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Children's roles in the social networks of women in substance abuse treatment

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Abstract

This study examined the status of children and the types of support available from children as reported by women in substance abuse treatment. Findings indicate that children are viewed as sources of social support to women on treatment. Children were viewed as providing as much sobriety support to respondents as that provided by adult network members. In addition, both children living with the respondent and children in the care of others were viewed as providers of specific types of social support. Implications are drawn for practice and research.

Keywords: Maternal substance abuse; Social networks; Children with substance-abusing parents; Social support

1. Introduction

A significant number of men and women in substance abuse treatment programs are likely to be parents (Marsh & Cao, 2005). The 2002 National Survey on Drug Use and Health reported that almost 5 million adults who were alcohol-dependent or alcohol-abusing had at least one minor child living with them (Office of Applied Studies, 2003). Past year substance abuse or dependence by parents is thought to affect about 10% of all preschool-age children, 8% of children aged 6–11 years, and 9% of 12- to 17-year-olds (Office of Applied Studies, 2002). In a summary of the literature, VanDeMark et al. (2005) reported that one in four children is exposed to a family member's alcohol abuse or dependence, and one in six children lives with parents who abuse illicit drugs.

Relationships with children are particularly salient for women clients, who constitute the focus of this study. Women in substance abuse treatment are likely to have been living with their children prior to treatment and frequently cite parenting concerns as a reason for entering treatment (Kissman & Torres, 2004; Office of Applied Studies, 2004). On the other hand, the fear of "losing" children through child welfare involvement often deters women from seeking help for substance abuse problems (Smith, North, & Heaton, 1993). Although children may serve as both a motivator and a barrier to substance abuse treatment, few studies have examined the role of children in the treatment process. Yet, family involvement and support are positive factors in treatment completion and outcome (Havassy, Hall, & Tschann, 1987; MacDonald, 1987; Mueser, Noordsy, Drake, Fox, & Barlow, 2003). This study examines the types of support provided by minor children, as specifically perceived by 86 women in residential and outpatient substance abuse treatments. Differences in support perceived by children versus support perceived by adults are also examined in light of implications for treatment and recovery.

1.1. Women, substance abuse, and social networks

Given the social nature of substance use, assessment of social networks is often helpful in understanding addictions

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(Drake, Brunette, & Mueser, 1998). Rebuilding and mobilizing supportive relationships are considered key tasks in recovery (Cosden & Cortez-Ison, 1999). This is especially true for women in that there is a consistent association between substance use patterns and women's relationships with significant others in their social networks (Boyd & Mast, 1983; Wells & Jackson, 1992; Wilsnack & Wilsnack, 1991; Wilsnack, Wilsnack, & Klassen, 1984). For example, many male partners of women with a substance use disorder tend to offer inconsistent support for recovery (Laudet, Magura, Furst, Kumar, & Whitney, 1999). O'Dell, Turner, and Weaver (1998) found that drug-misusing women had very small social networks and received minimal support for sobriety from partners and parents. Boyd and Mieczkowski (1990) reported that women stated that their friends, mothers, or sisters were the most likely relationships to help them get off drugs, but 30% of these women said they knew no one who would help them to stop substance use. In addition, substance-using network members are likely to continue to maintain presence in the networks of women following treatment, complicating and compromising recovery (Ellis, Bernichon, Yu, Roberts, & Herrell, 2004; Falkin & Strauss, 2003; Trulsson & Hedin, 2004).

Many women do not seek help for substance abuse problems due to fear of involvement with the child welfare system (Kissman & Torres, 2004). Others drop out of treatment due to the competing demands of parenting (Daley & Gorske, 2000) or because they feel overwhelming guilt and shame for their substance use and the impact it has had on their parenting (Cox, 2000). Practitioners have begun to address the parenting needs of women in substance abuse treatment programs (e.g., Harris & The Parenting Workgroup, 2001). Yet children are frequently considered the "invisible" members of the social networks of women with substance abuse problems (Kroll, 2004).

This study sought to document the role of children in the social networks of women in substance abuse treatment. The research questions guiding this study were: (1) How many children are reported in social networks of women in substance abuse treatment? (2) What is the custody status of children of women in substance abuse treatment? (3) How do women in substance abuse treatment describe the support provided by children in their social networks? (4) Are there differences between perceived support provided by children and support provided by adults?

2. Materials and methods

2.1. Data collection

Using a cross-sectional survey design, data were collected by trained interviewers in face-to-face interviews lasting, on average, 1 hour 45 minutes. All measures were pretested prior to their use in this study. Respondents received a US$45 payment plus transportation costs for participating in the interview. The study was approved by the Case Western Reserve University for the protection of human subjects, and confidentiality was assured through a certificate of confidentiality.

2.2. Sample

The study sample consisted of 86 women with current substance use disorders who were recruited from two substance abuse treatment programs: a residential program (n = 41) and an outpatient program (n = 45). Typically, infants through preschool-age children lived with their mother in the residential program; school-age children visited on weekends. To be eligible for the study, women had to be 18 years or older, with no known diagnosis of schizophrenia and no current use of any medication typically prescribed for a major thought disorder. Additionally, the women had to have been in their treatment program for 3 weeks or more.

Of those women who were eligible for the study, 92.6% (101 of 109) were successfully contacted and asked to participate. Ninety-seven of those contacted agreed to participate. Ten women gave consent to be interviewed but were not interviewed before the end of the study. In addition, the case of a 75-year-old woman was deleted as an outlier, resulting in a final sample of 86 cases.

2.3. Measures

Mental disorders were assessed using the Computerized Diagnostic Interview Schedule (C-DIS). All of the women in the study completed the following mental disorder sections of the C-DIS: generalized anxiety disorder, depression, dysthymia, posttraumatic stress disorder (PTSD), and mania/hypomania. The C-DIS has demonstrated reliability and validity (Helzer et al., 1985; Robins, Helzer, Croughan, & Ratcliff, 1981) and is based on criteria from the *Diagnostic and Statistical Manual for Mental Disorders, Fourth Edition* (*DSM-IV*). It provides a *DSM-IV*-compatible diagnosis and distinguishes current from lifetime disorders (Robins et al., 1999).

Substance use disorders (alcohol, drugs, or both) were determined from the results of a structured Computerized Intake Assessment Instrument (CIAIC-C). The CIAIC-C is a uniform assessment tool developed for the county in which this study took place. It is administered on intake and yields a *DSM-IV*-compatible diagnosis (University of Akron, 2001). Authorization to use this previously collected information was sought, so that study respondents currently in treatment would not have to complete yet another substance abuse assessment.

Dual disorder was defined as presence within the last 12 months of at least one mental disorder (anxiety; depression; dysthymia; PTSD; mania, hypomania, or both) *plus* at least one substance use disorder (abuse or dependence). Each respondent was assigned to one of two groups

based on the assessed substance use and mental disorders: dual disorder or substance use disorder only.

Social network composition and perceived social support were measured by the Social Network Map (Tracy & Whittaker, 1990). This instrument asks about social network size and composition, perceived social support (emotional, concrete, and informational), and social network functioning (network members who yielded negative results in their interactions with the respondent; network members using alcohol, drugs, or both; and members supporting sobriety, close relationships, reciprocal helping relationships, duration of relationships, and frequency of contact). Reliability of scoring, as measured by test–retest of social network members and percent agreement of ratings, was demonstrated in one study, although some relational aspects of social networks, as measured by the instrument, were less stable than others (Tracy, Catalano, Whittaker, & Fine, 1990). In this study, respondents were asked to identify "as many people as you can come up with" with whom they had any form of contact in the past month. Respondents were prompted to think of "people who made you feel good, people who made you feel badly, or people who otherwise played a part in your life." Detailed questions were then asked about each individual network member (e.g., how often that network member could be relied upon for different types of support [*almost always*, *sometimes*, *hardly ever*]; whether support was reciprocal; whether the network member used alcohol, drugs, or both; and so forth). Sobriety support was measured by the number and the proportion of people in the network who were reported to "almost always or sometimes help you stay clean." The number of people in the network, as well as the percentage of the total network available to provide various types of support, was computed, with higher numbers representing greater support availability.

Demographic information about the respondents was collected via the demographic section of the C-DIS and included the following variables: age, racial/ethnic identification, educational level, marital status, number of children, and employment history over the past 12 months. In addition, respondents were asked about the custody status and living arrangements for each of their children, both at the time of the interview and for 6 months before to the interview. For each child not living with the respondent, the following question was asked: "Is this child under a relative's care, in foster (nonrelative) care, adopted, or in some other form of care?" Adult children were those 18 years or older at the time of the interview; minor children were less than 18 years.

2.4. Data analysis

Data analysis began by computing the descriptive statistics for each social network variable and by generating graphical descriptions of social network characteristics for each group under study. Differences between sites were examined using one-way analysis of variance (ANOVA). *T* tests were used to examine the mean differences between the two groups: dual disorder and substance use disorder only. Between-group comparisons of network characteristics and perceived social support from children and adults were then examined using ANOVA. Missing data were negligible in this study, but in the few instances when missing data did occur, pairwise deletion was employed in the analysis.

3. Results

3.1. Characteristics of women

Table 1 contains descriptive information about the women in this study. Respondents ranged in age from 21 to 55 years, with a mean age of 34 years. Eighty-one percent of the sample was identified as African American. Forty-five percent of respondents had a high school diploma or general equivalency diploma (GED). More than three fourths (78.7%) of the women were living with a partner at the time of the study. Twenty-nine percent of the respondents had worked full time in the past year, but only for an average of 1.6 months. At the time of the interview, 40% (34) of the respondents had received welfare assistance in the past 6 months.

Nearly all of the women (91%) had children. On average, the women had 3.1 children (range, 0–12). The mean age of the children was 8 years (SD = 5.3 years). Five percent (10) of the children were less than 1 year old, 34% (62) were between 1 and 5 years old, 29% (53) were between 6 and 11 years, and 31.3% (57) were between 12 and 17 years.

Although women in the outpatient treatment program tended to be younger than women from the residential treatment program (a mean of 31 years as compared with 37 years, $F = 11.44$, $p < .001$), there were no other demographic or socioeconomic differences observed between the two sites. Since their initial intake into substance abuse treatment services up to the time of the study interview, the women on residential treatment reported

Table 1
Respondents' characteristics

Characteristics	Values
Mean age (years)	34
Mean number of children	3.1
African American (%)	81
High school diploma/GED (%)	45
Never married (%)	72
Living with someone (%)	76
Received cash assistance in the past 6 months (%)	40
Worked full time in the past year (%)	29
Worked part time in the past year (%)	25
Substance use disorder only (%)	44
Co-occurring substance use and mental disorders (%)	56
Major depressive episode	41
PTSD	28
Manic episode	21
Generalized anxiety	14

an average of 6.8 months (*SD* = 3.2) and the women on outpatient treatment reported an average of 4.8 months (*SD* = 3.6). Fifty-six percent of the women were in the early phase of their treatment, whereas one third of the women were in the later phase of treatment.

3.2. Substance use and mental disorders

We found that 56% of the women respondents (*n* = 48) had a current co-occurring substance use and mental disorder, whereas 44% (*n* = 38) had a current substance use disorder only. Of those women in the dual-disorder group, 58% (*n* = 28) had more than one mental disorder, and 52% (*n* = 25) was dependent on more than one substance. Of the women with a substance use disorder only, 53% (*n* = 20) was dependent on more than one substance.

Forty-one percent (*n* = 35) of all respondents met criteria for major depressive episode, 28% (*n* = 24) met criteria for PTSD, 21% (*n* = 18) met criteria for manic episode, and 14% (*n* = 12) met criteria for generalized anxiety disorder. Substances of abuse in this sample were primarily alcohol (14%) and marijuana (14%). More than half of the women in this sample met the criteria for current alcohol and cocaine dependence (52% and 58%, respectively), and more than one quarter (28%) met criteria for marijuana dependence.

3.3. Number and status of children

The women in this study reported 256 children: 42 (16%) adult children and 214 (84%) minor children (see Table 2). Of the minor children, 41.1% lived with their mother at the time of the interview, 37.4% lived with a relative, and 15% lived with foster parents. Examining the data by women rather than by children, 68% of the women had one or more of their children in other people's care, 76% of these women had children under a relative's care (either formal or informal kinship care placements), 28% had children removed and placed in formal foster care placements, and 8% had children removed and placed with adoptive parents.

Table 2
Status of children reported

Variables	Total no. of children	*M*	%
Age			
≥ 18 years	42	0.49	16.4
≤ 17 years	214	2.49	83.6
Total	256		
Children living with the respondent			
≥ 18 years	4	0.17	9.5
≤ 17 years	88	1.21	41.1
Children not living with the respondent			
Under a relative's care	80	1.60	37.4
In foster care	31	0.62	14.5
Adopted	8	0.16	3.7
In other types of care	7	0.14	3.3
Average no. of days not in respondent's custody		167.08	

Table 3
Support perceived to be available from children

Type of social support	%
Closeness	90.0
Sobriety	84.3
Emotional	46.1
Reciprocity	45.0
Concrete	42.0
Informational	24.6
Negative	2.8

The mean number of days, during the past 6 months, that children were not in their mother's care was 167.

3.4. Social network size and composition

The mean network size was 13.6 people (*SD* = 5.56), including, on average, 4.8 family members, 2.3 professionals, 2.1 friends, 1.5 household members, 1.2 persons from church/organizations, 0.9 person from work or school, and 0.7 neighbor.

The most frequently reported total network size was 20; the range for network size was 4–40. On average, the respondents listed three children as part of the composition of their networks (range, 0–10). Women reported a mean of 1.3 children as part of their household and 1.3 children as other family members; therefore, children constitute a sizable portion of the social network. In fact, when children are omitted, the mean network size is reduced to 11.4 network members. One hundred eighty-two children were reported in social networks. The majority of women reported children as part of their social network; however, eight women did not include any children in their network. Therefore, the following network findings relating to children are based on the 78 women who supplied network data that included children. It is also important to point out, though, that 14 women reported a number more than the number of their own biologic children in their network, presumably children of other family members or network members.

In terms of the age breakdown of children reported in social networks, on average, 1.9 were less than 5 years, 1.7 were 6–11 years, and 1.6 were 12–17 years old. Younger children (less than 5 years) tended to be within the household than under other family members' care (1.1 vs. 0.69), whereas older children (12–17 years) tended to be with other family members (0.49 vs. 1.1). Children living with other family members included both biologic children of the respondent and other relatives' children (nieces, nephews, grandchildren, and so forth). Regardless of the relationship of these children, they were viewed as providing support to the respondents.

3.5. Perceived social support

Table 3 lists the different types of support attributed from children. Nearly all (90%) relationships with children were viewed as close, and respondents generally reported high

Table 4
Children's support, by age group

Variables	≤ 5 years (n = 39; %)	6–11 years (n = 31; %)	12–17 years (n = 35; %)
Concrete support	32.1	58.1	39.5
Emotional support	37.8	50.5	52.4
Informational support	14.1	23.4	31.0
Sobriety support	81.2	88.7	81.4

levels of support from children. In particular, 84% of the children were viewed as providing support for sobriety. Almost half (46%) of the children were considered to be sources of emotional support (e.g., listen to feelings), and 40% were depended upon for concrete support (e.g., help with chores). As might be expected, a smaller percentage (24%) was viewed as providing information support (e.g., advice or guidance).

When social support was examined by age group (children aged < 5, 6–11, and 12–17 years), the 6- to 11-year-olds were notable in the greater amount of concrete and sobriety support they were reported to provide as compared with the other age groups (see Table 4); however, ANOVA failed to yield statistically significant differences among the age groups. In addition, there were no statistically significant differences observed in children's support by site (residential vs. outpatient), by dual disorder status, or by child placement status.

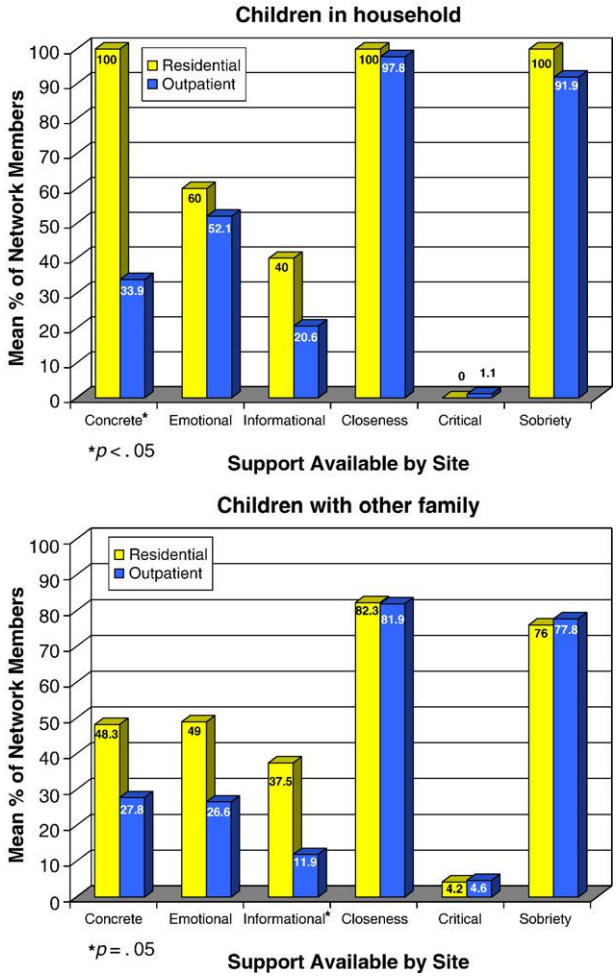

Fig. 1. Social support available by site, and the relationship of children and women in residential and outpatient substance abuse treatments.

Table 5
Perceived social support from children and adults

Type of social support	Children (M %)	Adults (M %)	t	SE
Concrete	42.0	41.5	−0.094	6.191
Emotional	46.0	56.4	1.674	6.265
Informational	24.6	49.0	4.566*	5.343
Closeness	89.8	51.9	−9.343*	4.063
Critical	2.8	8.1	2.389**	2.197
Sobriety	84.3	78.7	−1.180	4.716

* $p < .001$.
** $p < .05$.

There were differences, however, between the residential and outpatient programs in the types of support available from children living in the household and from children living with other family members (see Fig. 1). As compared with children in *households* of women in outpatient treatment (M = 33.9, SD = 44.74), children in *households* of women in residential treatment (M = 100, SD = 0) were reported as providing more concrete support, $t(33) = 3.26$, $p < .05$. On the other hand, children living with *other family members* of women in outpatient treatment (M = 11.9, SD = 32.22), compared to children living with *other family members* of women in residential treatment (M = 37.5, SD = 49.5), were reported as providing more informational support, $t(39) = 2.03$, $p = .05$. This may be because, as noted earlier, children living with other family members tended to be older. It should be noted, however, that there was no statistically significant difference by type of treatment in the sobriety support perceived to be available from children.

3.6. Adult versus child support

Table 5 compares the mean differences between the support available from children and the support available from adult network members. A statistically significant greater proportion of adult network members, than child network members, was viewed as negative in interactions with the respondent. Not surprisingly, adult network members were also more likely than children to be considered sources of informational support. Relationships with children were reported to be closer than relationships with adults. Most interestingly, however, both children and adults in the social network were seen as providing the same amount of sobriety support; there were no statistically significant differences in sobriety support from children compared with that from adults.

4. Discussion

This study examined the status of children and the types of support provided by children as reported by women in two

substance abuse treatment programs. Although practitioners often recognize the important role that family members play in substance abuse treatment, the role of children is often ignored or neglected. Overall, these findings indicate that children are integral to the social networks of—and are viewed as sources of social support to—women in treatment. Consistent with other studies suggesting that children serve as motivators to entering and completing treatment, children in this study were viewed as providing as much sobriety support to respondents as that provided by adults. In addition, children living in the same household as the respondents were reported to provide concrete support, whereas children in the care of other family members were seen as sources of informational support.

A strength of this study is its in-depth focus, separating out children from adults in the social network and distinguishing those children living in the respondent's household from children living with other family members. Ultimately, this study shows the importance of *all* children in a woman's social network: biologic children living with her, biologic children in the care of other people, and children (nieces, nephews, and grandchildren) of other family members. However, a limitation of the study is the difficulty of collecting complete and accurate data about children. As noted earlier, not all of the women included their children in the social network. It is also the case that self-report data on the custody status of children may have underreported the number of children in placements. The research interviewers found that some women would not or could not bring themselves to discuss children that they had "lost" to placements earlier in the course of their substance use. It was not uncommon for women to have children at home, children in informal kinship care, *and* others in formal kinship or nonrelative foster care; keeping all this information straight was difficult for some women in this sample, particularly given their mental health status (Sands, Koppelman, & Solomon, 2004). Additionally, our data collection method did not allow us to determine the specific relationship status of those children identified as living with other family members.

Nonetheless, there are a number of treatment implications that can be drawn from these data. The fact that 68% of the women in this study had experienced out-of-home placement of one or more of their children points to the family service needs of women in substance abuse treatment. The placement rate of children under a relative's care (37.4%) in this sample is twice as high as the percentage of African American children living with grandparents or other relatives (16.9%) within the city in which the study took place (U.S. Census Bureau, 2000). The percentage of children in foster care is also higher than the 6.6% of all children in the county who are under the care of nonrelatives (The Center for Community Solutions and United Way Services, 2005). Consistent with other researchers' observations of parental substance abuse, these placement rates suggest the vulnerable situation and multiple needs facing women with substance abuse problems (Schilling, Mares, & El-Bassel, 2004).

Parental substance use has multiple impacts on the lives of children. Children living with a substance-abusing mother are at increased risk for a number of negative developmental outcomes (Carmichael Olson, O'Connor, & Fitzgerald, 2001), emotional and behavioral problems (VanDeMark et al., 2005), and child maltreatment (Magura & Laudet, 1996; Schilling et al., 2004). Wells and Shafran (2005) conclude that, in many localities, the child welfare system has become a de facto substance abuse treatment system due to the large number of cases involving parental alcohol or drug abuse. Such families often face a combination of risk factors in conjunction with parental substance abuse, including maternal mental illness, exposure to violence, poverty, inadequate housing, and other environmental problems (Cash & Wilke, 2003; Nair, Schuler, Black, Kettinger, & Harrington, 2003; Singer et al., 2002). Creating a positive social support system may be a necessary factor for women who are coping with these types of stressful life conditions (Manji, Maiter, & Palmer, 2005).

These study findings indicate that treatment providers need to be aware of the extent to which women clients may rely on support from children. The data show that children are seen as sources of substantial amounts of social support; this applies to children living with their mother as well as those children living under other people's care. Certainly, out of sight is not out of mind when it comes to social support.

Focusing only on adult relationships misses the fact that children may be a strong source of support for women in treatment, particularly for women in residential treatment, where the need for support may be greater. Strict definitions of *nuclear family* and ignoring the role of relatives in childrearing may overlook children who are considered part of the social network but who may not live with their mother or who may not be biologic children. Although there were no statistically significant differences in the support provided by children of different ages, the amount of support reported from children 6–11 years may be clinically significant and suggests that this age group might be an important target for family intervention.

The amount of emotional care provided by children to their parents is not unknown to substance abuse treatment providers (Kroll, 2004). From a family system perspective, the care provided by children of substance-abusing parents has often been referred to as "role reversal," "parental child," or "parentification" (Bekir, McLellan, Childress, & Gariti, 1993). Although the treatment world has tended to view this as negative for a child, Godsall, Jurkovic, Emshoff, Anderson, and Stanwyck (2004) argue that parentification within the context of close kinship ties, support, and caring, as exists in many African American families, may not imply adverse effects for children; they propose the more neutral term of "filial responsibility" to describe this pattern of the child as a caregiver.

Substance-abusing women are frequently challenged with the prospect of losing their children; this potential threat may result in their perceiving more support from their children than what they actually received. A limitation of this study is that information was only collected from the mothers. In addition, a number of other factors may likely influence the amount and the type of support provided or perceived to be available from children. Although this study's findings did not show statistically significant differences in children's support by age of child, by site (residential vs. outpatient), by mother's mental health diagnosis, or by involvement with the child welfare system, clinical experience would suggest that the child's age, understanding of the mother's substance abuse problems, quality of the mother–child relationship, and prior treatment episodes would likely influence both received and perceived support. These variables, however, were not within the scope of this study of social networks.

This study then suggests additional areas for future research. The impact on children who provide support to mothers in treatment requires attention as the children themselves frequently have needs for services and support (Conners, Bokony, Whiteside-Mansell, Bradley, & Liu, 2004). Intervention research with children of women on treatment is needed both for minor and adult children. Although this study has focused on children's roles while women are involved in treatment, the roles of children following treatment (during the ongoing recovery process) needs further study, especially because women with substance use disorders may experience difficulty being reunified with their children following the completion of treatment (Maluccio & Ainsworth, 2003; Wells & Guo, 2006). Longitudinal studies, with information collected from women *and* children, are needed to determine the role of the child's growing understanding of the mother's substance abuse and the impact of treatment episodes over time on the type and the amount of children's support. Qualitative research methods could explore the meaning of support for women in treatment programs. Finally, a more comprehensive and routine data collection about the children of women in treatment is needed.

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