has been away from me a long time. When to stay firm with saying no means no.*

The following are responses from the pre program questionnaire item "What are you most concerned about as a parent?" The most frequently noted concern was that the children were lacking faith and trust in the parents . Parents also wrote that they were afraid their children would become involved in drug or alcohol abuse. Parents express a fear of their own relapse. There is also the pervasive theme of guilt over the way the parent's addiction affected the children. Parents said they were concerned over the effects of separation as well as how they coped with stress .

*How to maintain calm when he gets me upset , how to learn patience and teach him the difference of his parenthood, me the mother and the foster mother.*

*I want to be able to handle having my three children back home again with me .*

*I'm mostly concerned about me relapsing when times might get rough. Being a mom in recovery is not easy and I want to be able to cope with whatever comes my way and be strong.*

Although there are other concerns for the children, such as school and sex education , these comments all contain the very real threat that drugs pose in the lives of their children.

*One of my children going down the road that I did.*

*That my child doesn't come out like me because they say drug*

*addiction can be hereditary.*

*To be more patient , loving and have them depend on me and trust me again. My oldest kids I don't want to drink or drug. I would like them to stay in school and not be shot up or killed.*

*My most concern is that my children go to school and be independent young girls ,also to make sure that they stay away from drugs.*

*Being able to protect her from drugs and telling her about sex. Also about her schooling.*

*My children understanding my addiction and that they never have to use.*

These parents remark about their separation from their children , the losses that their children have been through and the effort it will take to become adequate parents and reenter the child's life.

*I haven't seen them in years and I need to know if they are all right.*

*My most concern is doing everything I have to do to get my kids back.*

*I hope that this will give me the courage to get back into my children's life. That they will still love me and not judge me for leaving them.*

*Just losing all my rights and never being there to be a mother.*

These comments reflect parents' worries over the effects of their addiction on their children'.

*The welfare of my children and the effects of my abandonment toward them.*

*The damage my alcoholism and my absence has caused my children emotionally.*

*How what I did affects my children and I hope I haven't caused too much damage and if I have that I can repair it.*

*The health, welfare, mental states of my children.*

Parents' concerns in these comments touch upon communication skills . One parent mentions communication on the issue of disclosure about the parent's addiction and other are concerns about the overall management of parenting tasks .

*How to be a loving, caring and providing father and how to communicate with him . Staying clean and sober and passing on values, manners and good ethics.*

*I need to learn how to communicate. To stop yelling at them and using profanity.*

*The questions that will be asked of me about the past and there is a list of them.*

*My worry is teaching my 4 boys to grow into men.*

*I hope to learn how to play with them, listen to them and for them to learn from me . ...being a real father.*

*That maybe I won't learn how to love and care for them in a way to help them have values.*

*I don't know how to act like a parent.*

## Responses to Creative Writing Activities

One element in the early phase of a group is the establishment of a shared experience and the discovery of values that may be shared by group members . Macgowan's model includes the creation of a working alliance in which there is participation in the beginning phase of the group . To accomplish these aims groups have done a creative writing activity. In the first session parents write a poem that begins with the line "the first time I held my child'. Each person is given a file card and asked to complete the line . Parents are asked not to put their names on their cards and are told that they do not to make a rhyme . They are encouraged to be free in following their memories and feelings without trying too hard to make sense . After the cards have been collected the poem is read to the group . Hearing the poem read has been a dynamic way that the group finds the common ground in the universality of childbirth. Here is a poem from one of the groups.

*The first time I held my child*

*I knew I was truly blessed*

*My love blossomed all over me.*

*I was overjoyed at what I brought into this world.*

*The first time I held my child*

*I felt his tiny arms and hands*

*The bond of loved filled my life*

*The sense of belonging to my child made me warm.*

*The first time I held my child*

*I knew she was mine to keep*

*total and complete*

*I didn't know what to do.*

*The first time I held my child  
 He was a gift and I was scared  
 The moment of pain was relieved  
 I knew she came from heaven above  
 Now this feeling of holding her was nothing but love.*

*The first time I held my child  
 I said "My God, what a beautiful sight."  
 I didn't know I could do it.  
 Now what do you think?  
 The first time I held my child  
 I cried tears of joy.  
 To me it was a miracle.*

Despite the fact that most of the people in the program had never written a poem it was not difficult for the groups to come up with some highly expressive and sensitive writing. Some groups decided to write poems with opening lines that they suggested. Some of this poetry appears in the National Journal of Poetry Therapy (Plasse, 1995) The poem represents a collective expression of a universal experience. As one mother said, her contribution to the poem was but one aspect while others wrote about feelings that she also had but could not express without their collaboration and interaction .

*My baby was born premature , with drugs in his body . When Nettie read the poem, it was beautiful . It flowed . It was more about love than about pain. My part had the pain but I also felt joy, only the others expressed it for me.*

Doreen, whose daughter is 13 years old, said that she gave her daughter the poem and that she carries it in her wallet.

*My daughter tells people, I am a godsend , that was part of my line . I thought our group's poem was amazing and beautiful. Each person has their own vision and we all came together under one miracle, the miracle of a new life in the world.*

Ellen was in the same group as Doreen and said this about the poem.

*You see all of us has a few lines and the opening part was mine and I loved the way it sounded That was my first really happy experience in the parenting group ;but not the last. It's not just that my part was chosen to be first, but that it was a product of all the girls in my group . The feelings inside us are the most valuable things we have.*

For Mary and many of the other mothers, the birth experience was bittersweet.

*The poem brought back old stuff, memories, I was five months pregnant when her father left. I was in love. We were going to get married. I was in the hospital and I couldn't believe my baby was so beautiful. The group poem was nice, the group worker made a pamphlet out of it . I have it and I'll show it to her when she comes home. I never wrote a poem before.*

The fathers who took the program in the men's residence read the poem at their graduation ceremony . This father remarked about how he felt about the poem.

*I've never heard anything like it , the patchwork that comes together to make one . Everyone was saying the same thing yet in a different way. It was extremely beautiful because feelings were involved, not thoughts. It meant a lot to me. We read it at graduation. When Liz first read it back to us that's when it got to me. I never wrote a poem before, never read one before. I would love to read it to anyone who would listen. It really touches me, I catch emotions when I think of these things.*

## Responses to the First Assignment - Bonding

The first session introduced the concept that bonding with children can occur at any point in a child's life , not only during infancy. The assignment from the session asked parents to write about how they could create a bond or strengthen the bond they have with their children. Here is an example from a mother's journal assignment that shows her attempts to become closer to her son who is living with his grandmother.

*During the week I called my son and I told him we would spend some time together this weekend. If I tell him I am going to call him, I have to make sure I do it so he is not disappointed. Our bond could be broken if I don't . So when I got to my mother's house my son was expecting me. (Oh yes, I greeted him with a big hug and kiss , part of bonding too.) I took him out to Macdonald's and we sat and talked. I mostly listened because he had a lot on his mind. I kept eye contact with him, I saw pain in his little eyes so I figured just to listen to him . I find it hard not to interrupt. , but this is a learning process. It was effective to call him to set up the next date.*

Comments from interviewed parents tended to focus on the pain of not having a strong bond with their children and the struggle to begin a relationship or to regain a bond that was frayed by distance , neglect and conflicts within the family due to the parent's addiction.

This father was upset at his long distance relationship with his son but found ways to become closer to him.

*Since I am separated from my son it hurt me actually hurt me to do the assignment on how to bond with our children. Listening to other fathers talk gave me a lot of ideas. I never sat down with any fathers , even with my own father. It's scary that nobody takes parenting seriously. Now I can bond with my son on the phone talking about what he watches on TV. I can relate with him the things he does in school and I can remember how it was and the card that I send him and the things I send him through through mail, he'll definitely remember*

*these phone calls. Now things are starting to build up and it's beautiful.*

William, a father of five, was critical of himself and how he had tried to bond with his children.

*I learned that I do too many things at one time. I took the kids to Toys are Us and bought them a battery powered truck or a Nintendo, I mean I was cool. I was being a dad. I thought that was bonding, they always asked for things and I got them and they kissed me and said I love you. I thought that was bonding. But I had no real bond there. I didn't really know what was going on inside them...To me it's absolutely ludicrous . I should be coming closer to them after all I learned.*

This mother mentioned how she was able to feel close to her daughter at the time that her daughter began to menstruate. Here she brings up later sessions in PIR that contributed to the sense of bonding she had gradually developed with her daughter.

*Now the relationship (with my daughter) is much better. She says "Mom let's bond" She learned that from the homework which we did together. I showed her the paper on the sexual milestones and she read the whole thing and I asked her how she felt about it and she said everything was true and I haven't spoke to her before about it and she hasn't gotten her period and if it is wasn't for the class I probably would never have spoken about it. We touched a lot of subjects that we haven't touched before because of the assignments. You could say we bonded over them.*

### **Contributing and Participating through Journal Work**

Participation and contributing further a sense of belonging to the group and are dimensions of engagement in the GEM model of Macgowan. In the PIR group parents are required to write in their journals. The reading of the journal to the group became the parents' way to contribute to their own learning and

gave parents the opportunity to contribute to the group's education. Many parents were comfortable writing and found the journal enjoyable and a valuable learning tool. The following responses from the interviews show that even those who were not comfortable writing remarked that they thought the journals were valuable or that they learned a lot from them. Here are some responses to the question "What was the experience of doing the journal assignments like for you?"

Parents who had poor writing skills were self-conscious about reading in front of the group. They were assigned a partner to help with the assignments. Denise was a parent who got help from a group member and her counselor. If she had become discouraged by the journal writing she might have dropped out of the program feeling that she had failed once again.

*At first I had a hard time with the journals. But Ellen helped me get the spelling right and looked it over with me. N ( group worker) sometimes sat with me and we'd go over what I'd wrote. The journal assignment would be about the same problems I was having in my recovery. I got into it and the group liked it, what I wrote about. I never used to talk. Instead I'd act out, just get restrictions, lose my passes and then I'd end up on the street because I didn't want people to know my business. So it was very important that I'm talking now and that my journal made me open up.*

According to Ellen the journal was an important tool for surfacing thoughts and feelings that she could not express verbally. Ellen was one of the few parents who gone to college and therefore she better than average writing skills.

*I know it sounds contradictory but I didn't want to do the journal and yet I found that I'm best at putting my thoughts on paper. In the beginning it was painful but after you get them down on paper and then you read them back you go through that inner pain. The writing and the reading, they work hand in hand, the sharing whatever you write, it helps. I am capable of getting stuck. I said to myself ' oh my*

*god, I'm not going to read this to anybody'. But in the group you realize that you're not the only one who left their child alone. When you're at your lowest you say 'I'm not going to write this down', but just put it down anyway, don't get stuck in your negative thinking.*

One parent felt uncomfortable speaking spontaneously in the group. She found that the journal allowed her to prepare her ideas in advance. She participated through reading her written work to the group and felt she was appreciated by the group worker who praised her.

*I've found that I could express myself better in writing than in speaking. I think and it comes to me. When I read to the group this week, it was coming from my heart. The group worker writes 'excellent' or 'good' and it makes me feel good about myself.*

It did not surprise me to hear from Doreen that she had continued adding to the journal she started years ago when I had been the group worker. Doreen could write in a natural, conversational voice. Doreen had had years of therapy in and out of hospitals and she was a keen observer of herself, her child and the people in her world. She would hand me many pages of material full of self-scrutiny that were remarkably fluid and insightful. In the interview she spoke about the journal work.

*It benefits me when I reread the things I wrote, I learn. Do you remember the autobiography that I wrote? It was thirteen pages long. I've added more. Sometimes I get up at night and write for the journal assignments. If you write it honestly you will see things that you think you don't want to share with other people. And then when it's written down on paper you see you can in fact tell the group.*

For this mother a letter she wrote to her children helped to turn around her otherwise marginal involvement in the group.

*A lot of times during the reading out loud I'd be restless and impatient*

*and I'd be thinking' when is this going to be over? I've got to get out of here.' Then I wrote the letter to my children and I wanted to read it so badly and my counselor knew. So she let me read first . I started to cry and then before I knew it we were all crying and I haven't felt like running out of the group anymore.*

The following comment was made by a father who is a very articulate speaker but felt badly about his written skills.

*I did all the assignments and I hated them. I am an avid reader, I'll read anything but I don't write. My penmanship is atrocious. I don't even like to look at my paper. I don't wish to write, I like to communicate verbally. My skills are extremely poor.*

Another father used his journal to reach out to other addicted people when he began to work as a peer counselor.

*All my journal I carry around with me , it's in my bag. I keep it with me everywhere I go. I run and go get my stuff and read to the people I work with in the HIV outreach program.*

The journal can be used to help parents communicate to their families. This parent showed her journal to the father of her child.

*I don't say things to most people about how I feel . I'm not good at talking but I wrote things that I couldn't believe came from me until I read them to the group. I showed my child's father and he was so surprised and he said " Did you really write that ?"*

**Responses to the Sessions on Discipline and Child Abuse**

The journal work and interview comments concern the issue of discipline which is the focus of two PIR sessions . The curriculum offers parents alternative ways of setting limits and asks parents to report back to the group . The responses of parents confirm that they felt they needed help finding constructive ways to set limits. Parents reported that they were either too harsh in their discipline or neglected to assert their authority as a result of feeling guilty about their addiction .

Addicted parents often have a high incidence of abuse in their backgrounds . Here is an excerpt from a journal assignment written by a mother who expressed her resolve not to perpetuate the type of harsh discipline that was used in her childhood. The assignment asked parents to look at a list they drew up in the session on why hitting and screaming are harmful to children and write about them.

*I believe in punishment like taking away things from my son that he likes . Mostly I confine him to the house cause he likes to be out and I also take away his video games. I don't believe in hitting him because as I was growing up my father beat me and I always stated I wouldn't hit my child . I grew up disliking my father and maybe that's why I ran away and got into so much trouble. So I discipline my child as I see fit according to the behavior that's displayed . My son needs a lot of attention , the positive kind.*

As parents learned about the consequences of verbal abuse and harsh punishment they began to question their behaviors . In this comment from the interview this parent ,with a history of abuse, felt anxious about how she had disciplined her children.

*When it came to the part about learning about discipline that was pretty scary. I found that I did a lot of things wrong with my kids. When I see my kids it reminds me of the way I was raised. .I was verbally and very abused mentally and physically. I always said that I'd*

*never do that to my kids.*

This father's journal assignment for the sessions on discipline shows that he used some of the tools and skills for recognizing when and how to set limits.

*This weekend I took my son to the park. I let him run ahead of me and I ran with him. I watched as he picked up branches off the ground. He was very happy, I could tell. The way he laughed and sang, the way he seemed to be talking to himself. I noticed that when I played with him that when I called him to come to me he did not want to come to me. He just wanted to keep running around. That when I used a remedy, I ignored him then I told him that I was leaving. Then he'd come running to me, it felt good. At home he is always looking for attention. I try the best that I can to give him attention he needs, I know that I'm a little better. Thanks to parenting skills.*

Some parents felt they lacked authority to discipline their children because they were not sufficiently involved in the daily life of the child. Participants were asked if they found these sessions helpful or important. This father had come to question his approach to discipline.

*I'm the kind of parent that let their children get away with just about anything. I have a concept that I had prior to parenting skills. Give the child room to express himself ...not to impose my thoughts or ideology because if I try to then my lunacy would only show up in my child. But after taking parenting I realized that maybe preventive guidance is needed.*

Here a mother spoke about how her addiction undermined her sense of authority.

*I try to take the advice like to take TV away from my son. I didn't do that before, I didn't want him to get mad at me, so now I'm doing it, taking the TV away when he does something bad. He has an attitude problem ..I don't want him to think I don't love him. He always says that but now I put my foot down.*

The group workers' ideas about discipline were not always accepted . Here a parent recalls that the group debated among themselves and did not all come to the same conclusion.

*I listened to some of the parents and a lot of them said that they would discipline their kids in public, which I think embarrasses kids. Some parents defended hitting, they didn't go along with the group leader and other parents who said that hitting kids is always wrong.*

This parent remembered one of the central points from session 12 about why children misbehave.

*Kids misbehave because they want attention. If you are using you are not going to be concentrating on the children. We have to look into ourselves before we get angry with our kids.*

The session on discipline contained the concept that discipline was about learning rather than punishment for bad behavior. This parent remembered and seemed to understand that concept.

*I never thought about discipline being learning I always thought it was punishment for badness. Kids have reasons for bad behavior and we learned about the reasons so now its not so much about my children being bad as me asking myself what is bothering them.*

### **Sexuality of Children and Protection of Children from Sexual Abuse**

Children growing up in homes with an addicted parent tend to be at higher risk for sexual abuse . Some studies report that sexual abuse of children is twice as likely to occur in families where there is an alcoholic parent. In session 9 parents discuss their values and how they can protect their children from sexual abuse . An informal survey done in the day treatment center of the agency last year found that a majority of parents had been sexually molested some time during their childhoods. The themes in the following excerpts touch

upon a strong wish to protect the children from sexual abuse, the awareness of the dangers that children face when there is alcoholism and addiction among family and extended family members, and the need to evaluate whether they are putting their children at risk through their relationships with sexual partners. The sense of support from the group seems especially potent in helping parents confront this difficult topic. In the interviews parents were asked what they had learned and whether it was relevant or helpful to them as parents.

*That was a session I'll never forget. There were so many tears , people were crying about what happened to them. The group worker helped some of us comfort each other. Some people today don't like to be touched because of the past. We learned that we have to use the past to protect the kids today.*

This parent spoke about the group's resolve to protect the children.

*I remember there was a lot of pain in the room, we promised each other never to let this happen to our children.*

Some parents made the connection between drug addiction and child endangerment.

*I guess the most important thing I learned is that staying clean and sober is important not just because I need it but, we can't protect our children if we don't get help with this disease.*

This comment begins with the declaration that it is important to protect children from sexual abuse. This women's resolve may have been strengthened through being able to talk to other parents about her own experience.

*It's so important to listen and protect your children . If only my mother had listened to me. When I told her what my stepfather was doing to me she sent me off to live with my grandmother. She actually stayed with him and sent me away. I started drinking and drugging to drown out the anger and the pain . I know that my life would have been different if she had listened to me .*

This parent seemed to distance herself from people in her group around this topic which may have been too difficult for her to think about.

*If there's one thing I learned, I'm never to let it happen to my kids. Some people in the group have already got to live with that but I don't think I could ever forgive myself if I let anything like that happen to my kids.*

This father's use of irony and his critical attitude toward women was his way of creating distance from this difficult topic.

*It was kind of funny a how no one wanted to hear that their children had been sexual yet how many women were there who had their first babies when they were 14 or 15 ? We have to be better examples if the teens are going to take anything we say seriously.*

Like many women in recovery this mother may have been in an abusive relationship with a boyfriend or husband.

*I remember the assignment where we had to list the qualities of a father and what we liked in a lover. That was something. I just don't let a man stay over , it's too soon in my recovery and I got to thinking that I may never be ready to bring a man into my house again as long as I have my children there. My first job is to take my children home and keep them with me, safely.*

Doreen used the group to share her experience . She expressed the hope that in talking about herself she could help the young women in her group.

*Most of us need ongoing help . I take my daughter with me to a therapist ... I'd rather be a single mother than have a man in my house right now . The girls in my group are just beginning to really understand this and I think maybe I put some light on this for them . They know that I spoke up because they don't have to put their children through what me and my child went through.*

Men were also victims of sexual abuse . In the father's group there was a deeply felt need to be recognized which was accompanied by the feeling that they had been excluded from the support of their families.

*You know this doesn't just happen to women and girls. Lots of the guys in my group were abused as kids too. We broke down , we cried and we helped each other. We want to protect our sons and our daughters . Families need fathers , we don't want to be locked out, we want to protect our children too.*

### **Participation in Group Exercises and Communication Skills**

Macgowan's criteria for engagement includes "working on one's own problems" . Participation becomes more meaningful when it is characterized by self-disclosure of sensitive personal information or feelings ( Macgowan , 1997) . In the PIR program this dimension cannot be separated from what occurs in the interaction with others during group exercises. Group activities are often the vehicle for parents to become aware of personal problems and deficits in areas that are essential to the tasks of healthy parenting . Participation in group activities aims at developing communication skills . These skills are based on understanding the meaning of children's behaviors and responding appropriately.

In the PIR curriculum there are sessions devoted to communication skill exercises and role plays that focus on critical parent child situations . The following are responses from the mothers to questions about exercises and assignments during sessions on communication skills. The women in residence developed their own communication exercise of setting up telephone appointments with their children in the evenings. The parents spoke about the importance of listening and of learning how to say positive things to the children . They mention the learning that took place within the group when parents listened to each other's journal entries which included statements of praise that

they said to their children.

Marcella recalled the activity in which parents interviewed each other and practiced listening skills . They then discussed how it felt to be listened to.

*When we did the interview exercise I was with Vera, she looked into my eyes and my face, she didn't interrupt, she named my feelings with the right words. The other people in the group were all smiling at the end when it was over because we had that good feeling you get when someone really listens to you.*

Here is a description of how the women looked forward to telephone calls from their children in order to use their communication skills.

*Everyone in the group does the phone call appointments and when the children call we jump up to answer it and she (my daughter) knows them and they know her. I call her even to say how the group went. I've made the phone appointments and I found that she'll answer even before a complete ring. So many promises I've made and so many promises I've broken and yet she is still there on the other end of the line.*

In session 10, "Raising your Child's Self-Esteem" the journal assignment was for parents to write out ten statements of praise and encouragement that they could say to their children. This parent remarks about how it is not the same to encourage a child as to praise a child. This was a key concept in the session

*We had to find something in the child that would make us praise them. It isn't as easy for me to say something encouraging as it is to praise a child who is successful. But I keep trying with my children , they need it and I see how they light up.*

The obstacles that make it difficult to be verbally nurturing are summed up by

this parent .

*I'm much better at criticizing than at praising, I don't remember if my mother ever praised me . So it was difficult to find words to say something good about my kids even though I feel it. I picked up some ideas from listening to the other mothers.*

When this mother began a dialogue with her daughter about her addiction her own self-esteem improved. The daughter's acceptance then became a basis for the mother to speak in a way that enhanced her daughter's self-esteem .

*I didn't know how to talk to my daughter about my addiction before I started the group. The most important thing I'm learning is how to listen. I used to feel that she would throw my addiction in my face but she never did that. I remember writing about that and I showed her which felt good. It actually brought us closer. It helped me do the homework which was about self-esteem and praise. To write 10 statements and I never looked at it like that , that I didn't praise her for being so compassionate and this actually helps both of us feel better about ourselves.*

Doreen spoke about her communication with her daughter incorporating the idea of bonding from the first session.

*Not being judgmental, being there with unconditional love, regardless of what's right or wrong. You reprimand your child but you do it with love and respect. For a teenager communication is bonding. I try not to knock her down but accept her point of view even if I don't agree. I will tell her in a respectful way how I feel.*

This mother mentioned how the sessions on improved communication skills contributed to her understanding of the importance of praise and encouragement. She was helped by the suggestions of other parents in the group .

*The assignment to write out 10 things, I never looked at it that way*

*before . But when I tried to do it , then I knew I didn't praise her enough . I thought I knew how my child thought but the class helped me to find out more. Like the assignment where I had to turn off the TV and without distractions to talk. The eye to eye contact I never did that before. I don't let her finish, I interrupt her and if we don't let them finish we cut them off . I can now listen and be more patient.*

The discussion from the sessions on communication may have helped this parent recognize her dysfunctional ways of handling communication with children.

*I learned that I tend to hear what I want to hear. To be able to listen just listen to them express themselves without me cutting them off, it 's a part of my denial.*

Mercedes spoke about changes in her relationship with her son when she began to listen more and react less.

*My son asked me about each class. I tell him everything and he loves it. We talk more now. He used to scream and stamp his feet and it scared me. Now it's better. I don't interrupt him so he doesn't interrupt me. We try to hear each other's story. I never thought about eye contact until I learned that here.*

Here is a comment about session 8 in which parents practice the verbal skills of acknowledging children's feelings .

*I had a hard time with the identification of feelings, I really didn't get it at first. It's me, I know the right way to respond. The most important thing I learned in parenting skills is to listen to my child. At times I must listen and sometimes it needs feedback and sometimes it don't.*

## Relationships with the Group Workers

The Group Engagement Measurement includes the dimension of relating to the group worker (Macgowan, 1997) . One of the primary tasks of the group worker is to establish a therapeutic alliance in which rules and goals are established and guidance provided. Macgowan emphasizes that support for the leader will gradually be translated into support for the aims of the group. Group workers were valued both for their organization and management roles and for their warmth and sensitivity in reaching out to parents. This combination of authority and nurturing was valued by the parents. Being able to identify with the worker was important to parents. The worker is seen as having an insider's knowledge based on the fact that workers often were recovered addicts themselves or shared their experience as parents.

In this comment the parent perceived the caring of the group worker through her commitment to management and work tasks that had been part of the contract phase.

*Nobody in the groups I was in before cared as much about whether I did what I said or not. But N. is different. If I don't show up on time or do the work right she knows and she doesn't let me slip through the cracks. She wouldn't let me graduate until I did all the assignments. At first I thought she didn't believe in me but now I know that it was me that didn't believe in myself.*

The relationship with the group worker also called upon the worker to convey genuine affection and give physical comfort when needed. The caring of the group worker was especially meaningful to this woman who had been through a great deal of abuse.

*The group worker , she saw that I was beginning to draw back ... but she knew exactly what to do. I could have faded into the walls but she knew when I needed a reach out , a caress ....I really needed it because I just came out of an eight year abusive relationship physically,*

*mentally, spiritually abusive and for me it was 26 years and so much pain that's still in me. But the group worker wouldn't let me just isolate. In other programs I didn't speak, I didn't participate. This is different, they really care and try to get you to feel that it's okay, it's safe. They don't make it easy for you to hide.*

This parent felt that the group worker, like a good parent, helped to make the group feel like a warm family.

*The group worker made me comfortable. They would speak to us like so warm and like family.*

The group worker's skill in controlling group dynamics and keeping order helped this group member feel the group was a safe place to share her thoughts and feelings.

*They helped me out and we had really great conversations with not everyone's talking at the same time. Only groups I've gone to are NA meetings but it's not the same. I'd be to myself, I'd be scared. This was different even though NA is confidential and it's the same in the group but I felt comfortable and I was able to say anything.*

The leader's willingness to talk from personal experience was important to some of the women.

*J. really understands. it's not like he's up there and we're down below. He's been there too, he even tells us about his kids and that he's still learning with us.*

The group worker here is perceived as being unpretentious but one whose opinions were respected.

*N. is like one of us. She made me feel that whatever I wrote, it was okay as long as it was coming from the real me. She helped me get over my nervous feelings about my writing. She understands and is patient. She knows where I am coming from.*

The disclosure by the group worker about her own parenting issues helped this parent feel a rapport with the worker. The worker did not just talk about herself but listened to others.

*She was very open. She took in everything that each individual in the group said. It was beautiful that she responded to everyone and she was a parent too and she explained about her children. It made it helpful. I look at how people cope especially people who work with addicts and then go home.*

This father spoke about the group worker and how he expected her to help him make his first contact with his son. He came to understand that he would need to do this himself but that she would support his efforts.

*When I first come into the group I thought she would make the contact for me, that she'd know the procedures that she'd be the one picking up the phone . She turned that around on us and we had to be responsible for being the contact person. I wanted her to be with me the first time I called.*

The group worker can sometimes serve as an external superego for group members. This seems to be true for this women in her struggle with authority and with her own self-destructive impulses.

*She makes me feel better knowing she's running the group. If I'm thinking of doing the wrong thing or going somewhere . When you're used to doing things your way, you can't accept criticism and how I have to ask myself what part did I play in this. Usually I'd have something blocking me, an attitude of "Who do they think they are?"*

Here again the worker's role as authority is appreciated by a parent.

*She allowed me to be myself, she allowed the group to express themselves, there were some immature people who wanted to play but she kept that more or less under control.*

This parent felt the genuine caring of the worker gave her confidence and allowed her to take some risks within the group.

*The group workers gave me a lot of feedback and it makes me feel*

*confident . Even if it's negative they let you talk. I've been to a lot of programs but here the counselors are more close, they hug you and talk , even if you need anything they go out of their way more than they have to.*

### **Relationships with Group Members**

Parents with substance abuse problems often have few friends and are prone to depression and isolation. Discussions in the PIR group often follow the reading of the journals when problem-solving and expressions of support and encouragement are voiced. In one of the final sessions a list of community agencies and resources is compiled . The group worker encourages parents to add their names and phone numbers to the list . As the PIR groups come to an end some of the parents have continued with peer-led support groups using the agency facilities for meetings. Here are some responses to questions about the impact of group members on each other and the need for continuity.

*I know we'll need each other when this is over and we're surrounded by the people, places and things we left before we came to live here.*

This mother felt that she would be able to call the women in her group. In making the resource list parents offered their telephone numbers to be added to the list.

*There are women I know I will call then I'm back home. Some of us have the same issues. It boils down to nothing is different , you've heard it all on the news . But it is good practice for me to hear what other people have to say. It's easier for me to share my experiences in the group with people who have been there. They always say " each one, teach one" . You learn from someone else that you're not alone.*

Denise was a parent whose social skills were very poor and her trust in others tentative at best.

*There are 36 girls here ( in residence) and not all are here for the same*

*reasons. I would have to say that now I have some trust, I learned, you're not going to trust everyone . But in the group we all have been through things and we admit to what we have done to our kids while we were druggin.*

Veronica had been dependent on her parents but became more connected to the group members .

*I always turned to my parents for help but the group said, you are the mother and she is the child, you need to be in control . Their feedback was so great, they made me feel like I could accomplish anything with my daughter.*

Doreen spoke of the importance to her of learning from others in the group.

*When people share their experiences in their journal I just listen to learn. All of us have been through so much we have so much to learn from each other and I always learn something, even if I can't use it today. Not everything applies to me and I may share something that others can use but nothing is really lost or wasted.*

For this father the group had experiences in parenting that he learned from as he was beginning to think of himself as a parent.

*Everyone has a different story and I loved it. It gives me ideas about how to be a father, some have been there and done that . I used them to study how not to make some mistakes I learned from them. They learned about my pain.they learned that they had the chance to be with their kids. I felt a jealousy of men who have been there and seen their children walk and talk . It makes them think, it is not a game, to get their lives together and we fell into a bad situation . I thank God for the parenting program, so many places don't have any.*

This father saw the group members as sources of on-going support.

*I'll definitely keep in touch with the men in the group. It's for my*

*health, it's very easy for me to discuss my business and to ask them about theirs. We're in close contact and we will do things together with their children. I'm getting a trip together to go to Great Adventures ..we went to Ringling Brothers . When the children are there everything else changes, we have to share this.*

William was reluctant to change his detached style of relating to people.

*I am estranged from friends and relatives .I've never had a phone book, I've never called anyone. I feel that friends can lock you into positions and you can't move on and do new things . That's just for me. ..I like to travel and broaden my scope in other areas and that's one of the problems that I have with my family. I lack stability . To those that are a friend to me I can be a friend. The experiences I've had in the group are a part of me. There are one or two people that I can call but the bond of friendship I am not extending to everyone.*

### **Parental Responses to the Impact of Addiction on Children**

The following responses come from the interview question "How do you think your addiction affected your children? " . Parents describe a range of emotional distress among the children which includes developmental delays, learning difficulties , social and behavior problems. The final comment , from the other end of the spectrum of concern, comes from a father who describes himself as a functional addict and denies that his children knew or were affected by his addiction .

This excerpt captures what most parents felt was the most painful effect : the loss of trust between parent and child. Her children were not protected from the downward spiral of her addiction.

*I'd say it's not trusting me, that's number one. And it's getting it to come back because Mommy says she'll come back and promise them something and then don't do it. I could say pretty much my kids is hyper, very hyper. They don't stay still, they do things to get my*

*attention. My oldest, me and her we were always closest. She was so close I didn't want her around because she knew when and where I got high..she used to take her bike and ride and look for me and she'd find me and I'd be high and I'd say 'go back home' and she'd go to the corner and follow me. I'd find myself running from her ... She's now having problems in school and she didn't come home but stayed at a girl's house. So now she's with an aunt. The younger ones love their grandmother but they want to be with me. They are so smart, when I used to leave and go and drug you know my son, the baby he used to cry and cry because I used to leave out the house and I'd never come back for days and when I came back he'd scream and nobody could control him.*

This mother describes the reversal of roles between parent and child and the trauma of separation .

*My daughter has been through so much , she has been in foster care twice, she's seen me go through so many things and sometimes she feels she has to take care of me . She wants to grow up so fast and I'm afraid she's already too fast with boys. Sometimes I feel sad because I missed out on the early childhood years but then again there was nothing I could do about it, drugs is a disease . My upbringing and society stopped me from having that time with my daughter.*

Failure to assert parental authority is described as an effect of addiction.

*I always felt that I couldn't punish her or hit her because of my addiction. I thought she'd throw that at me. I wouldn't do anything, I'd let her do anything she wanted. She didn't see me as her mother .*

A mother describes feeling like she neglected her child and may have caused serious emotional problems that have not yet unfolded.

*I believe that I've failed my child. I don't feel I was there enough in her life. The fact is, she's been through traumas. At my sister's it was noisy, she had to adjust with me being in and out. My sister was active. I*

*asked the group leader if she was going to explode because of all she's gone through . She holds things inside. She still worries that I am in the streets. She really misses me. So many times I've started and stopped, people lose trust in you. I've asked her if she wants to come to me and she'll say she misses me but no she doesn't want to live with me now.*

This mother felt that one of her children suffered developmental delays due to the separation from her.

*The fact that my kids are not with me now. Thank god they are with my mother and not in the system. They cry and have tantrums when I have to leave . They miss their home and their toys. My youngest son's speech seemed to stop developing the day he was separated from me.*

Poverty and homelessness added to the effects of addiction on this mother's relationship with her son.

*We went through a lot together when we lost our apartment and we went from one shelter to another. That bothered him a lot so he's still got a lot of stuff bottled up inside that he won't let out . You will tell him something and he stomps his feet and answers you back , it scares me.*

The child's vigilance is characteristic of children who have been repeatedly separated from their parents.

*My daughter is always watching me and is up under me all the time. When we're together she doesn't want to let me out of her sight. I think it's because I used to go out to the store and then not come back for days. She worries about me so much and she isn't like other children, free, you know , like a child should be.*

This parent spoke of are behavioral and school related problems .

*My daughter had to repeat two grades , she's smart, it's not that, it's*

*just that she lost time because of me and being moved around so much to different schools. She thinks she's not smart and we fight sometimes because she doesn't want to go to school and I don't blame her, she's supposed to be with kids her own age.*

Not being a father to his son caused this father to fall deeper into addiction. He also expressed the fear of the alcoholism being hereditary.

*Alcohol was an escape to get away to forget him. I did not want to know that I had a son. I thought he would have problems especially that he had no father figure growing up. Not being there for him in school, missing his first steps, not being there to help him out. I'm also really concerned about passing on the alcoholism and substance abuse, it's a reality that I have to face.*

This father describes himself as a functional addict and denies that it affected his children although he is bitter about his separation from them :

*I've been using some form of chemical or narcotics for the past 30 years. I'm what you call a functional addict. I've kept jobs and educated myself the best that I could, self-educated. I never was what you call high or intoxicated around my children. If I went to a club I would have a couple of glasses of champagne or some cocaine, it was like an elite thing. When I began to deteriorate I had already separated myself from my family. They never saw that, matter of fact they knew nothing about it. I didn't want them to see that so that way it made it just about impossible to see them to patch things up.*

### **Responses from Post Program Questionnaire**

The following are parents' written responses to the question "What, if any, changes do you see in yourself as a parent since you took the parenting skills group?" The themes range from being more patient to having better listening skills. One of the parents writes about having made peace with the family members who are caring for her child. The opening sessions of the PIR

curriculum address this issue. It was gratifying to read how this parent was able to change her attitude toward the family . Her comment is presented first. Some of the comments reflect back directly to topics and skills from the curriculum, others focus on personal obstacles that parents are working on or feel they have succeeded in overcoming.

*Since I joined the group I've learned to be more patient and understanding to my sister and foster mother and to be grateful rather than being resentful and jealous. I have a better understanding as to why my children behave the way they do. I also see now that I was the problem so now I am ready to be a different and better parent.*

*I learned how to have a little more patience and to be more disciplined with my anger.*

This parent writes that communication skills helped to make her more tolerant and patient .

*One of the many things that I've worked on and practiced is patience, tolerance and understanding. I used my tools from this session and I've not acted out on my children when they got bad reports. I talked to them calmly and the end results were so much better, thank God.*

The importance of listening to children seemed to be resonant with parents.

*I learned that my daughters are people too, they have to be heard at all times.*

*I know how important it is to listen first even if you disagree . Children tend to shut down if you don't.*

*I've learned how to listen to my children and not be so judgmental.*

This parent describes her enjoyment when playing with her child.

*I have a lot more patience with my son. I talk a lot more with him and pay more attention to what he is saying when he talks. I'm happily spending more time doing things with him.*

The following comments touch upon changes that the parents see in themselves.

*I don't allow myself to be stressed as much as I used to when my kids are together with me. I find that if I allow them to be children they don't have to be perfect in the way I want them to be.*

*I really do praise my child more and I see my responsibility increase and my love for my child grow.*

*The changes I see is that I will be more giving of myself.*

*I am more responsible and patient with my children and appreciate them a whole lot more.*

This parent is beginning to deal with disclosure issues.

*I notice my children are asking me more questions about what is going on with me and I feel more at ease answering those questions.*

Many parents in recovery will be reunited with their children after treatment .

These comments come from parents who are preparing to become more involved

*I see that I will be a good parent when I get my child back thanks to the skills that helped me and I am happy I did it.*

*I am taking steps to have my child back and it should be soon. I learned to communicate better with my daughter.*

*First I would like to say that I have answered this questionnaire without seeing my daughter in over 4 years and I feel that as a result of taking the parenting skills group I am prepared to see my child and talk to her and ready to assume my role as a father figure to her.*

The parent is referring to session eight in which parents learned to use a word that identified the child's feeling.

*I am able to label feelings and read my children's feelings even when they can't talk to me. I feel more confident as a mom and a parent today. I've learned hope.*

Or more simply put.

*I learned how to talk to my children.*

The program is open to parents who have lost parental rights but still are ready to learn about themselves .

*I lost my parental rights to my children before I took the class but I'm grateful that I did take the course because I've learned a lot about myself and positive ways to interact with children in general.*

A theme in these comments is the need to continue growing as a parent

*I thought I knew it all . The parenting group really showed me I still have work to do being a single parent.*

*I've learned to become a better parent and listener. This course has helped me to better understand the needs and wants of my child and I must look at the role I've played and must play to better myself.*

This parent felt that the written work will be a source of guidance.

*I now possess the tools and I know how to use them when situations arise. If I ever get stuck I can always relate back to my notes when necessary. I can now speak to them about sex, abuse, depression and yes even drug addiction .*

**Summary of**  
**Qualitative Data on Engagement Dimensions**

The responses from the qualitative data clearly show that the subjects became engaged on all seven dimensions of the Group Engagement Measurement ( Macgowan, 1997) . The first dimension in the measurement is contracting and the data presents several components in this dimension including reactions to the formal contract and the recruitment process . The second dimension of the measurement is attendance which was included as a requirement in the contract for attainment of a certificate of completion. The third dimension ; contributing, was operationalized through journal reading , discussions and group activities. The fourth dimension is relating to the group worker. The responses of the subjects demonstrate that the group members were able to form significant relationships with the group workers . The fifth dimension ; relating to group members, was evident in the parents' comments about learning from each other. This occurred as a result of group discussion and activities that fostered mutual support . The sixth dimension was working on one's own problems . Parents' comments about their investment in their journal work and their efforts to understand the impact of their addiction on their children clearly show the effort that they made to work on their problems. The seventh and final criteria of the GEM is , working on the problems of others. The PIR group structure encouraged the members to become involved with each other's problems. At every session the group listened as each person read from their journal assignment . This was then followed by discussions in which parent's advised and gave support to each other . Parents' remarks from the interviews attest to their having become involved with each other's problems. In some cases their comments indicate that they developed a greater understanding of their own lives through identification and empathy with the problems of other parents.

## **CHAPTER VI**

### **Summary and Analysis of Data**

This section of the dissertation will summarize the findings from the quantitative and qualitative data. The sources of the data are the pre and post questionnaires, behavioral survey of changes and the interviews with parents . The data have been organized to examine changes in parental perceptions of environmental and psychological stresses , efficacy in management of parenting tasks, and behavioral changes that impact on the parent child relationship . The data to be discussed will be presented in the following sections : (1) stresses on the parents and the state of their interpersonal relationships ; (2) parental perceptions of their efficacy to interact and communicate with their children ; (3) parental concerns over the well-being and mental health of their children; (4) parental efficacy in discipline and limit-setting (5) changes in parental visitation, contact and living arrangements of children.

#### **Parental Perceptions of Stress and Interpersonal Relationships**

Parents in the study reported agreement with feelings of anxiety in several areas of their lives . Three stressful issues were identified in the study: fear of relapse, demands from children and guilt over the effects on the children of the parent's addiction . Because addiction is known to be a chronic and relapsing condition , the study looked at parents' level of concern over relapse and found in pre and post scores a high degree of anxiety even though there was a statistically significant improvement . The study also asked how parents feel about the demands from their children . With only a slight improvement , parents remained in agreement with the statement regarding feeling stressed by the demands of their children .

Clearly , the most powerful source of stress for the parents came from feelings of guilt over the effects of their addiction on their children . Moreover,

there was no significant change after the program . This indicates that having gone through the PIR program did little to allay parent anxieties for their children. This implies that there is a need for follow-up with other types of supportive parent groups or family counseling once parents have completed the program.

The PIR curriculum material confronts parents with issues of infant, child and adolescent mental health . As parents' consciousness was raised regarding the consequences of their behaviors during their addiction, their guilty feelings were also heightened . Nevertheless, there was some lessening of anxiety in the post program measurement. The written portion of the prepost questionnaires helped to provide a wider picture of parents' anxieties. Parents wrote about being worried that the children might become alcoholic or drug addicted . They expressed a lack of confidence in being able to control their older children and their teenagers. Further confirmation of these concerns can be heard in the interviews where the theme of guilt was strong and consistent.

While the PIR program presents knowledge that can be a burden ,it does this in the context of a supportive group where parents can get relief by knowing they are not the only ones to have maltreated their children. The learning and the group mutual support may in fact have an equalizing effect with a slight edge coming from group support as indicated by the change toward a decrease in guilt .

Addicted parents also tend to be socially isolated and in troubled relationships with their families .Therefore, the study looked at how parents viewed their relationships with family and if they felt they had any friends. Parents scores show they agree that their families do not trust them to stay in recovery in both pre (2.57 ) and post (2.70) scores. Although parents' scores indicate improved trust from families , parents' responses remain on the side of agreement that their families do not trust them to recover from their addiction.

The parent interviews presented a fuller view of the relationship with family. Most of the parents I interviewed spoke about improved relationships with their families although they had had stormy episodes prior to seeking treatment that they also discussed.

The benefit of interpersonal support in the group is reflected more clearly in the outcomes for parents on the question of social isolation. At the start of the program the parents' scores (2.61) tended toward agreement that they had no friends and felt alone most of the time. After the program parents tended to disagree more with the statement that they had no friends and were lonely (2.82). The post score for this item showed a statistically significant change ( $t=1.91$ ,  $p=.03$ ). The quotations from interviews with parents confirm this change. Parents spoke of having found others with whom they could share painful admissions and could identify with the needs and goals of other group members. There were several comments from the interviews in which parents said they planned to keep in touch with each other once the group ended.

#### Parental Perceptions of Efficacy in Interactions and Communication with Children

In the area of parental interaction with children, statistically significant changes were found in the prepost scores. The PIR program stressed the importance of play, stimulation and engagement with children by the parent. The pre and post questionnaires contained two items on this topic. One asked parents how they perceived their ability to mentally stimulate their children and the other was concerned with whether parents enjoyed playing with their children. On these two items, parents reported changes in a positive direction. Parents reported feeling that they could mentally stimulate their children better and that they enjoyed playing more with their children.

At the start of the PIR program parents had little confidence in their abilities to mentally stimulate their children. The increase in confidence after the

program indicates that parents valued being able to bring their children enriching experiences and felt that they were becoming more skilled in this task. The scores went from 2.75 to 3.30 and were significant to the .001 level.

Another source of information on how parents communicated with their children came from the journal reports. In reports about home life and visits , parents describe playing games and generally focusing on being more attentive to their children.

Being able to improve their communication skills was a goal that more than half of the parents identified in their written responses to the final questions in the pre program questionnaire. The data from the questionnaires also tell us that parents thought their children were not getting enough praise and encouragement from them and that they were yelling and screaming too much. In the interviews with parents there is a strong sense of the parents' estrangement that is coupled with the wish to communicate in a more nurturing way with their children. As one parent stated , " I didn't praise my child enough when we were together , and now I see how much she blames herself .I'm trying to say all the good things she needs to hear. " Regarding disclosure, a parent remarked. "When I first came into the group I didn't know how to talk to my daughter about my addiction. ..I used to feel that she would throw my addiction in my face. " Disclosure of addiction is an area of communication for this parent where there was improvement.

The PIR curriculum has long recognized that parents need help in these areas and therefore has sessions which focus on learning and practicing communication skills . The specific communication skills that parents learned in the program were (1) how to improve and increase praise and encouragement (2) alternatives to yelling at children and (3) talking to children in an age appropriate way about disclosure of the parents' addiction . In all three areas, positive changes occurred in parental self-perception that were statistically

significant. The significant changes were that parents felt they praised their children more ( $p=.031$ ), they yelled and screamed less ( $p=.007$ ) and they saw more value in the importance of talking to their children about their recovery ( $p=.023$ ). In the behavioral survey 95.8% of parents reported that they "speak in a more encouraging way" and 95.8% reported that they praise their children more. Over 80% said they argue less with their children. These findings confirm that after the program, parents felt they were better able to enhance their children's self-esteem and simultaneously be less punitive.

Parents' belief in the importance of self-disclosure was strengthened to a significant degree in the post program measurement. In the interviews, parents told of how they showed their notes and journal assignments to their children and involved them in discussions about the group. Although there was no behavioral question specifically on disclosure to children, the changes toward more nurturing communication suggest that as parents were gaining greater intimacy with the children they were also finding greater acceptance from them.

#### Parents' Perceptions of their Children's Well-being and Mental Health

The data from the pre post questionnaires on concerns of parents about their children's emotional well being shows that there was only slight alleviation of concern and there were no significant changes. The words of parents from interviews and journals continually return to the themes of children's fears of loss, lack of trust and need for attention. These sources of data indicate the seriousness and depth of parental perceptions about their children's troubled lives. The four specific areas of inquiry for which there is data from the questionnaires are as follows: The first was the parental perception that children were not getting enough attention from them, the second was the perception that children were afraid they would be abandoned, the third asked parents what they thought about the child's trust in the parent's ability to conquer addiction and the fourth asked parents if they agreed that their children

were confused about the parent's addiction.

There was slightly greater agreement in the post scores that children were afraid that the parent would not be there for them. The direction of the change, toward greater awareness of children's fear of abandonment suggests that the PIR program raised parents' consciousness and empathy for these feelings. On the question of children's trust, there was a slight increase in which parents felt the children trusted them to stay in recovery. The growth in trust may well be a result of the additional time in treatment that had passed from pre to post testing. Another possible explanation for the difference in these two items is that children's fear of losing the parent is a more deep-seated and global feeling than their trust in the parent's recovery.

Although not statistically significant, there was a strong trend in the item on giving attention to the children ( $P=.17$ ) which indicates that parents felt they were giving more attention to their children. Nevertheless, parents still agreed that their children needed more attention (2.22).

What is striking about these findings on children's well being and mental health is that even though parental perceptions did not change significantly, parental behaviors did. The behavioral survey of changes shows that 87% reported they made more phone calls to their children, 83.3% said they saw their children more often and 62.5% said they took their children out for a pleasant activity more often. Then there is the data on frequency of visitation. In the women's residence there was a 40% increase, in the men's residence a 47.3% increase and in the outpatient group there was a 22.2% increase. Despite the increases in visitation, telephone contact and the like, the responses of parents indicate their awareness that the children's need for time and attention from the parents would not be turned around quickly or easily. More profound structural changes as in custody and living arrangements did not show up in the post program data.

### Parents' Perceptions of Limit-setting and Discipline

One of the most difficult tasks for parents in general , and therefore for addicted parents as well , is to constructively handle children's problem behaviors . The subjects in this study responded to the question in the pre program questionnaire with requests for guidance on matters of discipline. One parent wrote " I need help to stop using profanity with my children." Another parent wrote " I lose my temper and I'm afraid I'm going to lose my children if I don't learn how to control myself." The PIR curriculum helps parents understand the reasons why children engage in common misbehaviors. The item which asks parents about their understanding of their children's misbehavior shows a significant change( $p=.05$ ) in which parents came to feel they were understanding their children's behaviors better after the program. When this item is placed next to the item on yelling and screaming which changed very significantly ( $p=.007$ ), this suggests that parents were better able to tolerate their children's misbehavior and respond less punitively.

Parents in recovery have been described as inconsistent in their ways of disciplining. There is evidence of this in the interviews which confirms the data from the questionnaires. The excerpts presented in the qualitative section showed how parents saw themselves failing to understand how to discipline. There were parents who were not involved in the daily management of their children as well as parents who didn't want to deal with discipline issues because of the limited time they had with their children. The data from items on the questionnaires indicate this inability to set limits . Parents responded that often they cannot say no to their children and felt unsuccessful in being able to get the child to obey them. There was only slight improvement in the post scores .

### Changes in Parental Visitation and Contact

The changes in parent child contact that emerge from the study can lead

to some understandings about the influence of treatment setting, and client characteristics .

The most dramatic finding is that , during the PIR program, parents' contact and visits with their children increased considerably in all treatment categories. In the women's residence there was a 40% increase in visits , in the men's residence a 47.3% increase and in the outpatient group there was a 22.2% increase. The residential programs had almost twice the increase in parent child contact as compared to the outpatient, day treatment programs.

The greatest increase occurred among the fathers who lived in the men's residential program. Of the 19 men who participated in this study, six either made contact with their children for the first time or after more than a year's absence. One explanation of the long separation of the fathers in the residence is that many of the men had been incarcerated . The rest of the group of fathers who visited more regularly increased their visits on a monthly , weekly or bimonthly basis. The first contacts between the fathers and their children should be followed up with ongoing help to solidify the father-child relationship. For fathers whose patterns of visitation increased in frequency, there is an ongoing need to coordinate treatment goals with the increased visitation .

Although women had more frequent contact than men prior to the program, the women's residence showed increases in contact that were also substantial. Before the program 35% of the women reported seeing their children daily or weekly. After the program 55% reported daily or weekly visits with children. The increase among the parents in residential treatment suggests that the more comprehensive services of residential treatment resulted in more frequent visitation and contact with children. The outpatient group were parents who attended both day treatment and methadone maintenance . As a group their changes in visitation were the most unstable. While 22.2% of these parents increased their contact , 11% decreased their

contact. The data from the outpatient population suggests that more emphasis be placed on strengthening the goal of parental involvement.

### The Living Arrangements of Children

There was a considerable contrast between the living arrangements of children whose parents were in residential treatment and the living arrangements of children of parents in day treatment. For the children of men in residence 79% lived with their mothers and the other 21 % lived with relatives .

The men's children had very low rates of foster care with none in foster care before the program and only 5% in foster care after the program. The living arrangements of the children of women in residence are similar to the men. For the women in residence, 63% of their children lived with a relative and 16% with the father . The foster care placements for the children of men in residence were higher , with 21% in foster care before the program and 26% in foster care after the program.

The parents in outpatient settings reported that 19% of the children lived with them but only 13% lived with the other parent and 25% lived with a relative. The total percentage of children of outpatients who lived with the parent or the family was 55% . This suggests that outpatients do not have as much family support as parents who are in the residential treatment settings. The outpatient parents also had the highest percentage of children living in foster care, 45% .

There were no changes at all in the living arrangements of the children of parents in day treatment and only slight changes in the living arrangements of the children whose parents were in residential treatment . This is a finding that stands out in contrast to the very substantial increases that took place in visitation and contact with the children in all settings as reflected in the data from the post questionnaires and the behavioral survey . The changes that did

occur for the residential parents, both women and men, were similar. For both residential settings there was a 5% increase in foster care placements. For the women there was a decrease from 16% living with the father to 5% living with the father after the program and an increase in relative care which went from 63% to 68%. Children in the care of a parent or relative in the post program figures remained high at 73% for the women and 79% for the men. The slight increase in non-relative foster care for the men and women in residence suggests several possibilities. Perhaps having a parent in treatment caused the remaining parent to enter treatment as well. It is also possible that once the parent left the home and entered treatment, the stress of caring for the child became too great for the remaining parent or family member.

The data on children's living arrangements comes from comparisons of the responses from the pre and post questionnaires. The time period between administration of the pre and post questionnaires ranged from 3 months to 5 months. This is a relatively short period of time to be able to chart changes in living arrangements of children. Since the data was collected, there have been reports from the residential group workers that some of the parents who were discharged after completing their treatment requirements went to live with their children. Long term studies are needed to follow up on the progress of these parents and their children.

## **Limitations of the Study**

The study is based solely upon the reports of parents who have completed the program and as such relies entirely upon the self-perceptions of parents . It is possible that parents' responses are biased and overly subjective . Parent reports about changes in punitive behaviors and problematic life situations could be distorted to appear more favorable than they in fact are. Despite information to the contrary , the researcher may be thought of as an authority figure and therefore able to sanction or reward parents for their responses. Overall, the pre post changes show the strength of the program.

This is also a short term program that was studied within a year of completion . Ongoing parenting support is needed with ongoing evaluation.

The study sample has certain limitations as well. The first limitation is the small size of the sample. The second limitation is that the sample is not purely random. The study looks only at parents who were able to complete the program and not at the parents who dropped out of the program.

The study does not have a control group of parents for comparison . Therefore, it is not known to what extent the positive changes in parenting were a result of other forms of treatment or from participation in the PIR program alone. In future studies this problem could be addressed by doing a comparison study of the PIR program with a group using a different form of group work model and curriculum to determine which types of treatment were relatively more effective.

A limitation in the measurement is that I did not use established and pre-existing scales on parenting success and effectiveness for comparison and analysis with this study . Instead, the study used individual indicators on parental attributes I had selected that were tailored to the program. There were also no pre post data on behavioral changes .

## **Conclusions and Recommendations**

Research done on parental behaviors after treatment for addiction shows that treating the addiction alone is in itself not sufficient to correct parental deficits and dysfunction (Mondonaro, 1989; Lawson & Wilson 1980 ). While parent education has been advocated by the National Institute of Drug Addiction (1989) as a basic program element in effective substance abuse treatment , the content of such a program has not been spelled out. In order to be effective, a parent education program must recognize and address the specific needs of addicted parents.

The fundamental premise of the PIR program has been that addicted parents can learn discrete concepts about child development, attachment theory and communication skills and that the experience of such learning in a supportive group will contribute to changes in parents' self-perceptions in key areas of child rearing. The PIR program has shown that significant changes did occur for the parents in substance abuse treatment who completed the program. Many of the PIR graduates reported that prior to this experience they had never completed a structured course or treatment program . The fact that these parents were able to successfully meet the attendance and work requirements is a refutation of the notion that addicts are poor candidates for rehabilitation in parenting.

In order to have completed the program parents had to make a commitment to working on their own goals as well as become involved in the goals of others in the group. Engagement in the PIR program was a multidimensional process as is shown in the analysis of engagement using the criteria from Macgowan's Group Engagement Measurement construct .

The data from the PIR program shows positive changes in parenting attitudes and child rearing behaviors. Similar changes have been documented in the research literature on Adlerian parent education programs . Adler

articulated what was then, a new structure for the family, one that moved away from vesting autocratic powers in the parents and toward opening up communication between parent and child (Berrett, 1975; Freeman, 1975; Hinkle, Arnold, Croake & Keller, 1980) Surveys of other parent training group programs have documented positive effects on child behaviors and parental measurements of self-efficacy. ( Huhn & Zimpfer, 1989; Nystul, 1982 ;Patterson, Chamberlain & Reid 1982 ) . None of these studies , however, involved addicted parents as subjects .

The outcomes in this study demonstrate that the optimum time for parents to get help is while they are in treatment in a substance abuse facility . The program therefore needs to be in place in order to take advantage of the opportunity to reach addicted parents when they are ready to accept help.

The foremost recommendation that comes out of this evaluation is for parent education and support groups to become a standard service component for any social service agency that provides treatment to adults with drug and alcohol abuse problems. To do this would mean that agencies would need to view their clientele in a different way. Many agencies use basically a medical model that views addiction as a physical problem requiring drug detoxification , abstinence-oriented counselling and behavioral modification. The reframing of addiction as a family problem would necessitate a paradigmatic change in the way that substance abuse agencies work with clients. This may require that on in-take the client's interest in working toward reunification or other parenting needs be explored more thoroughly. A psychosocial at intake of the parent with a substance abuse problem would include questions about the health of children . Linkages could then be established with child welfare personnel.

The data in this study coming from the men's residence should be one of the best arguments to support parenting skills groups for men who are fathers . Nevertheless it took almost 10 years for the BASA agency to consider

conducting the parenting skills group at the men's residence . The men were simply not identified as also being fathers. Ironically, substance abuse agencies were first designed to treat alcoholic men (Reed, 1987) and most still operate within that framework. When men in addictions treatment are recognized as being fathers a seismic shift in perspective can take place. The assessment of the man's needs should include supports and services that could help him to become a better father . These services would most likely include parent education , family therapy and help with child and family visits

The failure to think of men as being fathers is reflected throughout the literature on parenting and addiction. When parenting and addiction are the key words in a literature search the result is an outpouring of abstracts on pregnancy , women's health and motherhood.

The findings in this study indicate that a time-limited program in parent education leads to greater contact with children but not to major changes in living arrangements or to reunification. The need exists therefore, to continue parent education and parent counselling for longer periods of time. Taking the PIR can be seen as a first step in the process of resuming parental responsibilities.

Within the addictions field there are other sub-groups of vulnerable parents who I feel should be offered parenting programs in the settings where they may receive treatment. These include substance using parents who are in HIV clinic programs, parents who are in prison and teenage parents in the foster care system. The mission of the PIR groups is not necessarily to reunite children with their parents. Over the years the program has helped some participants make more informed choices about what is in the best interests of their children .

Public schools and colleges do not list parenting skills or child development in their required courses . Parenting ability is thought of as

instinctual . It isn't learned so much as inculcated . We learn through living in a family and if families do not know how to help children grow into healthy adults it is a private matter. This of course bears no resemblance to reality , especially where there is an alcoholic or drug addicted parent. Parenting skills groups educate as well as treat individuals and where self-awareness may be more difficult to determine , learning can be tested and measured. This is why the recommendation is made for the psychoeducational group to be part of substance abuse treatment.

## **Part VII**

### **Appendix**

**Pre Program questionnaire**

**Post Program**

**Behavioral Survey**

**Interview Guide**

**Intake Data Form**

**Parenting In Recovery Contract**

**Parent Child Contact Report**

**Curriculum**

**Bibliography**

**Pre-Program Questionnaire**

**Your I.D is the last four digits of your social security number\_\_\_\_\_**

**MMTP \_\_\_\_\_**

**CasaBanome\_\_\_\_\_**

**Amethyst House\_\_\_\_\_**

**Day Treatment \_\_\_\_\_**

**Men's Residence \_\_\_\_\_**

**Number of children under the age of 18 \_\_\_\_\_**

The purpose of this questionniare is to get feedback on the Parenting Skills program.

Your thoughtful and honest answers to the questions on this questionnaire can help the agency improve the program and make it more responsive to the needs of parents like yourselves. We will be asking you to fill out this questionnaire before and again after you have completed the program. We will not be reporting on individual responses to the before and after questionnaires. All information will be treated with confidentiality. Please do not put your name on this form, use only the last four digits of your social security number. This will insure your anonymity. Your participation is voluntary and no penalty or withholding of services will occur if you choose not to fill out the questionnaires. If you have any further questions about this research you may call Bea Plasse at 212-227-5856 or contact Dr. Michael Smith the research advisor at 212 452-7029 .If you find that some of the questions in the questionnaires are upsetting to you your group leader as well as the counselors here are willing and available to speak with you . You may also call the day treatment center's counseling office at 718-583-5315 to arrange to speak with a counselor of your choice.

**1. At this time my child(ren) live**

**with me full time \_\_\_\_\_**

**with a relative \_\_\_\_\_**

**in a foster home or foster group home \_\_\_\_\_**

**other\_\_\_\_\_**

2. I see my child(ren)

every day\_\_\_\_\_

once a week \_\_\_\_\_

twice a month\_\_\_\_\_

once a month \_\_\_\_\_

I have no contact now with my child(ren)\_\_\_\_\_

other \_\_\_\_\_

3. I often feel nervous and worried that I will relapse.

Strongly agree	agree	disagree	strongly disagree
1	2	3	4

4. I often feel stressed by the demands of my children.

Strongly agree	agree	disagree	strongly disagree
1	2	3	4

5. Sometimes I do not understand why my children misbehave.

Strongly agree	agree	disagree	strongly disagree
1	2	3	4

6. I think that I do not praise or encourage my children as much as I should.

Strongly agree	agree	disagree	strongly disagree
1	2	3	4

7. I find that I yell and scream at my children more than I should.

Strongly agree	agree	disagree	strongly disagree
1	2	3	4

8. My children are not getting enough attention from me.

Strongly agree	agree	disagree	strongly disagree
1	2	3	4

9. Often I can't say no to my children .

Strongly agree	agree	disagree	strongly disagree
1	2	3	4

10. My children are afraid that I will not be there for them.

Strongly agree	agree	disagree	Strongly disagree
1	2	3	4

11. At this point in my recovery my children do not trust me.  
 Strongly agree    agree            disagree    Strongly disagree  
 1                    2                    3                    4

12. I think I can learn to become a good parent.  
 Strongly agree    agree            disagree    strongly disagree  
 1                    2                    3                    4

13. My children are confused about my addiction.  
 Strongly agree    agree            disagree    strongly disagree  
 1                    2                    3                    4

14. I believe it is important for me to talk to my children about my recovery.  
 Strongly agree    agree            disagree    strongly disagree  
 1                    2                    3                    4

15. I feel that I hit my children more than I should.  
 Strongly agree    agree            disagree    strongly disagree  
 1                    2                    3                    4

16. I believe that my family does not trust me to stay in recovery.  
 Strongly agree    agree            disagree    strongly disagree  
 1                    2                    3                    4

17. I feel alone and without friends most of the time.  
 Strongly agree    agree            disagree    strongly disagree  
 1                    2                    3                    4

18. I don't really enjoy playing with my children.  
 Strongly agree    agree            disagree    strongly disagree  
 1                    2                    3                    4

19. I feel I am not good at helping my children develop their intelligence.  
 Strongly agree    agree            disagree    strongly disagree  
 1                    2                    3                    4

20. It is difficult for me to have a regular mealtime with my children.  
 Strongly agree    agree            disagree    strongly disagree  
 1                    2                    3                    4

21. It is hard for me to get my children to bed on time.  
 Strongly agree    agree            disagree    strongly disagree  
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DATA SHEET  
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**22. My children do not pay attention to me when I tell them what to do.**

**Strongly agree    agree    disagree    strongly disagree**

**1**

**2**

**3**

**4**

**23. I feel guilty about how my drug use has affected my children.**

**Strongly agree    agree    disagree    strongly disagree**

**1**

**2**

**3**

**4**

**24. What do you hope to learn in order to help your children?**

**25. What are you most concerned about as a parent?**

## Post Program Questionnaire

**Your I.D is the last four digits of your social security number\_\_\_\_\_**

**MMTP \_\_\_\_\_**

**CasaBanome\_\_\_\_\_**

**Amethyst House\_\_\_\_\_**

**Day Treatment \_\_\_\_\_**

**Men's Residence \_\_\_\_\_**

**Number of children under the age of 18 \_\_\_\_\_**

The purpose of this questionnaire is to get feedback on the Parenting Skills program.

Your thoughtful and honest answers to the questions on this questionnaire can help the agency improve the program and make it more responsive to the needs of parents like yourselves. We will be asking you to fill out this questionnaire before and again after you have completed the program. We will not be reporting on individual responses to the before and after questionnaires. All information will be treated with confidentiality. Please do not put your name on this form, use only the last four digits of your social security number. This will insure your anonymity. Your participation is voluntary and no penalty or withholding of services will occur if you choose not to fill out the questionnaires. If you have any further questions about this research you may call Bea Plasse at 212-227-5856 or contact Dr. Michael Smith the research advisor at 212 452-7029 .If you find that some of the questions in the questionnaires are upsetting to you your group leader as well as the counselors here are willing and available to speak with you . You may also call the day treatment center's counseling office at 718-583-5315 to arrange to speak with a counselor of your choice.

1. At this time my child(ren) live  
with me full time \_\_\_\_\_  
with a relative \_\_\_\_\_  
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2. I see my child(ren)

every day \_\_\_\_\_

once a week \_\_\_\_\_

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once a month \_\_\_\_\_

I have no contact now with my child(ren) \_\_\_\_\_

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3. I often feel nervous and worried that I will relapse.

Strongly agree    agree    disagree    strongly disagree

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22. My children do not pay attention to me when I tell them what to do.

Strongly agree    agree    disagree    strongly disagree  
1                    2                    3                    4

23. I feel guilty about how my drug use has affected my children.

Strongly agree    agree    disagree    strongly disagree  
1                    2                    3                    4

### **Post Program Behavioral Survey**

**Please check the item that it is true for you. Leave it out if it does not apply to**

## Post Program Behavioral Survey

Please check the item that it is true for you. Leave it out if it does not apply to you.

1. Since I joined the group I have written a letter to my children . \_\_\_yes\_\_\_no
2. Since I joined the group I call my children more. \_\_\_yes\_\_\_no
3. Since I joined the group I see my children more often. \_\_\_yes\_\_\_no
4. Since I joined the group I have taken my children out for a pleasant activity. \_\_\_yes\_\_\_no
5. I speak in a more encouraging way to my children now . \_\_\_yes\_\_\_no
6. I praise my children more now. \_\_\_yes\_\_\_no
7. I talk more with the people taking care of my children now. \_\_\_yes\_\_\_no
8. Since I joined the group my children seem to be doing better in school . \_\_\_yes\_\_\_no
9. I have had less arguments with my children lately. \_\_\_yes\_\_\_no
10. Since I joined the group I can say no to my children when I need to. \_\_\_yes\_\_\_no
11. Since I joined the group my children seem calmer . \_\_\_yes\_\_\_no

Comments ( If needed on any of the above items.)

12. What , if any, changes do you see in yourself as a parent since you took the parenting skills group ?

**Interview Guide - Parenting in Recovery**

by **Bea Plasse**

What were your reasons for coming into the parenting skills group?  
What were your concerns about your children when you came for SA treatment ?

Can you tell me about how you were handling your children before you came into treatment?

What , if any, effect did your drug addiction have on the way you handled your children?

What are some the most important things you learned in the group?  
How did being in the group make you feel about yourself as a parent?  
Can you describe any changes in the way you talk and listen to your children since you were in the group?

Can you describe how you are handling your children when they do things that you don't like ?

Can you describe how, if at all, your relationship to your family has been affected by having been in the group?

If you do not live with your children - how often do you see them? Has your contact increased or decreased?

When you signed the contract do you remember what you were thinking?

What was the experience of doing the journal assignments like for you?  
Could you tell me about any assignments that stand out in your mind?

What do you remember in the session on childrens sexuality ?

Can you tell me what the session on protecting children from sexual abuse meant to you?

What, if any , skills do you think you've used in talking to your child?

What stands out in your mind about the discussions on discipline and punishment ?

Do you still have your journal?

Do you ever look at it or read it over?

What was the experience of writing a poem like?

What did you think of the poem your group composed?

How do you feel about your reading and writing abilities?

How did you feel about reading to the group from your journal?

What kind of help, if any, did you get to do the assignments?

Describe how you felt about your relationship with the group leader.

What did the group leader do in the group to either make you feel comfortable or uncomfortable?

What did you think of the group leader's comments on your homework ?

Describe how you felt about the other parents at the beginning of the group.

Did your feelings toward them change by the end of the group? If so, how?

Did you feel safe to talk about personal matters with them?

Did you feel that their issues and problems were similar or different from yours?

Did you think you learned anything from them?

Do you plan to keep in touch with any of the people in the group ? Did you make friends with anyone in the group?

What part of the PIR program seems most important to you?

What part of the PIR program did not work for you ?

What was missing from the PIR group that you wanted or needed to learn?

What are you concerned about as a parent now?

# Parenting Skills Group Intake Data Form

Date

1. Name of Parent

2. Age

3. Address and Tel.

4. VIP Program Modality

5. Date enrolled at VIP

## Data on Children

6. Ages , gender, and places of residence for each child. (kinship, foster care, group home, hospital etc.)

7. Health problems , special needs or disabilities of child(ren)

8. Living arrangements of children ( in home ,placement)

9. Legal Status of Parent (rights terminated , termination hearing pending, frequency of visitation .)

10. What areas of help would parent like to get from the parenting skills group .



# Parent Child Contact Report

Name of Child and age

Place of contact

Date of contact

Hygiene, Appearance, Mood of child

Activities between parent and child (sports, games, outings, arts and crafts, meals, conversation)

Communication skills : (praise, encouragement, identification of a feeling or need, conflict resolution ,comfort, physical affection, limit setting and discipline)

Concerns and problems

# Parenting in Recovery



Written and Compiled by Bea R. Plasse, ACSW

# **PARENTING IN RECOVERY CURRICULUM AND GROUP LEADER MANUAL**

## **ORIENTATION and INTRODUCTION**

Arrange the seats in a circle . Have Flip chart or black board within view of circle.

1. Present group with the dates of attendance, meeting time and place. Attendance requirements and lateness rules .
2. Journals. Bring paper, folders, name-labels, and have group assemble their journals with their names and agency name. Journal pages should be removable.
3. Work requirements. Every session has a written assignment that becomes part of the journal. Handouts will be kept with journal . For people who require help with reading or writing they must see the group leader who will assign a person in the group or a staff member with work with them.
4. Confidentiality. To be strictly maintained within the group except where the safety and welfare of the parent or child is involved. Members will be informed by the group leader prior to any sharing of information with outside authorities.
5. Guidelines for a positive group experience. Avoid passing judgement or labeling another person. Instead talk about what would work for you . Share your experience.
6. Rules about eating and drinking .
6. Question and answer period.
7. At the end of the session distribute contracts . A copy of the contract should be given to the group leader and copy is kept by the parent.

## Session One (cont.)

**Leaders Guidelines:**

You have just done an important piece of contracting with the group. They now know your expectations about journal keeping, attendance and confidentiality. It is time to set the tone. For your first group activity your goal is to capture the joy, fear, wonder and intensity of the experience of becoming a parent. Everyone in your group has had this experience and despite perceived differences, resistances and covert antagonisms you will attempt to use the shared role of parent as the common ground with which to bring the group together in a working alliance.

**Group Activity:**

The leader passes out a file card to each group member and tells him or her that they are going to write a poem. Each person will write a line of the poem on the cards they have just been given. They do not have to sign their names to their card. The opening line of the poem is: *The first time I held my child...* the leader will then collect the cards and read the poem. It is a good idea to have the poem typed and ready to be passed out to the group at the start of the next session. Care should be taken to arrange the lines in a way that maximizes the poetic flow and looks pleasing on the page.

Next - On a blackboard or flipchart leader writes "Our Goals For Parenting" .The group can call out ideas which the leader will write as a list. The items on the list might include, being more patient, controlling my anger better, or learning about child development. If the group has trouble getting started the leader can propose ideas and list them. Ask the group to write these along with you. Discussion should be encouraged as you make this list.

**ASSIGNMENT:**

Using the list the group has come up with have the group write on whichever items they feel *they* need help with. Ask them to write about their reasons for selecting that item.

## The First Year of Life and the Establishment of Basic Trust

### Journal Reading and Collection of Assignments

Allow 30 minutes for reading and discussion of last session's assignment .  
Collect them . Pass out the Poem "The First time I held my child."

### Points to Cover by Group Leader

The goal of the first year of the infant's life goes beyond survival of the body. The infant, in order to develop to its human potential, must become attached to a mothering figure who is a consistent presence. Attachment to a nurturing person is also called bonding. Bonding is a process that takes place through holding, feeding, changing and stimulating the baby . After the first year of the infant's life there will have been numerous experiences of such interactions and the effect will be to establish a sense of basic trust.

**Basic Trust** means that the baby feels his needs will be met with regularity and without inordinate pain or frustration. Basic trust also translates as " I can find the world a basically good place where I can experience pleasure."

### **Failure to Thrive Syndrome**

First observed during world war II in the nursery care of orphaned or separated infants. These babies and toddlers were cared for by a variety of nurses and many were unable to bond with a maternal figure. The result was that these babies did not develop well. They were unable to perform the expected milestones of development. Some stopped eating, stopped growing and stopped crying. Those who had a nurse who they could bond with did better.

### **Foster Care versus Institution Care**

Because of changes in the nursing staff of an institution a baby's needs for consistent attachment cannot be met. Foster homes with one mothering (or fathering) figure are able to provide the long term bonding and attachment need that is unique to the human infant.

### **Discussion Point**

How do you want your children to view the foster parents or family members who are now caring for your children ?

What can you do to improve that relationship?

### **Key concepts**

1. The human infant requires a long period of individualized care. In order to become truly **independent** in later life an infant and young child must be

allowed to be **dependent** .

2. An infant's life is largely governed by bodily needs. These include cessation of hunger pains, need for sleep, need for soothing touch and holding and an increasing need for stimulation and play.

### **Group activity**

The group activity is to write a letter addressed Dear Mom, ( some people may insert the name of another relevant person such as father). The letter will be written on a flip chart that everyone can see. The letter should tell the parent how the person feels today about his or her recovery and their goals in parenting . As each person speaks the group leader can quickly consult the group for approval before writing down in the letter . Group leaders, please try to get everyone to make some contribution to the letter.

**Homework Assignment:** You may choose to do one or both.

1. Why is bonding between parent and child important to you? How do you bond with a child who is no longer an infant? Use the group's letter to help you answer these questions.

2. Fill out the parent child contact report if you have a visit this week with your child.

Compiled and written by Beatrice R. Plasse, ACSW

## Pregnancy: The Hopes and the Realities

Open with reading of assignment from last week.

### Group Discussion and Activity

The origin of one's life as a parent does not begin when the baby is born as may be believed by many people in the group. The acceptance of a pregnancy and the decision to carry the pregnancy to term mark the onset of the numerous changes in identity and life experience that go into becoming a parent. In this session the group will explore the motivations behind pregnancy in some detail. The goal in this session is to help people in the group gain insight into their motives and how these may have set them up for failure. By exploring the roots of a pregnancy it is hoped that parents can make connections with the later problems they encountered with their children. In addition, these insights can help to prevent future pregnancies founded on unresolved developmental or family-of-origin problems in the parent. The group leader will have ample issues to discuss during the session as items are added to the list. The group leader will use a flip chart and ask the group to write simultaneously in their journals a list entitled *Motivations For Becoming a Parent*. The following list of motivations for becoming a parent come from parenting skills groups that were conducted in substance abuse programs.

### Motivation For Becoming a Parent (suggested items)

- \* To give love to a child who will be "all mine."
- \* Because a couple are ready to be parents and have planned for a family.
- \* To get the love I never felt from my mother.
- \* To keep my boyfriend from leaving me.
- \* To get off drugs.
- \* To gain independence from my family.
- \* Out of ignorance of birth control.
- \* Peer pressure from groups of teenage parents.
- \* To gain status in my family.
- \* To prove to myself that I can produce a baby.
- \* To postpone the pressures of leaving home.
- \* To boost poor self-esteem.
- \* To avoid the pressure of high school and academic failure.
- \* To gain respect accorded an adult.

**Assignment:** Look over the list and write about the reasons *you* became pregnant. For men, write about the way that the pregnancy effected you and your motivations for having a baby. How was the reality different from the fantasy during pregnancy? How did this lead to problems you experienced with your child?

# INFLUENCES ON THE PARENT AND CHILD

## A SYSTEMIC VIEW

Open with reading of assignment from last session.

### Guidelines to Group leader for discussion

In this session parents will look at the myriad forces that effect a parent and child. When the parents consider all the forces impacting on themselves and their children they can begin to perceive themselves as part of a greater whole. The saying "It takes a village to raise a child" speaks to the necessity of connections to others and the benefits of being a part of a community. Addiction and isolation often come hand in hand. In this session parents can begin to see how they have the ability to make choices to bring constructive forces into their lives. The use of drugs and other destructive influences will be seen to effect not only the parent but also the child. In your discussion you will need to point out that parents are connected to a variety of systems. The most immediate system is the physical body of the parent, which is effected by the foods and drugs that enter their bodies. Beyond the parent's body are the environment, the home, the household, and the neighborhood they live in. Looking at the neighborhood will mean seeing the problems (crime) and the resources (churches). Beyond the community they live in will be the state they live in and its policies, the country and government and even the planet and ecosystem. At each level of systemic influence the group leader should incorporate the child as being effected as well as the parent. In your discussion it can be helpful to speak in metaphorical terms. Draw a circle on the flip chart and call it "the parent". The leader can compare the circle to a planet, a seed, or a womb. Each is metaphor for a vital system that is effected by its environment.

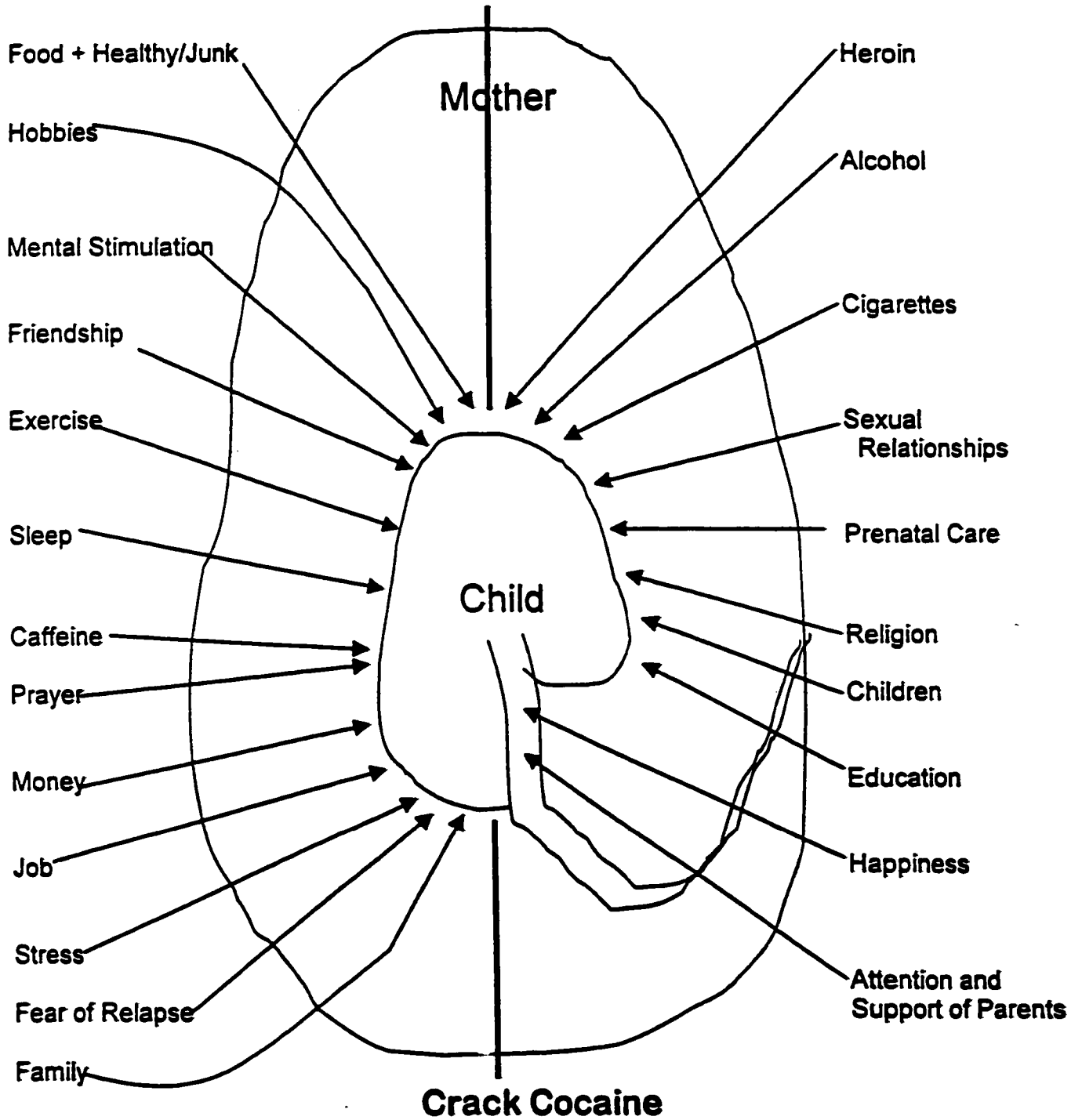
### Group Activity

The diagram that will be created by the group is a visual representation of the variety of influences effecting a parent and child. The group activity is to draw this pictorial model which as is found on the following page. Using an unlined sheet of paper the group will draw a circle to represent the self and inside the circle they will draw a smaller circle to represent the child or developing fetus. The group will brainstorm all the influences they can think of and place them around the mother circle. The goal of this activity is to help the group think about the various forces (both positive and negative) impacting on a mother's life and how in turn the child or fetus is effected by these factors.

**Journal Assignment:** Choose five positive influences and five negative influences. Comment on how they currently impact on your life.

# INFLUENCES ON PARENT AND CHILD

## Recovery Program



# ESSENTIAL ROUTINES FOR FAMILY LIFE

## To the Group Leader

The session will begin with the group reading their assignment. Have the group discuss the questions posed under each routine.

### 1. Eating and mealtime

Think about how you feel when you eat alone as opposed to how you feel when you eat with family or friends. For some families, the only time they are together is at mealtimes.

Do you have a regular time for meals?

Do you ask the children to help set up or clean up?

What were meals like when you were active?

How are meals now?

### 2. Sleeping

Infants and toddlers need naps. Sleep needs vary from child to child.

Bedtime is a time when children need soothing routines and parents are most tired.

#### Group Activity

Make a list of bedtime preparations and routines

For example:

⌘ Read a book

⌘ Say prayers

⌘ Talk over the day

⌘ Hugs and kisses

⌘ Brush teeth

Do you have a set bedtime for your young child or a curfew for the older child or adolescent?

Do you have a routine to get your child ready for bed?

### 3. Play and Stimulation

Your child needs opportunities for large motor movement and play every day.

Find your Neighborhood Park or playground.

Your child needs to be stimulated by quiet play or games that require thoughtfulness.

What activities does your child enjoy?

Why is it important to get a child to be physically active?

What kind of board games would your child enjoy?

### 4. Homework and chores

Children want to have responsibility and power within the family.

When chores are age appropriate children feel they are contributing and important.

When parents take an interest in helping with homework children have a better chance at success in school. By setting aside time for homework and creating a place that is quiet to do the homework, parents convey that they value education.

**Assignment:** Choose from one or more of the routines and write about how you can improve that routine for you and your family.

# TODDLER YEARS 1 - 3

## The Struggle for Independence and Self-Control Separation and Individualization

**To the Group Leader: Read last week's assignment.**

### Group Activity

Divide into sub-groups. One person takes notes. Report back after 10 minutes on solutions and ideas stimulated by the following situations.

#### Situation 1

Night after night my 2-year-old screams and cries when I put her in her crib at night. We pick her up and she wants to play. Finally she collapses into sleep in our arms. We are exhausted. Help!

#### Situation 2

I can't seem to take my 2-1/2 year old into a store. He wants to touch and handle everything. He refuses to stay in his stroller or in the shopping cart. He runs down the aisles and when I reach for him, he throws a tantrum.

#### Situation 3

I must leave my daughter (age 3) at day care everyday in order to work. She clings and cries in a heartbreaking way. The staff tells me that she recovers quickly after I leave. What can I do to help her and to feel less miserably guilty?

#### Goals of these years:

- A sense of good will and pride.
- A realization of being, separate, independent.
- Able to make choices.
- Confidence, good self-esteem.
- (Erikson)

#### Dangers in these years:

- A lasting feeling of self-doubt, shame.
- Dependency, fear of taking risks.
- Depression, despair, poor self-image.

#### Positive Parenting Strategies for Challenging Years

- ☺ Arrange home environment to allow for exploration, play and free safe movement.
- ☺ Baby-proof your home.
- ☺ Avoid compulsive neatness, your toddler has little self-control and needs parents to provide safe limits from exhaustion, over-stimulation and loss of control (temper tantrums).
- ☺ Parents need to know that the toddler is afraid of too much independence.
- ☺ This is a time when toddler pushes mother away but still needs loving, tender reassurances.
- ☺ Understand that "no" means, I can choose. I am my own person.

## Session Six (cont.)

- ☺ Don't personalize the negativity of your toddler.
- ☺ Don't expect a toddler (up to age 3) to be able to share toys.
- ☺ Keep expectations realistic.
- ☺ Expect sudden aversions to bath, eating and going to sleep.  
This can be a painful and confusing time for the child and the parent.
- ☺ Try to maintain a sense of humor.

**Assignment**

What is happening in your child's move to be more independent?  
(Every age has some new drive to separate.) How does this make you feel?  
Proud, left out, wishing for a new baby, relieved to be less depended upon?  
Perhaps several of these feelings and more not mentioned.  
Write about these in your journal.

Brazelton, T. Berry. Toddlers and Parents. Delacorte Press  
Erikson, Erik H. Childhood and Society. W.W. Norton & Co.

# Ingredients of Good Communication

**Group Leaders: Read from last assignment.**

## **Key Concepts**

- 1. Quiet your mind, turn off the noise in your head and focus on what your child is about to say. This is the most difficult but also the most important element in focused and effective communication. Turn off radio or TV. Stop what you are doing and be *present*. If you can do this, the rest will be relatively easy.**
- 2. Show your interest by being aware of your facial expression, and your body language. Make eye contact in a natural way. Sitting together facing each other is preferable to standing. It shows that the parent is not about to walk away. Talking across a room or with a table or desk between you will make it harder for the parent to give a loving touch to the child. With adolescents it is sometimes not a good idea to sit face to face but side by side to avoid making the teen feel intruded upon.**
- 3. If you are busy or distracted when your child wants to talk make an appointment with your child. Find a time that is good for both of you and follow through at that time.**
- 4. Don't interrupt until the child is finished with their thought, sometimes it is good to ask the child if they have finished before you respond.**
- 5. You can show you are listening with short statements of affirmation "I see" "okay, I'm listening" "MMM". When you don't understand or aren't sure of what your child said you can say "So did you mean that..." or "If I understand you correctly..." or "Correct me if I'm wrong but do you mean..."**
- 6. Mirror the child's affect. When the child looks concerned you should look concerned. If the child is sad or crying, acknowledge that you see they are upset and that you are ready to listen. Don't immediately try to cheer up the child until you understand what is bothering the child.**

## **Group Activity**

**Now it is time to practice using the skills you have learned about effective communication.**

**The group members turn their chairs to face the person to their left or right so that pairs are formed. One person will be the interviewer and the other the interviewee.**

**Distribute interview #1 and allow 5 to 10 minutes for the interview to take place. Then switch roles and distribute interview #2. Each person then gets the chance to play either interviewer or interviewee.**

## Session Seven (cont.)

## Interview #1

1. What qualities do you look for in a friend?
2. Visualize yourself a year from today. What goals will you have attained?
3. What issue do you think your child is currently struggling with?

## Interview #2

1. Why is communication between you and your child important?
2. What did you do recently that made you feel good about yourself?
3. What do you think your child worries about?

**Group Discussion**

What emotions did you experience when you were being interviewed? Did the interviewer seem to be listening? How did you know the interviewer was listening? What does it feel like to be genuinely listened to?

**Journal Assignment**

Make an appointment with your child for a talk.  
Use the skills that were covered in this session.  
Record in your journal what the experience was like for you and for the child.

# COMMUNICATION SKILLS

## LISTENING TO THE CHILD

**Open session by reading last assignment.**

### **Leaders Guidelines**

Negative thoughts and feelings get acted out destructively when there is no safe way to express them. When children can express their feelings at home they are less likely to get in trouble in school.

Parents need to learn good communication skills and tolerate the intense and sometimes frightening feelings their children may have. Here are some tools that can help children and parents to listen better to each other. I suggest for further group activity that you have the group role play the cartoon situations in the book How to Talk so Kids will Listen and Listen so Kids will Talk, by E. Mazlish and A. Faber.

### **Key Concepts**

When people have painful or angry feelings they need to express them in words or through creative play so that they do not become destructive to themselves or others. In other words... Children will behave well when they feel good.

All *feelings* are acceptable, but *actions* must be limited to protect the family.

Home needs to become a safe place to express negative feelings.

Parents need to become the primary listeners to their children's concerns.

### **The Tools**

**Talk it out** - Give the feelings a name. Say how you feel in a message beginning "I feel upset when..." Avoid name calling or labeling behavior.

**Play it out** - Punch a pillow, punching bag or soft toy. Use a doll or a puppet and have the child speak through the toy when they cannot own a feeling because it may be too frightening.

**Art** - Draw a picture of how you feel. (Keep crayons and pencils around the house.)

**Writing** - Put your feelings and thoughts down on paper. Send a note.

**Say nothing and just listen** - make eye contact, show your interest.

### **Group Activity**

Complete the attached page "Acknowledging Feelings".

### **Journal Assignment**

This week write about a situation in which you identified a feeling in your child and how you listened and spoke to the child.



## **Teens - Alcohol and Drugs**

### **Discussion**

Brainstorm the reasons why teens are drawn to using drugs and alcohol.

( Here are a few suggested reasons.)

1. Peer pressure.
2. To avoid social anxiety or boredom.
3. To prove the teen is grown-up .
4. To relieve the feeling of being lonely or isolated.
5. Drugs and alcohol are cheap and easy to obtain.

### **A Dozen Strategies for Preventive Responses for Parents**

1. Set an example.
2. Be direct and clear about limits, curfews and consequences.  
example " I will ask any teenager who brings drugs or alcohol into our house to leave." or "There must be an adult present at the party. " or "I must speak to the adult in charge before I let you sleep over your friend's house."
3. Talk to your children in an age-appropriate way about your history and the values of recovery that you have incorporated in your life.
4. Take your teen to an NA meeting.
5. Arrange to have your teen meet a person you admire who has gone through recovery.
6. Support your child in sports and exercise activities with peers.  
Have group name different athletic activities from their own or their children's experiences .
7. Encourage music and art activities or lessons.
8. Support friendships with positive peers and role models.
9. Join community centers in your neighborhood.
10. Join a church or synagogue youth group.
11. Do outdoor activities with your teen, hiking, camping out, skating.
12. Encourage your child to find a part time job or work for a community service organization.

### **Assignment**

**What pressures is your child or teen now facing?**

**What helps you stay committed your recovery program and lifestyle?**

**How can you help your child avoid drug addiction?**

## Children's Sexuality and Protection from Sexual Abuse

**To the Group Leader - Read last journal assignment**

Pass out the chart entitled "How Children Develop Sexually". Highlight the fact that children have sexual responses although their sexuality is not aimed at sexual intercourse, orgasm or other forms of adult sexual gratification. Children experience genital pleasure from birth. Boys can have erections and girls lubricate vaginally. When adults expose children to too much adult sexuality they are overstimulating their children. Adults need to protect children from witnessing sexual intercourse, or being sexually molested.

### **Sexual Abuse of Children**

Sexual abuse occurs when adults or older adolescents force children into sexual acts involving touching of the genitals, oral genital contact or penetration of the anus or vagina.

### **Prevalence of Sexual Abuse**

Annually 100,000 to 500,00 children are sexually molested in the United States. In the drug addicted and alcoholic family system sexual abuse is twice as prevalent.

### **Making Your Home Safe**

↳ Listen carefully when children talk about a family member or adult who may be molesting them. Observe when children seem fearful or withdrawn around people in the household.

↳ Children do not understand what they are seeing if they witness sexual intercourse. They may interpret the sounds and sights of intercourse as violent, hurtful and frightening.

↳ Parents should avoid excessive nudity around children.

↳ Parents should respect children's need for privacy when they are dressing or toileting. Adolescent children should not share their beds.

### **Group Discussion : Parents and Sexual Partners**

What are your ideas about when to bring home a lover to spend the night?

What feelings might a child have about a parent's new partner?

How can a parent prepare a child when the parent feels ready to introduce a new partner?

### **Assignment**

Make two lists. One will contain the qualities you look for in a sexual partner the other will contain the qualities you look for in a parent.

## HOW CHILDREN DEVELOP SEXUALLY

### From Birth to Age 12

From the moment of birth, children begin learning about themselves as sexual people. The concept of development is quite helpful to parents. Simply understanding that particular behaviors are predictable at specific ages allows parents to relax and nurture their children's growth. This chart outlines the typical psychological processes, thoughts, and behaviors related to sexuality that many children experience as they progress through childhood. Use it as a guideline for understanding age-appropriate concerns and behaviors.

#### Children from birth to age two may

- Explore body parts, including genitals;
- Begin to develop an attitude (either positive or negative) toward their own bodies;
- Experience genital pleasure (from birth, boys have erections and girls lubricate vaginally);
- Be encouraged by family (and society) to develop a male or female identity;
- Learn the expected behaviors for boys and girls.

#### Children at ages three to four may:

- Become aware and very curious about gender/body differences;
- Touch themselves and learn to masturbate on their own;
- Play house, doctor, or explore other forms of sexual play activities with friends and other siblings;
- Establish a firm belief that they are either male or female;
- Mimic adult sexual behavior;
- Begin to repeat curse words;
- Ask questions and peek under clothing of dolls or friends;
- Be curious about own origins and ask, "Where did I come from?"

#### Children at ages five to eight may:

- Continue sexual play activities and masturbation;
- Become curious about pregnancy and birth;
- Have strong same-gender friendships. Girls and boys are often socialized to communicate in very different styles;

- Show strong interest in male/female gender roles that are often stereotyped;

- Have a basic sexual orientation;

- Have a new awareness of authority figures: teachers may be seen as knowing more than parents;

- Compare their own situation with those of peers; complain about lack of fairness;

- Begin to conform with peer group style of dress and speech;

- Engage in name-calling and teasing.

#### Children at ages nine to twelve may:

- Enter puberty, especially girls. Early development may be perceived more positively by a boy than by a girl;
- Become more modest and express a need for privacy;
- Experience emotional ups and downs;
- Have romantic crushes on friends, older teens, music and TV stars, counselors or teachers;
- Continue to attach importance to same gender friends;
- Feel awkward;
- Masturbate to orgasm;
- Be strongly influenced by peer group;
- Have sexual or romantic fantasies;
- Face decision-making about sexual activity and drug-taking;
- Initiate sexual intercourse as early as age 12.

This chart was adapted from: *When Sex Is the Subject. Antiques and Answers for Young Children* by Pamela M. Wilson, MSW. (Santa Cruz: Network Publications, 1991)

## Raising your Child's Self-Esteem

**Group Leader** – Begin with group members reading last session's assignments.

### **Key concepts for Group leaders**

A young child learns to value herself through the ways in which the parents show they value the child.

As the parents show their pleasure and faith in the child, the child learns that she is lovable and worthwhile.

Parents who praise, encourage and enjoy their children build high self-esteem in their children.

**Definition of praise** - Words and sometimes actions that applaud, commend or give great value. Parents need to praise and give recognition to their children's achievements.

**Definition of encouragement** - Words or actions that show appreciation for the child's struggle and effort regardless of whether the child is successful. Parents need to recognize their child's efforts to meet a challenge and not only focus on their strengths and successes.

Parents who play with their children and provide mentally and physically stimulating activities help their children develop good feelings about growing up, learning and taking risks.

Parents should find opportunities for success. Point out improvements and encourage efforts. Ask children to contribute to family life. Give them responsibilities they are ready to handle.

Search for ways to compliment a child. Look for opportunities to express your delight in the child and your faith in the child's abilities.

Example (When siblings fight) "I noticed that you let your sister have the first cookie, you can be such a kind big brother."

### **Group discussion**

Children participate in the following activities that are opportunities to build self-esteem.

- ♣ school plays
- ♣ recitals
- ♣ sports events
- ♣ holiday celebrations

Can you list others?

Do you remember special events in your childhood in which your parents encouraged and praised you?

**Journal Assignment:** Write out ten statements of praise and encouragement you can say to your child.

## Discipline and Punishment

**Begin with group reading their statements of encouragement.**

**Group Leader:** As a basis for your discussion consider the definition of the word *discipline*. The root of the word is from the Latin "Disciplina" which means to teach or instruct.

**Webster's New Twentieth Century Dictionary States.**

**Discipline 1.** the training that develops self-control, character, orderliness and efficiency.

**2.** The result of such training, self-control and orderly conduct.

The job of a parent is to teach the kind of social behaviors that children need to know to get along with others. When we teach children we are also saying that we are going to prevent them from getting out of control. The adults set limits by being in control and never becoming violent. Violence does not teach a child discipline but fear.

**What is a disciple?**

The follower of a great or inspiring teacher.

Aren't young children like their parents' disciples?

The goal of discipline is to become self-disciplined.

**Definition of the word Punish from Webster's New Twentieth Century Dictionary**

**1.** To cause a person to undergo pain, loss or suffering for a crime or wrongdoing.

**2.** To impose a penalty on a criminal or wrongdoer for an offense.

Many Research studies show children perform better when they are rewarded and encouraged than when they are criticized and punished.

### **Group Brainstorm:**

How do you function best? When you are encouraged or when you are criticized?

What makes you want to learn something new? Anticipation of rewards and praise or fear of failure or humiliation?

**Activity:** Make a list of non-violent penalties that serve to reinforce your values, set limits and establish the parent as in control. These might include loss of TV privileges, allowance and for young children "time out."

Make a list *Reasons Why Hitting and Screaming Are Harmful To Children*

### **Journal assignment:**

Choose at least three items from the list of reasons why hitting and screaming are harmful to children and write about them. Why did you choose these items?

## **UNDERSTANDING CHILDREN'S BEHAVIOR**

**Begin by asking group members to read their assignment from last session.**

### **Group Leader Notes**

The group leader's lesson for this session should incorporate the following concepts about children's behavior. Building insight into the reasons why children misbehave can prevent parents from labeling their children as innately bad and then reacting with harshness. Journals should be taken out and notes written during this session. To cover all four misbehaviors and remedies expect to use this material over two sessions.

### **Key Concepts**

- ☞ Misbehavior is often a result of a child's ignorance of socially and morally correct behavior.
- ☞ Seek ways to replace punishment with teaching and talking.
- ☞ Not until bad or negative feelings can be safely expressed will good or positive behavior exist.
- ☞ Children act right when they feel right.
- ☞ All children want to belong and be important.
- ☞ A misbehaving child is sending a message for parents to analyze.

### **Reasons why children misbehave**

1. To get attention from the parent.
2. For power - when parents are in a power struggle.
3. For revenge - the child who is angry and hurt.
4. Depression and self-hatred - when anger is turned inward.

### **Group Activity**

Have group list how children behave when they want attention. Your list should include the following.

### **The Need for Attention (Suggested reasons)**

1. Children speaking, yelling or abusing their voice.
2. Banging toys or objects loudly.
2. Frequent whining or talking like a much younger child (baby talk).
3. Talking incessantly or interrupting.

4. Playing the clown at home or in school.
5. Being argumentative, seeking to engage parent in frequent bickering.
6. Showing off with risky behaviors and physical stunts.
7. Getting into minor accidents - accident proneness
8. Sibling fights and tattling.
9. Refusal to let parent out of sight.
10. Inconsolable crying at partings or bedtime.

Help the group think of ways to remedy each of the four problem behaviors. Here are some guidelines leaders can offer to move the group along.

#### **Remedies for attention-seeking behaviors.**

1. Make time for one-to-one focused attention with your child every day or at every visit. Include holding and physical comfort.
2. Make an appointment (with a mutually agreed upon time) to speak to child on phone when you are away.
3. Write letters as often as possible when you are away from child.
4. Redirect child into positive and contributing behavior when child seeks attention.
5. Ignore the attention-getting misbehavior but give attention during pleasant times.
6. Talk over your visiting schedule and get child to repeat the information to you to ensure that the child understands.

#### **Power Struggle**

(Group leader can ask group to contribute ideas).

Behaviors:

1. Refusal to do homework or chores.
2. Verbal hostility and disrespect of parents.
3. Using siblings to take sides against the parent.
4. Arguing for greater privileges.
5. Choosing adult activities or overinvolvement with adult conversation  
Ex. Child prefers paying job over sports or peer activities.
6. Frequent negativity and arguing.

#### **Remedies for Power Struggles**

1. Recognize the problem.
2. Withdraw when the struggle is over unimportant issues, refuse to fight.

## Session Twelve

3. Hold fast to your values when it is important, but refuse to argue.
4. Give child more responsibilities, share your power.
6. Offer greater privileges when child handles responsibilities well.
7. Talk about the struggle during peaceful times.
8. Set up time to be together in an activity that the child chooses.

**Revenge**

When children are hurt and angry they often misbehave to get revenge. "You hurt me, now I'll hurt you" is the message underlying these problem behaviors.

This calls for great patience and understanding from parents. Children who feel their parents have chosen drugs over them are often seeking to hurt their parents to provoke a confrontation and get the issues out in the open.

**Behaviors of Children Who are Seeking Revenge**

(Group leader can ask the group to contribute their ideas.)

1. Stealing money or valued things from the parents.
2. Destroying parent's property.
3. Failing in school.
4. Hitting or becoming violent with parent.
5. Hurting a sibling
6. Verbally abusing parent.

**Remedies**

1. Make appointment with child to air all complaints.
2. Listen without interrupting - acknowledge child's anger but prohibit violence.
3. Talk to children about your addiction and recovery.
4. Give children a chance to make amend' en they steal or destroy property.
4. Stay involved with school progress.
5. Encourage expression through writing letters, drawing, talking.
6. Go to a friend or professional to cool off and deal with your hurt feelings.
7. Set limits firmly and unemotionally. (Ex. You must be home by 10 P.M. if you expect to go out this weekend.)

**Depression and Self-hatred**

This is the most serious reason for misbehavior. When children feel they cannot change the parent or the environment they tend to blame themselves or they become resigned and hopeless. Depression in children appears in various ways, from being lethargic, to restless and agitated. Depression is anger turned against the self.

**Behaviors of Depressed children**

1. Becoming indifferent, withdrawn.
2. Overeating, lack of appetite.
3. Sleeping too much, insomnia.
4. Truancy in school, dropping out of school.
5. Preoccupation with thoughts of death or illness.
6. Isolation from friends.
7. Self-mutilation, cutting the arms or legs with razor or knife. Body piercings ,tattoos.
6. Sexual promiscuity
7. Drug abuse.
8. Suicide or attempts to commit suicide.

**Remedies for Depression**

1. Make special time for one to one talks every day. Reassure child of your love.
2. With child's involvement write down all the fears and feelings.
3. Take seriously any threats of suicide
4. Stay close to child, make holding and caressing part of your interaction.
3. Arrange for success. Give child opportunities to develop talents or abilities.
5. Get professional counseling or family therapy.
6. Don't give up

**Journal Assignment**

During the coming week observe your child for any of the four problems in behavior. Analyze the reasons behind the child's behavior and how you could remedy the behavior.

## Preventing Isolation Creating a Resource List for Home Use

Many parents are struggling to remain drug-free while caring for children without sufficient supports. Single parents may be isolated, married parents may also feel isolated if their partner is not supportive or is away from home during the day. Parents need a network of people and places to turn to in order to combat isolation. A resource list can prevent stress, exhaustion, depression and loneliness that can lead to relapse and also poor parenting. The isolated parent may have turned to drugs initially because of the stresses of being alone with children. This session is devoted to exploring with parents how isolation can lead to problems. In most parenting groups there are children in the care of foster parents or relatives. Parents often have high hopes about how wonderful things will be after being united with their children. Parents will need to have a safety net of people to call in their communities. To begin a thoughtful discussion the following questions should be asked.

### Group Discussion

- How does isolation from people in the family and community lead to irritability with my children?
- What are the dangers for a parent who is alone with her children on a day when the weather is bad and there are no plans for the day?
- How did the stress of caring for your children contribute to your drug abuse?

### Creating a Resource List

The group leader will ask the group to create a directory of community resources by naming what places and people they can think of that exist in any community. The items on the list should include:

#### **Places in the Neighborhood**

- local church or synagogue
- place where NA meetings take place

**Session Thirteen**

- library
- YMCA or community center
- hospital or clinic
- Police precinct

**People to Call**

- the parents sponsor
- family members
- people in parenting group
- people in recovery program
- pediatrician
- clergyman
- guidance counselor at children's school
- social workers, therapists in recovery program
- school principal
- neighbor in apartment building or on block

**Assignment**

**Take the list of resources and input the names of specific places and people in your community. Include telephone numbers and hours of operation. This list should be posted by the telephone in your home.**

## **Helping Parents Talk to Their Children About Separation**

### **Group Leaders - Discuss with the group each of the starred concepts.**

**\*Many children of recovering addicted parents have been placed with relatives, in foster care or in group homes. The circumstances at the time of placement are frequently chaotic. Children may only partially understand what has happened and as a result, they may distort ideas they have picked up from what they overhear adults saying.**

**\*Children may blame themselves for the separation. They need to know that they did not do anything wrong.**

**\*When parents visit their children they need to speak to them in an age-appropriate way about the change in their lives.**

**\*Plans for the future should be discussed only if they are known. Promises about coming home should not be made if they cannot be kept.**

**\*Depending on the age of the child and how much the child knows of the parent's drug use, it is important that the parent share some information about the treatment the parent is undergoing.**

**\* When the parent sees the child the parent should encourage cooperation between the child and the relative or foster parent who will be taking care of the child.**

**\* Parents need to reassure the child that during their separation the parent will visit, call or write to the child on a regular basis.**

**\*When parents are unhappy with the care their child is receiving, they should seek help to make changes as soon as possible.**

### **Elements in a Healing Communication about Separation**

**1. Acknowledge the child's distress over the separation.**

**Example: "You seem scared and worried that I'll never come back"**

**Session Fourteen (con't)**

- 2. Comfort the child by holding, stroking or caressing.**
- 3. Reassure the child that it is not her fault you are not able to be together.**
- 4. Tell children the positive steps you are taking in order to be back in their lives**
- 5. Give the child a calendar and mark the day you will be visiting with a smiling face, a star or any distinctive sign. Tell foster parent to mark off the days with the child. This could be done before the child goes to bed or whenever the child seems anxious.**
- 6. Give the child a message of your faith in the child's strength**

**Distribute role play to group.**

## **Group Activity- A Role Play of A Parent Child Visit.**

(Groups can add to or personalize this role-play. It is meant to be used only as a guide)

**Child:** (begins to whine or cry) I don't want you to leave. Why do I have to stay here without you?

**Parent:** For now this is the best place for you to be... I see how sad you are. (Touch child) It's very hard to say good-bye.

**Child:** I hate being with (grandmother, aunt, foster mother) she doesn't understand me, not like you do. If I could go home with you I'd do all my chores, I'd be no trouble, I could help you.

**Parent:** You aren't here because you did anything wrong, you have always made me so proud of you. I do expect you to cooperate with the people here. It is important to me that you can continue your schooling, enjoy sports and games and all the activities that you do so well, make friends and be good to the friends you have. And while you are doing good things to help you grow and learn I will get the help I need to grow and learn too. (Be more specific about your recovery program and addiction when appropriate to child's age or experience.)

**Child:** But how long do I have to wait?

**Parent:** Here, let me show you when I'll be back to see you. (Take out calendar and count the days together.) I will also write to you so that you will get a card from me during the time when I can't be here to see you.

**Child:** I wish you didn't have to go.

**Parent:** I know that you will be sad and miss me sometimes just as I will miss you. When you feel sad remember that I believe this is the best arrangement for you right now and always keep my love for you in your heart and mind. Now before I go, let's talk to the foster mother and tell her when I'm going to visit you. We can give her this calendar to put on the wall above your bed.

**Assignment:** Write in your journal about why it is important for you to speak to you child about your separation from the child. What does your child need to know about the separation?

## Empowering the Group

### The Position Paper

**Group Leaders: Review resource list. Ask group members to add their names and telephone numbers, put on a flip chart or blackboard for group to copy.**

The goal of the session that follows is best stated by the term "empowerment". Social work has a long history of empowerment movements (Simon, 1994 *The Empowerment Tradition in American Social Work*.) Parents become empowered when they see that the community can use their knowledge and self-awareness. As you come to the end of the parenting course it is fitting for the group to make a contribution to the community. In this session, the parents will create a position paper which will be a document setting forth their values and recommendations that others in the treatment center can benefit from. There can be a sense of accomplishment as the group realizes that it has developed an expertise while in the group. Each statement in the position paper is like a plank in the group's platform. The group takes a stand, sets forth its ideas and values and does so as a collective endeavor. Once the position paper has been written the group leader should print it attractively and distribute the paper to the group members. The group leader can think of appropriate times and places to have the position paper presented. The graduation ceremony may be a suitable time to share the position paper.

Also if the agency has meetings each morning this time can be used to have a group member read the position paper. If the agency has a newsletter the position paper could be published there. The position paper could also be sent to the local newspaper or mailed to other agency administrators.

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