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# Chapter 5—Breaking the Cycle: The Substance-Dependent Client as Parent/Caregiver

Many adults with substance abuse disorders were abused or neglected during childhood. Although most do not abuse their own children, they are at increased risk of doing so (Kaufman and Zigler, 1987). When children who are victims of maltreatment become adults, they tend to repeat a dysfunctional cycle and often lack mature characteristics: the ability to trust, to make healthy partner choices, to manage stress constructively, and to nurture themselves and others (Magura and Laudet, 1996). In addition, substance-abusing women report higher rates of childhood sexual abuse than non-substance-abusing women, and these women report increased episodes of abuse from their adult partners as well. Domestic violence is a reality in many of these families (Browne and Finkelhor, 1986; CSAT, 1997b; Ryan and Popour, 1983). Research shows that childhood maltreatment has developmental, behavioral, and emotional consequences that continue into adolescence and adulthood. Researchers are now examining childhood abuse and neglect as an indicator of the potential for substance abuse (Feig, 1998; Felitti et al., 1998; Whitfield, 1998). For example, one study (Felitti et al., 1998) found that medical patients with adverse childhood experiences (i.e., traumas) had a higher incidence of health disorders, including problems with alcohol (7.4 times that of control patients) and problems with illicit substance use (from 4.7 to 10.3 times that of the controls).

Sheridan proposes a model of intergenerational substance abuse, family functioning, and abuse and neglect that reflects both the direct and indirect relationship between parental substance abuse and family dynamics, child and adult maltreatment, and second-generation substance abuse. She indicates that unless effective intervention occurs, there is an increased likelihood that these patterns will be repeated in the next generation ( Sheridan, 1995). Parental substance abuse presents not only a risk for intergenerational transmission of substance abuse disorders but also substantial risk for repetition of problematic parent-child interactions, including abuse and neglect (McMahon and Luthar, 1998). These studies indicate increased risk factors, and counselors should not assume that their clients with histories of child abuse are mistreating their own children. The family system may function well enough when stress is low. Substance-abusing parents are already severely hindered in their ability to provide a safe and nurturing home to their children (U.S. Department of Health and Human Services [DHHS], 1999); increased stressors such as loss of jobs, poverty, and illness will only exacerbate the situation.

## Who Abuses and Why

Nearly one fourth of physical abuse and more than half of sexual abuse of children occur at the hands of adults who are not the victims' birth parents. They may be other relatives, caregivers, or partners. The likelihood of this kind of abuse is far greater when parents are using substances and, consequently, cannot provide adequate care for and supervision of their children (Reid et al., 1999). However, because most child abuse occurs within families, the discussion here will focus on parents. Providers should also note that most child sexual abuse is committed by males (Finkelhor, 1994).

Research on parenting styles and attitudes of abusing parents indicates several distinct characteristics shared by parents who abuse their children. These include seeing child rearing as

difficult and not enjoyable, using more controlling disciplinary techniques, not encouraging the development of autonomy in children while maintaining high standards of achievement, and promoting an isolated lifestyle for themselves and their children (Briere and Elliott, 1994). Observational studies indicate that abusing parents are less supportive, affectionate, playful, and responsive to their children and are more controlling, interfering, and hostile; they have fewer pleasant interactions with their children (Magura and Laudet, 1996). Abusive parents tend to "parentify" their children, expecting them to take on the role of caretaker. Because they do not have sufficient knowledge of child development, their expectations of their children's behavior are often too high, leading them to adopt inappropriate disciplinary practices (Wegsheider, 1981). In fact, most abusing parents do not help their children adapt to the major developmental tasks, such as regulating their sleep habits, preparing them to separate from their parents, enabling them to explore their environment safely and with appropriate limits, and making choices and becoming more independent (Levy and Rutter, 1992; Mayes et al., 1997; Rodning et al., 1989). Nor do these families successfully resolve issues of attachment, emotional regulation, autonomy, peer competence, or school and work competence (Cicchetti and Lynch, 1993).

*Damaged Parents: An Anatomy of Child Neglect* (Polansky et al., 1981) summarizes the characteristics of abusing parents identified by researchers in several different studies:

- The prevalence of poverty, substance dependence, mental illness, and large numbers of children per family
- Feelings of inadequacy and self-reproach, often related to early negative experiences
- Depression, difficulty putting sadness and needs into words, and anxiety discharged into activity
- Serious arrest in development, a sense of incompleteness resulting from a failure to internalize a separate identity (manifested by clinging to children), the presence of other abusive and unfulfilling relationships, and an inability to tolerate being alone
- A fear of taking responsibility and making decisions
- Severe difficulties in verbal communication
- Difficulty in seeking or obtaining pleasure
- Extreme narcissism, gross immaturity, dependency, and an impaired ability to empathize with a child's needs

The Polansky study cautions against overgeneralizing neglectful or abusive parents. Also, it is important to remember that poverty may be a common characteristic because poorer parents are more likely than affluent parents to be involved in public systems, which are mandated to report abuse cases. (Affluent parents tend to access private systems in which reporting is not required.) Nonetheless, the development failures above can signal to a counselor both a potential risk for child abuse and the possible effects of maltreatment in a parent's past.

At the same time, certain resiliency factors have helped many children avoid the cycle of abuse. These include being able to fantasize about another time or place, being able to read and learn about a better time and place, realizing that they are not responsible for the abuse directed at them, and having an adult in their life for a considerable period of time who sees them in a positive way. Resiliencies can be grouped in the following seven categories (Wolin and Wolin, 1995):

- ***Insight*** begins with a sense that life in the troubled family is strange. Such insight can eventually protect the child from a tendency to internalize family troubles and feel guilty.
- ***Independence*** is the child separating herself from the troubled family.
- ***Relationships*** fulfill needs that troubled families cannot meet.
- ***Initiative*** is the desire to overcome feelings of helplessness that a child can succumb to in the troubled family.
- ***Creativity*** is the ability to take pain and transform it into something artistic and worthwhile.
- ***Humor*** allows the child to make the tragic into something comic and laugh at his emotional suffering.
- ***Morality*** is developing a set of principles that differentiates bad from good both inside and outside the family.

Traditional models of parenting may serve as a useful context for understanding how a client views his own parents and the implications for repeating their behavior. The three major types of parenting styles have been described as authoritative, permissive, and authoritarian (Baumrind, 1971). The *authoritative* parent maintains reasonably close supervision, sets consistent standards, and keeps track of children without being overly directive. A *permissive* parent allows children to do as they please and sets few limits or guidelines, which may result in safety problems; this is often a neglectful parent. The *authoritarian* parent is directive and rigid and relies on punishment as a major disciplinary method; within this model, this is often an abusive parent. However, parents typically combine these styles when interacting with their children, and the effectiveness of the approach used depends largely on the family's culture, community, and environment.

Paradigms from developmental literature can also be useful in understanding the effects of environmental disturbances on the maltreated child. Belsky's ecological model, for example, contains four levels of analysis: (1) individual development, (2) family systems, (3) community, and (4) culture, all of which interact with each other and influence whether or not maltreatment will take place (Belsky, 1993). As this model shows, alcohol and drug counselors must understand the broader context of the forces that influence clients and their families. In turn, the counselor can help clients sort through those forces--family, neighborhood, community, or culture--to gain a better understanding about what is and is not good within their environment.

### Causes and Context of Parental Abuse

While most research has focused on repeat offenders, there is some knowledge and speculation about how certain dynamics and behaviors are integrated to shape an abusive personality. A common pattern of parent-child relationships is characterized by a high demand for the child to perform in order to gratify the parents and by the use of severe physical punishment to ensure the child's proper behavior (Pollock and Steele, 1972). Abusive parents also may be highly vulnerable to criticism, disinterest, or abandonment by their spouses or significant others, or to anything else that might reduce their already low self-esteem. These types of events produce a crisis of unmet needs in the parents who then expect the child to provide gratification. Unable to meet these parental expectations, the child is punished excessively (Pollock and Steele, 1972).

This pattern of overly aggressive and demanding behavior is often rooted in the parent's own childhood. Many abusive parents report that they were raised in a similar way, and these types of childhood experiences provide "lasting imprints" that are reflected in the way the adults feel about themselves and their children. More recently Dutton, in *The Psychological Profile of the*

*Batterer*, has identified characteristics such as the presence of a "shaming father" and the need for children to be excessively mature as factors that contribute to the personality of the batterer (Dutton, 1995).

## Role of the Counselor

Alcohol and drug counselors can play an important role in helping to break the cycle of child abuse and neglect that often plagues their clients. Many times, parents who were victims of abuse or neglect as children express strong concern and anxiety about the possibility that their children may be abused. By working closely and empathically with a substance abuser, the counselor has the opportunity to break the cycle.

To help determine whether a substance-dependent client is at risk for child abuse, the treatment providers should become familiar with the client's childhood--her parents' style of child rearing, family dynamics, possible traumas, and other events that may serve as a predictor for child abuse or neglect. At the same time, the counselor also needs to learn about the client's current family life, particularly parenting behaviors that provide some clues as to whether the client's children are at risk.

This information--along with the counselor's awareness of a broad range of parenting situations, cultural backgrounds, systems, social supports, and treatment options--will enable the counselor to better assist clients and their children. Although counselors can play an important role in breaking the cycle of child abuse and neglect, they cannot do this alone. They are only one part of the continuum of care that is needed to break this cycle. For this reason, treatment providers will need to reach out and work with child welfare systems, school systems, child guidance clinics, health care providers, and others so that parents who abuse substances get the help they need and do not abuse or neglect their own children.

While women with substance abuse disorders have often been the focus of interventions, breaking the cycle of child abuse and neglect also means including fathers who are at risk for neglecting or abusing their children, as well as significant others and family members who may share caretaking responsibilities. The recommendations offered in this section apply to all clients responsible for the welfare of children.

### Learning About the Client's Childhood

A client's childhood can offer information that can be useful in understanding the nature of current family relationships. There are important issues that can be explored tactfully, without necessarily using specific psychology or health care vocabulary. Asking questions about these concerns in a respectful manner helps develop a good relationship between the client and counselor. Although a counselor cannot change the past, she can help the client find the strategies to improve her current situation and the strength to recover. Many of the questions that follow may be asked during assessment, but they can also be rephrased and asked again in treatment. These questions are merely guidelines that should be modified to fit the needs of each particular client.

- What do you know about the circumstances around your birth?
- What was your infancy or early childhood like? How did your parents describe you and those times?
- What was your relationship with your mother or father like? Tell me about any special times with them.

- Did anyone in your family (including aunts, uncles, cousins) use alcohol or drugs? Do you personally feel that they had an alcohol or drug problem?
- Did any family member ever undergo treatment for alcohol or drug use?
- Who raised you as a young child? Who was important to you when you were growing up?
- Did you have any serious medical problems when you were growing up? Were you ever in the hospital?
- How were you disciplined when you did something wrong? How did your mother, father, grandparent, or other caregivers reward you?
- Were your parents involved and interested in your life and activities? Did it feel like they knew what you needed and what was important to you? How did your parents show you their attention, affection, and appreciation? (These questions will help to identify patterns of neglect.)
- As a child, did you like school? Were there any specific school issues regarding attendance, grades, or behavior? Did you graduate from high school?
- Did your family move a lot as a child? Did you go to several schools because of frequent moving?
- How well did you get along with your peers and teachers?
- What was the relationship between your parents like? Were they divorced or separated while you were growing up? Was there ever violence involved when they were upset with each other?
- How old were you when you started having sex? How many times have you become pregnant or impregnated someone else? How did you handle each pregnancy? Did you keep the child?
- Was a child protective services (CPS) agency ever involved in your life? Were you ever taken out of the home? Did you ever have a caseworker?
- Did anyone in your family ever have trouble with the police?
- Do you remember any particularly frightening experiences as a child?
- Did anyone in your family ever have an emotional problem, like depression?
- As a child, what did you do for fun? What do you do for fun now?
- Did you attend church regularly as a child?
- Did spirituality or faith play a significant role in some other way as you were growing up?
- How do you get along with your own children now? Could you describe any special times with them?

These interviews should not be hurried. The counselor should make sure that the client is comfortable and that the meeting area is quiet and peaceful. Some questions or topics may need to be reserved for a later time when the counselor has developed a more trusting relationship with the client. (Besharov, in *Recognizing Child Abuse: A Guide for the Concerned*, provides guidelines for interviewing parents who are at risk or are suspected of maltreating their children that can be adapted by treatment providers [Besharov, 1990].) (See also DePanfilis and Salus, 1992.)

### Learning About the Client's Current Home Life

In treating a client with children, the counselor will naturally learn how much of an impact parenting is having on the client's substance abuse. In the best of situations, parenting is stressful. For those whose own parents were not good models, it can be particularly difficult.

Parents who abuse substances are not a homogeneous group. They have a range of experiences and a range of parenting skills (Howard, 1995; Tyler et al., 1997). Some of these parents have been abused and neglected during childhood. Others may not have been abused or neglected but have been raised by parents who did not have adequate parenting skills. Both groups have been exposed to poor models of parenting.

Counselors are treating individuals with serious addictions that interfere with their normal daily activities and mental states. Taking illicit drugs requires parents to focus their energies on procurement. Parental priorities are not their focus; rather, the parents are focused on a need to care for themselves. Although the majority of these parents express feelings of caring and concern for their children, the addiction supersedes all other concerns. When under the influence of mind-altering drugs, such as cocaine and methamphetamine, parents are unable to foster whatever nurturing and sensitive parenting behaviors they may have.

By having clients describe their current home life, the counselor can gain additional insights into their degree of risk for child abuse or neglect. Treatment providers should learn about clients' current supports (i.e., family, teachers, counselors), as well as whether they are having financial problems, living in substandard housing, or unable to pay rent or provide medical care for their children. Some specific questions that can be asked include the following:

- Who are the people or groups that give you support? Do you have any special friends? Do you belong to a church, temple, or other religious or community organization?
- What type of social activities do you enjoy? How often?
- Have you been involved in the legal system? When? Have you ever been on probation?
- Who else lives with you at your home? Who else spends time there?
- Describe a typical week. What is your routine each day? On weekends?
- Describe your children's schedules. What do you do with them each day? On holidays?
- Are your children receiving ongoing medical care? Are their immunizations current?

Through these and other questions, the counselor should get a sense of whether clients are at risk of neglecting or abusing their children.

### Socioeconomic and Cultural Differences

It is important that counselors not mistake class and cultural differences for child abuse or neglect. Many practitioners may not appreciate the limitations imposed by poverty and cannot distinguish between neglectful practices and those that are caused by lack of money and education. (Family problems of poverty may require referrals for cash assistance or concrete services for heat, clothing, or food.) For example, in some communities it is not uncommon for preteens to babysit infants. A seemingly disorganized house does not necessarily reflect uncaring parents. It is also important for counselors not to overreact to cases of social deprivation in poor families. While poverty may expose the parents to more risks for child abuse, most poor families do not abuse or neglect their children (

## Clues That the Client May Be Endangering Children

In certain treatment settings, such as day treatment centers with child-care services, the counselor may have the opportunity to meet the client's children. Such direct observation can be beneficial in several ways. First, the counselor can see firsthand how the client relates to his children:

- How does the client react to his children's behavior?
- How does he respond to his children's emotional needs? Do his children make eye contact with him? How does he respond to the children's crying?
- How does he praise and discipline his children?
- Are his expectations age-appropriate?

With this information, the counselor can assess the client's parenting style. Some warning signs that these children are in danger of abuse may be obvious, such as a parent hitting a child. Other behavioral signs may include a child's yelling, screaming, not being able to sit still, flinching easily, or attaching indiscriminately to others. Regression to an earlier developmental stage is not uncommon. For example, a child who had been toilet trained or able to separate well from the parent may suddenly be wetting her pants or clinging to her parent. The counselor should be mindful, however, that these behaviors might indicate developmental problems, such as attention deficit/hyperactivity disorder. Whatever the case, the child should be referred to a health professional.

The counselor will also have an opportunity to check for any signs that could result from physical abuse or neglect. The counselor can see if the children are underweight for their age or if they are unkempt. The counselor can observe whether the child has any exposed bruises, cuts, or obvious fractures. The counselor can then ask the client to explain why the child is underweight or injured. If the client's explanation is suspicious and the story does not fit the child's physical status or injury, then the counselor would have cause to report this to a CPS agency (see Chapter 6).

In most treatment settings the counselor does not have the opportunity to meet the client's children. Over time, however, the counselor will learn more and more about the client. In an unguarded moment, the client may begin describing parenting behavior that is not appropriate. The client may also share something in group or via writing exercises. Figure 5-1 lists some examples of poor parenting behavior that could lead to child abuse or neglect.

**Box**

Figure 5-1: Behavioral Clues That Suggest Possible Child Abuse or Neglect. Name calling, verbal abuse, negative or belittling labeling of the child Stories that suggest children are living in unsafe conditions (e.g., spoiled food, (more...)

In situations where poor parenting is indicated but the client does not appear to be abusing or consciously neglecting the child, the treatment provider will need to direct the client toward those agencies and services that can help her become a better parent. At the same time, the counselor can talk about and reinforce good parenting practices.

## Incorporating Treatment Strategies for Child Abusers

Breaking the cycle of abusive parenting means understanding the background of the parent within the context of the family, neighborhood, and culture. When parents who abuse substances recall their own childhood, they often report deprivation in many areas--emotional, social, physical, and economic. If these parents recall histories of severe neglect or abuse during childhood and adolescence, the counselor can assume that most have missed out on opportunities to form healthy, trusting relationships with their caregivers and have not experienced a model of parenting that included a consistent, nurturing environment with appropriate roles and boundaries. The first thing substance-abusing parents typically need to focus on is how to build positive relationships with their children. Because many clients' parenting skills and styles reflect what they have experienced, they will be at an increased risk of parenting inappropriately, and some within this group will abuse or neglect their children. Most of these parents want to do the best for their kids--they just don't know how. Therapists should support their clients' desire to become better parents and assist them in identifying parenting support programs.

Just as counselors can expect that substance-abusing parents often will deny their substance abuse, they can also expect parents to deny neglecting or abusing their children. The challenge for the counselor is to help parents understand that their parenting behaviors may not be appropriate and that these behaviors can negatively influence their children's future development, especially their ability to trust others and to develop self-esteem and pride about their lives. When parents lack a reference point--that is, good parenting models--they will need help in

- Recognizing the importance of appropriate parenting behaviors
- Seeking help to become better parents
- Identifying others who can support them over time as they parent their growing children
- Understanding how current abuse of substances affects responsible parenting

At the same time, the counselor must not forget to articulate the positive aspects of the clients' experiences. Focusing on the negative or risk factors only results in shame and futility and is counterproductive. Increasing clients' self-esteem and self-efficacy (their effectiveness and ability to take responsibility) is a primary step to their understanding of the child-rearing role. Thus, it is important for the counselor to praise clients when they act according to appropriate parenting behavior--and point out that this shows they do have the qualities of a good parent within them. This will develop a trusting and helpful relationship with these clients. It will also help them break the cycle of shame by offering some strategies of hope.

Indeed, there is evidence suggesting that substance-abusing parents are aware that their parenting strategies may be counterproductive and worthy of change (Hawley and Disney, 1992; Levy and Rutter, 1992) and that they are highly concerned about the well-being of their children ( Grossman and Schottenfeld, 1992; Tunving and Nilsson, 1985). The counselor's relationship with clients also provides a positive model for the client of what constitutes a helping relationship. Consciously or unconsciously, clients may adopt techniques they experienced as significant in their own therapy when interacting with their own children--reflective listening, setting appropriate boundaries, treating others with respect, and providing encouragement and positive reinforcements, among others.

### What Abusing Parents Should Learn

To raise a child in a nonabusive and nonneglectful manner, it is important that parents have the basic knowledge and skills needed, including the following:

- Realistic knowledge about child development

- Parenting skills
- An understanding of the impact of child abuse on a person
- Good relationships with spouse and other adults
- Other personal development and social skills development

Treatment programs should establish guidelines on how to deal with these issues if they arise during counseling and know when to refer clients for appropriate types of intervention and support, such as child development and parenting specialists. Additionally, there are many types of support groups available for parents and children involved in abusive relationships. Parents Anonymous, for example, is intended to help adults who abuse children. Parents Anonymous also targets families who have been involved in incest and attempts to keep these families intact or reintegrate families that have been divided because of incest. Alateen, another 12-Step group, is designed for older children whose parents are alcohol dependent and who may be at risk for abuse.

#### Realistic knowledge about child development

Parents should understand the stages of child development and the expectations reasonable for children at specific ages. (An organization in Washington, D.C., called "Zero to Three" [see Appendix E] develops materials, including posters and wall charts, for parents and child care practitioners that define and explain key stages in the development of children from birth to age 3.) Abusive parents often believe that very young children (i.e., 2- or 3-year-olds), can stop crying on command, take care of themselves, and respond maturely to the caregiver's needs (Peterson et al., 1996).

#### Parenting skills

At-risk or abusive parents probably need help in basic child-rearing skills, such as how to use effective disciplinary behavior, how to reward, and how to effect desired responses.

#### An understanding of the impact of child abuse on a person

A number of resources are available that can help clients learn about the consequences of child abuse. "Choices" is avideotape produced by the Center for Substance Abuse Prevention that features interviews with parents who were victims of child abuse. The Public Broadcasting Service has produced several special programs on child development that are available on video. A book of therapeutic stories, such as *Once Upon a Time: Therapeutic Stories To* Heal Abused Children (Davis et al., 1990), which can help heal the damage of abuse, can be read to children or given to parents to read. If adults at risk for abusing children were also victims, they should understand why they were abused (e.g., their own parents did not know about child development stages) if they are not to become abusers themselves.

#### Good relationships with spouse and other adults

A mother's satisfaction with her spouse and her sense of support from friends and from the community contribute greatly toward a positive attitude about parenting. Strengthening these relationships helps to increase the possibility of improved maternal caregiver behavior (Belsky, 1984) and may prove helpful for fathers as well. Developing interpersonal skills is an issue that can be addressed in therapy and also in marriage counseling.

#### Other personal development and social skills development

These include stress management, assertiveness training, and the development of self-confidence. Learning such skills as managing stress and knowing how to deal with anger may lower the risks of abusing a child.

### Selecting the Most Effective Treatment Program

Data suggest that interventions aimed at breaking the cycle of substance abuse, child neglect, and maltreatment are more successful when they are family centered (Magura and Laudet, 1996). Critical services that may need to be provided for parents who abuse substances include

- Access to physical necessities, such as food, housing, and transportation
- Medical care
- Counseling on substance abuse prevention
- Training on parenting and child development
- Training in child care techniques (bathing, holding, packing a diaper bag, giving medication, etc.)
- Social services, social support, psychological assessment, and mental health care
- Family planning services
- Child care
- Family therapy and health education
- Life skills training in such areas as financial management, assertiveness training, stress management, coping skills, home management, anger management, conflict resolution, and communication skills
- Educational and vocational assessment and counseling
- Training in language and literacy
- Planned, continuing care after program completion

If clients are to receive appropriate help, it is essential that the treatment match their current abilities to function rationally and to be good parents. Other factors, such as clients' social class, culture, and resources, must also be considered. By addressing these issues, counselors can place clients in community-based treatment programs that address their clients' particular needs. For example, it is important in family therapy to plan what will be discussed when children are involved. The family therapist will understand the developmental needs of the children and, when appropriate, will provide information to the children about the nature of substance abuse, dependency, and treatment. The recovery process of clients can also be addressed.

Parenting classes and support around parenting, recovery, and parent-child relationships can be explored. This can be based on the licensing and credentials of the counselor. Usually in early recovery, family education and counseling around recovery is helpful. Later in recovery, more in-depth family therapy may be called for, and a systems approach can be taken. However, when domestic violence is occurring, a systems approach is counterindicated. When a CPS agency is involved, a team approach that coordinates treatment plans is essential. See TIP 25, *Substance Abuse Treatment and Domestic Violence* (CSAT, 1997b) for more on this issue.

Clients with children will fall into two general categories: those with custody and those without. At intake, the treatment provider should find out which situation pertains to a client. To give

appropriate guidance for both groups, the counselor should learn the following about the client:

- Current substance abuse (and means of procurement)
- Substance abuse by a significant other who may be involved in child abuse or neglect allegations
- Treatment plan to reduce substance abuse
- History of deprived childhood
- History of child abuse and neglect
- History of involvement with CPS agencies or court system
- History of out-of-home placement
- Attitudes about parenting, knowledge about child development, and awareness that parenting tasks change depending on the age of the child

Standardized screening measures are available to provide a second source of information on clients' attitudes toward parenting and potentially problematic areas: The Parental Acceptance and Rejection Questionnaire (PARQ) discussed in Chapter 2 has an adult version completed by the parent about her relationship with her child as well as a child version completed by the child about his parent. The Parent-Child Relationship Inventory (PCRI), also discussed in Chapter 2, is another instrument that can help clinicians explore their clients' potential problem areas in parenting.

### Treating parents with custody

Studies show that the overwhelming majority of minor children affected by parental substance abuse remain in the custody of their parents (Feig, 1998). When dealing with parents who have custody of their children and who have reported a past history of deprivation, neglect, or abuse, the counselor will need to determine the safety of the children and the support available to the client. Some clients may not have custody of their biological children but are living with or dating someone who does and therefore has a caregiver role. At intake, the counselor should make clear to a client that she is concerned about the client both as a person with a substance abuse disorder and as a parent with certain responsibilities. The counselor needs to state from the beginning that both the client's and the children's safety are of utmost importance. To understand the situation better, the counselor will need the following information:

- The children's daily schedule and the adults involved in their care or supervision
- The children's current health status
- The client's involvement with other agencies, such as family preservation, back-to-work, and job training programs
- The role of a significant other in the care of the children, his attitude toward the children, and any previous history of abusive or neglectful behavior toward children
- Previous or ongoing involvement with CPS agencies, the reasons for involvement, current child protective system plan, and outcomes from previous involvement with CPS agencies

Once this information is obtained, the counselor should determine the client's daily and weekly activities. This is important in understanding the stresses and tasks required of the parent. For example, a client is likely to relapse or escalate drug use if she senses failure or experiences

frustration. Therefore, the counselor must help the client to prioritize her responsibilities and tasks, and recognize the need to identify supportive help when possible.

One approach that the counselor may want to consider is to place emphasis on safety. The two words "safety first" can be used to guide all discussions about a client's approach to her daily tasks. By prioritizing tasks based on the parent's and children's safety, the counselor can focus clients on immediate action in a way that is positive and nonaccusatory. By framing the discussion this way, the counselor can help parents understand that it is a safe strategy to stay away from drugs; it is a safe strategy to make sure their children are in the care of a clean and sober adult; it is a safe strategy to make sure that their children attend Head Start or school; it is a safe strategy to keep children's immunizations up to date (Rubin, 1998).

Over time, the counselor will become familiar with a parent's treatment attendance record, the results of random urine toxicology drug screens, and the children's activities and can thus get a sense of the stress and risk factors in the client's life that might lead to abusive or neglectful behavior. The counselor also will learn about the parent's ability to organize a daily schedule for his family and himself, follow through on responsibilities, and acknowledge when these responsibilities may be too daunting. When a crisis in a client's life seems imminent, the counselor will be better prepared to help the client reexamine his priorities and consider, once again, a plan that will provide safety for the children and for him.

### Treating parents without custody

Counselors will often treat clients who do not have custody of their children. This group of parents presents some issues that are different from those parents who do have custody. The counselor's initial major concern is not about the safety of the children. Instead, it is about the safety of her clients, addicted parents who need to focus on being sober and on reuniting with their children in a timely manner. The counselor should learn about

- The CPS agency's plan for family reunification and the schedule to complete this effort
- The specific requirements for family reunification, such as the time allowed clients to begin abstinence from or reduction of substance abuse, the visitation schedule with court-appointed caregivers, and completion of parenting classes
- Age, health, and general developmental needs of each child
- Client's history of loss of custody of children and outcomes
- Client's history of drug or alcohol treatment and outcomes
- Client's current drug use, health status, income, and housing situation
- Client's history of childhood deprivation, neglect, or abuse

With the recently legislated fast-track adoption laws and the requirement that courts establish more rigid time lines for family reunification, treatment providers must help the parent to prioritize the tasks that should be done for a successful outcome. For example, the client who acknowledges he must change his substance-abusing behavior to become reunited with his children is setting a priority toward successful family reunification. The counselor must then help the client proceed with this goal, recognizing that as time goes by other issues will need to be addressed and be included in the tasks that are required for family reunification, such as improving his parenting skills, finding appropriate housing, learning about financial planning assistance, and searching for work.

For family reunification to occur, it is critical that the alcohol and drug counselor collaborate with the CPS agency professional to develop a realistic plan for family reunification. Together, they must ensure that the parent is not overwhelmed with too many tasks at one time. Moreover, the counselor must carefully consider the timing of referrals to the appropriate professionals or community-based programs so that the court timeline for family reunification is taken into account.

## Treatment Settings

Most substance abuse treatment settings do not have the resources to handle both substance abuse and ongoing child abuse concerns. Interagency networks and agreements can be most effective in these cases. Such cooperative arrangements should include a unified system of case management and clinical review. Following are a few selected programs in the United States that have incorporated both issues under one roof, which can serve as models for creative program development in other communities. The recent study, *No Safe Haven: Children of Substance-Abusing Parents,* (Reid et al., 1999) also reviews some examples of innovative combined services.

### Residential programs for women

Residential treatment programs can be exceptionally productive because of the way many women deal with the world. Research suggests that a woman develops in the context of relationships, rather than as an isolated individual (Surrey, 1985). In this model, where relationship and identity develop in synchrony, a woman's role as mother is intrinsic to her personal growth and serves as a motivation to facilitate treatment. Depriving her of children and other personal relationships can be detrimental to recovery.

#### *Parental Awareness and Responsibility (PAR) Village*

Located in Largo, Florida, this program admits cocaine-dependent women into a therapeutic community with children younger than 10 years of age. As many as 14 women live in separate residences with their children.

Begun in 1990, PAR Village was originally a research project funded by the National Institute on Drug Abuse (NIDA) to answer the basic question, "Will women stay in treatment longer as a result of keeping their children with them while in treatment for their substance abuse problem?" Women were randomly assigned to one of two treatment programs: one with their children and one without. Results showed that women who entered treatment with their children stayed longer, completed treatment more often, and had more positive outcomes (especially in retaining or regaining custody of their children) than their control group counterparts. As a result, PAR applied for continued funding through CSAT to allow the program to continue its successful treatment models (Coletti et al., 1997).

While in treatment, both control and experimental groups were provided with group and individual counseling, educational and vocational training, parenting and life skills training, medical services, substance abuse education, and relapse prevention. In the original NIDA study, results indicated that positive outcomes increased when women came to treatment with their children. The experimental group had significantly longer lengths of stay. In fact, at 6 months, 65 percent of women with their children were still in treatment, compared to 18 percent of the control group. Posttreatment custody also improved. Half of the women who came to treatment with their children retained or regained custody of their children at the 6-month posttreatment followup, compared to none of the control group.

*The Spring*

This long-term residential program in Carlsbad, New Mexico, is designed for female substance abusers who have children. This intensive and structured treatment program incorporates psychological, social, educational, vocational, and spiritual aspects of treatment and provides support services for the residents' children and adjunctive family treatment. Each resident shares a private room with her children. The children attend school or day care, and mothers go to classes. Children receive testing and counseling, and mothers care for their children. The comprehensive residential program consists of a broad range of activities, including 12-Step meetings, classes, and therapy groups.

*Village South Families in Transition (FIT)*

This residential program for women in Miami, Florida, is funded by CSAT and the Ounce of Prevention Fund of Florida. The program allows residents to bring up to five children, from newborns to age 12, to live onsite for 18 months. The FIT program also provides services to adult significant others and nonresidential children. The program includes an onsite child care center, primary health care and support services, drug intervention and prevention services for mothers and children, and counseling on job and life skills, parenting, and mother-child relations. There are family visits and weekend visits, and partners and other family members are involved. If a mother relapses and has to leave, the village can maintain joint custody of the children, and the mother can regain custody later.

### Day treatment

Although residential treatment centers have many advantages, parents may find this type of facility disruptive for family members, especially for older children who would have to change schools, lose contact with friends, and have less access to extended family. For many parents, intensive, family-oriented outpatient and day treatment programs are a more feasible alternative.

*Family Rehabilitation Program (FRP)*

Launched in 1990 by the New York City Human Resources Administration-Child Welfare Administration, this program targets mothers with newborns exposed to drugs (often cocaine) identified by the child protective system. It attempts to prevent the need for foster care of newborns and enable the families to provide for the long-term development of infants and other children. The primary client is the substance-abusing mother, who is offered both substance abuse treatment and intensive social services aimed at preserving the family unit. Services are provided through contracts with community-based volunteer groups selected to provide culturally sensitive services, including home-based visits. Unlike many family preservation programs, which are limited to 60-day interventions, FRP clients participate in services for about 1 year (Magura and Laudet, 1996).

*Project Connect*

This project is an effort to respond to the needs of both parents and children. It is a collaborative effort between a State department of child welfare, a private nonprofit agency, a school of social work, and a number of substance abuse treatment and health care agencies. Its goals are threefold: to reduce the risk of child maltreatment, to keep families affected by substance abuse together, and to increase the capacity of the local service system to respond effectively to the needs of these families. Funded by a grant from the National Center on Child Abuse and Neglect, Project Connect is administered by the Rhode Island Center for Children-at-Risk in Providence

and operates under contract from the Rhode Island Department of Children, Youth, and Families (Olsen, 1995). Families receive services for about 10 months in this program.

*Project SAFE (Substance and Alcohol Free Environment)*

Begun in the mid-1980s by the Illinois Department of Children and Family Services and the Department of Alcoholism and Substance Abuse, this program focuses on poor urban minority women with children. In this program, caseworkers identify women who have been accused of child neglect or abuse and have screened as high risk for substance abuse. Project SAFE takes a proactive approach by intensively recruiting women into the program. Once clients are in the program, the outreach caseworker calls clients daily, offers transportation, and helps to arrange child care throughout intensive outpatient treatment (Boundy, 1998). (For additional information on Project SAFE, see Chapter 7.)

*Relational Psychotherapy Mother's Group (RPMG)*

RPMG is a weekly parenting group offered along with substance abuse treatment. RPMG concurrently addresses mothers' unmet psychosocial needs and parenting deficits using a nonjudgmental and supportive therapeutic stance, emphasizing interpersonal relationships with adults and children, and employing a guided-discovery approach to exploring parenting and interpersonal deficits. During a 3-year pilot study, RPMG was tested as an adjunct to standard treatment offered in methadone clinics in New Haven, Connecticut. Compared to mothers receiving standard treatment alone, mothers receiving the supplemental RPMG were at lower risk for maltreating their children, reported higher levels of involvement with their children, and greater parental satisfaction overall. At 6-month followup, in addition to sustaining their gains, the RPMG mothers were less likely to use opiates than comparison mothers. Children of RPMG mothers also showed healthier levels of psychosocial adjustment than children of comparison mothers (see Luthar and Suchman, 1999 and in press).

### Incarcerated parents and parents in transition from incarceration

Typically, substance abuse treatment programs in jail or prison settings will limit the presence of children. However, some criminal justice and social service professionals believe that children should have the opportunity to visit their parents in jail. Children typically want to see and talk to their fathers and mothers. Two programs in New Mexico provide such family services. Project IMPACT, at both the Central New Mexico Correctional Facility in Los Lunas and the New Mexico Women's Correctional Facility in Grants, reviews parenting skills of inmate fathers and mothers and provides education programs, counseling, and family visits. The program eases transition back into daily family life and provides community services to inmates' children and spouses during their incarceration. A second program in New Mexico, Comienzos, which means "beginnings," is an education program at the Bernalillo County Detention Center that provides education on parenting, family violence, and related topics. In these cases, professionals found they could motivate parents to become involved in the substance abuse treatment programs while in jail if they had contact with their children. The California Department of Corrections and the Department of Alcohol and Drug Programs support a prison-based program called Forever Free from Drugs and Crime. Forever Free participants live in a separate 240-bed facility and receive treatment 4 hours a day, 5 days a week. Counseling, relapse prevention, and problemsolving and parenting classes are part of the curriculum. For more information, call the California Department of Corrections Office of Substance Abuse Programs at 916-327-3707. For more information on substance abuse disorders and criminal offenders, see TIP 30, *Continuity of Offender Treatment for Substance Use Disorders From Institution to Community* (CSAT, 1998b).

## Organizational Roles and The Need for Collaboration

In treating adults with substance abuse disorders who are suspected of abusing or neglecting their children or who are already involved in the CPS system, counselors must communicate and collaborate with representatives from CPS agencies, all while keeping the best interests and confidentiality of clients and their families in mind. Counselors also must understand the role of juvenile, family, and criminal courts in prosecuting cases of child abuse and neglect. Every system attempts to accomplish a specific set of goals to help further the well-being of clients and family members. However, the philosophies and processes used may be very different, and the potential for conflict (expressed or unexpressed) among agency representatives is great. It is important to find ways to collaborate with other agencies in a manner that builds and maintains trust--while continuing to adhere to Federal confidentiality laws. Figure 5-2 presents some suggestions for ways in which professionals from the child welfare and treatment fields can collaborate more closely.

**Box**

Figure 5-2: Strategies for Collaboration. *Program planning and administration* Provide joint training for substance abuse treatment staff and CPS agency workers Develop team staffing approaches Provide joint funding (more...)

### Core Functions of a Child Protection System

: The Center for the Future of Children (Schene, 1998, p. 36).

- Respond to reports of child abuse and neglect, identify children who are experiencing or at risk of maltreatment.
- Assess what is happening with those children and their families--the safety of the children, the risk of continued maltreatment, the resources and needs of the parents and extended families, and their willingness and motivation to receive help.
- Assemble the resources and services needed to support the family and protect the children.
- Provide settings for alternative or substitute care for children who cannot safely remain at home.
- Evaluate progress of the case during service provision and assess the need for continuing child protective services.

### Role of Treatment Providers

The main focus of the treatment provider is to provide interventions and support to help clients with their substance abuse and dependence issues and recover from the physical, psychological, emotional, social, and spiritual harm that their substance abuse has caused themselves and others. However, once child abuse or neglect is known or suspected, legal constraints take precedence because counselors are mandated to report cases to CPS agencies. It is not the role of the treatment provider to investigate child abuse; once the report is made, the provider's clinical attention should shift back to and remain with the client.

It is important for counselors to let clients know from the beginning that counselors must report suspected abuse and neglect because the law requires them to do so. However, the accompanying message to the client should be that even if a report is made, the counselor will continue to work with the client, providing treatment and support. (Counselors should emphasize that it is in a client's best interest to address abuse issues before a child is harmed and before a client has jeopardized her parental rights.) For clients who have been reported, an extra measure of support may be necessary. For example, although counselors' large caseloads would preclude them from routinely accompanying clients to court, exceptions could be made for some clients.

Even when accompanying clients to court is not possible, the counselor can create strategies to address the upcoming court date and related issues in treatment. For example, clients who abuse their children often have their own abuse histories and may have painful memories of having to appear in court as children to be placed in foster care. Discussing such memories with clients may prove valuable to the treatment process. Helping clients understand the court system and procedures may also strengthen the therapeutic bond. The role of the alcohol and drug counselor often involves teaching clients self-advocacy and communications skills--that is, helping them learn to approach various systems in ways that will produce fruitful results that meet their individual needs.

### Role of CPS Agencies

Every State has a CPS system to investigate reports of child abuse and neglect to determine whether the child in question is in danger and to intervene if necessary. The CPS agency initiates a comprehensive assessment of a child's safety and well-being in the family. The assessment can involve interviews with the child, the parents, and other family members; visits to the home to evaluate the environment and family dynamics; contacts with schools and other service providers who are or have been involved with the family; and testing to assess the child's health and development (see Kropenske and Howard, 1994). CPS investigations, foster care placement, and adoption services are different aspects of child welfare services, but these functions are organized and titled differently in various States and municipalities; in smaller (i.e., local) jurisdictions, roles and responsibilities may often overlap.

If the CPS agency determines that a child is (or is at risk of being) neglected or abused, it can initiate family preservation services to remedy the problems (see Figure 5-3). The CPS worker is responsible for developing a service plan to help the family improve in those areas the assessment found lacking. The service plan can cover housing, day care, transportation, clothing, food stamps, parenting training, individual or group counseling (including substance abuse treatment), and teaching the parent basic household skills. These services may be provided while the child remains in the home if the child's safety can be assured, or the child may be removed to foster care while services are provided.

**Figure**

Figure 5-3: Overview of Steps Through the Child Protective Services and Child Welfare Systems.

When it is determined that a child is not safe in the home, the CPS agency has the authority to remove a child temporarily and place the child in another living situation, such as foster care or with relatives (i.e., kinship care). Relatively few children are actually removed from their homes

(in 1996, children placed in foster care represented 16 percent of CPS cases), and most of those removed are returned to the parents' custody fairly quickly once their safety has been assured (DHHS, 1999; Goerge et al., 1996).

Children who are placed in out-of-home arrangements must wait for the legal system's procedures to take place before a final plan of family reunification or other permanent placement is completed. This plan generally focuses on reuniting the family while ensuring the child's safety and may include substance abuse treatment for parents, as well as other services. The plan and progress toward it are reviewed periodically by the court, and it must be demonstrated to the judge that efforts are being made toward the achievement of the planned goals. Recent Federal legislation mandates that permanency plans be determined quickly and that a permanency hearing be held within 12 months of adjudication of the abuse or neglect. If the child remains in foster care for 15 of the most recent 22 months, the jurisdiction must start the process of terminating parental rights and developing a plan for adoption or kinship care for the child.

CPS agencies are required to investigate all reports of child abuse or neglect within a short time--generally a week. Unlike other public service agencies, they cannot generate a waiting list when service needs outstrip resources. With increasing reports of maltreatment in recent years, backlogs of uninvestigated cases have grown, and CPS agency caseloads have soared. Many workers are assigned more than 50 families even though standards developed by the Child Welfare League of America (CWLA) call for caseloads of no more than 12 to 17 families (CWLA, 1989; Daro and McCurdy, 1991; Reid et al., 1999).

### Role of the Courts

The juvenile or family court judge has several placement options, which vary slightly by State. These are reunification with parents, adoption, or guardianship (often with a relative). Children aged 16 and above might enter an independent living program. After reasonable efforts are made at reunifying the child with the family within the timeframe stipulated by law, the court can terminate parental rights and free the child for adoption. Juvenile and family courts have heavy caseloads, and judges sometimes hear a new case every 15 minutes (General Accounting Office, 1999).

Some child abuse perpetrators are charged in the criminal court, which is generally more crowded and slower than the family court system. In some cases, families may be involved with both courts. In those cases, the juvenile or family court judge may decide to delay a decision about a child placement case until the criminal court acts.

To make the courts more responsive to families' needs, the Center for Innovative Courtrooms has begun to establish juvenile and family courts that offer a whole range of services. The Center's court in Brooklyn, for example, offers drug treatment as an alternative to incarceration, as well as welfare, domestic violence services, general equivalency diploma programs, and other services to prepare offenders to become productive citizens.

In Hawaii, the West Hawaii Counseling and Supportive Living Project has been designed to assist individuals and families in providing safe and nurturing homes for children. A core team of professionals consists of a clinical social worker, a substance abuse treatment professional, a clinical nurse specialist, a service coordinator, and an agency director. They are the primary service providers who conduct a service needs assessment, provide service coordination, and make referrals to other programs and providers in the community. The goal is to provide families and children with individualized treatment planning and services that are flexible and are delivered in a manner that respects the family and their cultural heritage. The target clientele includes

- Families threatened by their own inability to cope with the current stress in their lives
- Pregnant women and mothers with children at risk of child abuse or neglect due to mental health or substance abuse factors
- Families who require service assessment or counseling to provide a safe, drug-free environment for their children
- Pregnant women and mothers with children seeking a recovery program that may include a supportive living environment
- Pregnant women, mothers, parents, or adults with caretaking responsibilities for children
- Parents whose children may be temporarily living outside the home
- Parents whose parental rights have been terminated and who no longer have custody of their children

### Role of the Community

The effects of substance abuse and child abuse are felt by the entire community. Thus planners, policymakers, and administrators are developing collaborative community responses that involve community education and prevention efforts, as well as pooling community resources that support clients' treatment. For example, over the past decade, community leaders in Albuquerque, New Mexico, focused on the growing problem of homeless and "throwaway" youths. Local schools, churches, and neighborhood associations joined together to provide physical space and staff for emerging service programs. Outreach teams were created to work on the streets with youths, and clean and sober drop-in centers and shelters were established. In Connecticut, the Department of Children and Families is facilitating connection among social workers, schools, and hospitals. San Antonio, Texas, has created the Alamo Area Prevention and Treatment Providers (AAPTP) Association. This is a consortium of prevention and treatment providers whose mission is to (1) promote accessible and comprehensive prevention, intervention, and treatment services to individuals and families in the surrounding counties; (2) implement a seamless continuum of care that includes prevention, intervention, and treatment services; and (3) facilitate access to care through advocacy, positive community relations, and ongoing systems development.

### Importance of Collaboration

Because of the chronic and relapsing nature of substance abuse disorders, ensuring a child's ongoing safety in a home with a substance abuser, or working toward reunification of a family in that home, can be extremely difficult. Even when the parent seeks help or is ordered by the court to seek help, the parent's treatment needs and the family functioning issues related to child safety are rarely addressed simultaneously (CWLA, 1992; Young et al., 1998). The intertwined problems of substance abuse disorder and child abuse require that systems collaborate if they are to break the intergenerational cycle that has resulted in so much damage to society. However, historically, there have been barriers to such collaboration.

#### Different perspectives on dependency

Alcohol and drug counselors and CPS workers are both involved with clients with substance abuse disorders, but generally their perspectives on addiction are quite different (see DHHS, 1999). This difference is at the heart of the conflicts that historically have characterized relationships between these two groups of professionals and prevented closer cooperation. Much of the substance abuse treatment community views the alcohol- or drug-using parent who

neglects or abuses a child as having a chronic and often progressive disease that cannot be cured but can be treated. However, much of the rest of society, including some CPS workers and judges, view this parent as having made an irresponsible choice that has endangered a child. In addition, the CPS worker may perceive the counselor as willing to overlook unsafe situations for children to avoid alienating the parent and disrupting treatment. The treatment provider, however, may see the CPS agency worker as unwilling to give the parent's treatment a chance to work.

### Different clients, different goals

Another barrier to collaboration between the two fields is that the organizations have different clients and different goals. Although the CPS agency worker will seek to ensure the child's safety, the alcohol and drug counselor is focused on treating the parent.

### Different timeframes

For the treatment provider, relapse is an expected part of recovery from a condition that has taken years to develop and will take years to resolve. CPS agency workers and the courts are accustomed to working within shorter and more well-defined time frames (usually 18 months) because of their desire to prevent children from remaining for long periods in out-of-home placements and to ensure that permanency plans are made for the child.

A related factor is the overburdened public system and the frustration that professionals in both fields often experience, not only within their own agencies but also in dealing with other systems. For example, CPS agency workers who refer parents to a substance abuse treatment program often find that the program has a long waiting list and that no help is immediately available. Similarly, alcohol and drug counselors who report suspected child maltreatment often complain that their reports go unheeded or are dismissed for lack of evidence in a system where workers have time to focus attention on only the most egregious cases (Reid et al., 1999).

### Improving collaboration

Treatment providers and CPS agencies differ in their priorities and approaches to parents with substance abuse disorders. To improve their working relationship, these agencies do not need to lessen their commitments to their different missions; instead, they must recognize that both sets of goals are compatible and can best be achieved through joint efforts (Feig, 1998).



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