Building on Strengths: Recovery and Parent-Child Relationships

The first generation of research on children exposed to drugs revealed that simplistic gloom and doom expectations for these children were wrong. This research demonstrated that understanding developmental outcomes requires studying the effects of maternal drug use in the context of children’s caregiving environments (Lester & Tronick, 1994). There are also lessons to be learned from programs designed to improve caregiving by combining addictions treatment and parenting interventions.

Often programs that attempt to combine these services face several difficulties. One problem is the assumption that simply adding parenting classes to an already full treatment schedule will result in major improvements in parent-child relationships. While parenting classes can be helpful, the complexity of parent-child relationships in recovery must be addressed on an individual basis. A second issue is that some of the traditional methods used in addictions treatment (e.g., confrontational tactics and the use of punitive consequences) undermine rather than strengthen parent-child relationships. When negative disciplinary methods are used with clients, they are likely to repeat the same with their children. A third problem is the tendency to focus only on the mother-infant relationship while most recovering parents have several children. The multitude of relationship issues with these older children cannot wait to be addressed until the parent has completed treatment and reunification occurs. This article describes a model to illustrate how these difficulties can be addressed. The following three components of this model, which evolved at The Women’s Treatment Center (TWTC) in Chicago, Illinois, are designed to support and strengthen parent-child relationships.

Inquiry as Intervention: The Parent-Child Relationship Interview

When Robert Coles (Coles, 1992) asked Anna Freud for some advice in starting up a program for teenage parents in the 1970’s, he was surprised when she responded by simply suggesting that he turn to the young mothers and ask them how the program could be of help. Using this advice, family support staff at TWTC begin by interviewing parents about the relationship with each of their children using some questions derived from The Working Model of the Child Interview (Zeanah, Bеноit & Barton, 1986) and others that specifically apply to recovering parents. A few carefully chosen questions help the parent begin to think about each child’s development, identify strengths and areas of concern, reflect upon her relationship with the child and how her drug use has affected the relationship, and talk about changes she would like to make in the relationship. Mothers are also asked how they plan to help establish or strengthen the father-child relationship. Finally the parent is asked: “What parenting goals do you have as the mother of this child? What skills do you want to work on? How can we help you?” The parenting treatment plan emerges from the interview. For example, one parent interviewed about her three children responded with the following goals for each child:

(Ten-year-old child)
- Working on our relationship—I want him to be able to talk to me and trust me.
- I want to take him off individually and spend time with him.
- I want to keep him interested in school.
- I’d like to take him places.
- I want to start with him because he was exposed to more.

(Six-year-old child)
- I want to learn how to deal with her—I think I need more coping skills.
- I want to learn how to use proper discipline without getting my moods into it.
- I’d like to learn how to help her so she can do okay in school.
- I’d just like to learn how to have some fun with her.

(Seven-week-old infant)
- I want to be patient and not get frustrated when he cries.
- I want to show him love and affection.
- I want to listen to him.
- I want to keep learning month by month about his development.
At the conclusion of the interview parents are asked to prioritize the goals for each child and identify activities to address those goals. Parents are encouraged to use their own strengths and the strengths of each child to address parenting goals. For example, the interventionist might say: “Your goal is to establish a closer relationship with your child. You seem to be proud of his good grades and his reading skill. Can you think of some things you could do together that would show him you are interested in what he is learning at school? Since you like to read, reading the same book he is reading is a good idea.”

A supportive, respectful relationship between interventionist and client is established through this process. The client has identified her own goals and priorities as a parent, and the interventionist has modeled problem-solving to address these goals. The inquiry begins the intervention.

**Using Videotapes to Strengthen Parent-Child Relationships**

Understanding parent-child relationships requires a setting in which parents can talk about their children and be observed interacting with them (Cramer, 1986). When parents have the opportunity to observe themselves interacting with their children in videotapes of naturally occurring daily routines and to discuss the interactions with supportive staff, they can increase their own understanding of the relationship and make significant changes in their parenting. Addictions treatment staff are traditionally trained to focus on clients’ problem areas and address weaknesses directly in a manner that can be confrontational and punitive. They may unwittingly model behaviors that trouble the interventionist, a problem-solving approach is used: “How did he respond when you told him to pick up his toys? What did you do next? What else could you have done?” The interventionist helps the parent to identify all positive behaviors, but addresses only a few problem behaviors. The videotape is given to the parent with a listing of all the positive behaviors and topics discussed during the session. Subsequent sessions are added to the same tape so that parents have a record of their child’s growth and development as well as their own growth as parents. The interventionist can help the parent to recognize this growth through comparison: “Do you remember how you handled that on your last tape? Let’s look at what you did this time.” Parents respond favorably to the videotaping experience: “Each time she’s doing something different. The questions you ask me—it makes me think. It’s making me more aware and take notice.” With parental consent, the use of these videotapes with staff can help them overcome the tendency to focus on clients’ weaknesses as parents and learn strategies that can be used to strengthen parent-child relationships on all occasions when staff, parent, and child are present.

**A Mother’s Journal: The Story of Our Family**

Writing is an integral part of addictions treatment, but it is sometimes used for contradictory purposes. Clients gain insight writing about their lives as part of the 12 step process, but writing assignments used as a consequence for lack of compliance can have a negative impact on many clients who lack confidence in their literacy skills. Programs for at risk families realize the importance of fostering positive attitudes towards participation in family literacy activities. A Mother’s Journal: The Story of Our Family is a parenting intervention that also addresses these multiple literacy issues. This program for recovering parents can be implemented in a group or individual setting, but requires processing and feedback on a one-to-one basis.

Mothers are given a series of questions about their parents and grandparents; their own birth, names, childhood, and life experiences; the birth, naming, and childhoods of their children; the father(s) of their children; and their thoughts about themselves as parents. Many of these questions are aimed at helping the parent reflect upon past and present parenting relationships. Parents are encouraged to begin writing by responding to any topic that feels comfortable. They often begin by writing about their own names and those of their children. They may write about “safe” topics for many weeks before attempting to write about areas of their lives that are painful. They are introduced to a variety of writers of child and adult literature with whom they can identify. For example, when mothers are writing about their children’s births, they may read On The Day You Were Born (Frasier, 1991). The women are encouraged to find their own voices as writers. Issues of style, spelling, and grammar are presented as choices having equal value. Those who begin with little memory of their own childhood find that the process of writing often unleashes a flood of memories, both happy and painful. Parents reflect upon their relationships with their children at an increasingly deeper level. This process of writing, reflection, and supportive feedback may facilitate a cognitive reworking of earlier abusive life experiences and help to prevent intergenerational transmission of abuse (Main & Goldwyn, 1984). The mothers also begin to think of themselves as writers, gain confidence about their academic potential, and begin to read on their own and to their children. At TWTC, a parenting library for clients and staff contains books on parenting and child and adolescent development, children’s books, pamphlets, articles, and videos.

An important part of the journal writing process is the product that results. When the mothers’ writings are printed on their choice of attractive papers the journal is treasured. Mothers are encouraged to learn how to use a computer to produce...
Watch, Wait & Wonder: Healing the Mother and Child Relationship

It generally is accepted that dysfunctional relational patterns are transmitted from one generation to the next, and that nowhere are these patterns played out more than in the mother/child relationship (Muir, 1992). When a mother and child enter treatment, they are often scared, anxious, angry, and depressed (Levy & Rutter, 1993). They carry with them the dance of their ancestors, a rhythmic history of substance abuse, violence, shame and neglect. This dance performed out in present time perpetuates old traumas, reinforces chaotic parenting, strains the bond between mother and child, and interrupts emotional development.

When Amethyst House* began in the Spring of 1994, staff was looking for a way of working on parenting that would address the social and emotional needs of both the mother and child. The model had to fit with the program's family centered philosophy—enhancing the work the mom was doing in treatment, and supporting the skills her child was learning in the therapeutic nursery. Amethyst House staff believe that parenting is part of a relationship, and only in the context of this relationship can old wounds be healed and new skills learned. Additionally, working with the mother alone, although useful, often presents several problems. First, the child, having been exposed to a stressful environment is often developmentally and emotionally compromised, requiring immediate attention that can not wait until the mother improves. Also, the mother's own issues may influence her difficulties with her child, the actual nature of which may not appear until they are seen together (Lojkasek et al., 1994).

Watch, Wait and Wonder, a simple, but powerful child led approach to parenting, addresses attachment and trauma issues in the mother-child relationship while encouraging a parent's competence and self-reliance. Watch, Wait and Wonder (WWW), designed to be used with children over four months of age, was originally developed by Dowling, Wesner and Johnson in the 1980's (Muir, 1992). For the past several years, Elisabeth Muir and her colleagues have been comparing the technique with more traditional forms of parent-child therapies in a clinical research project in Toronto.

The Watch, Wait and Wonder Process

The first step is the assessment. The mother is asked about the child's developmental history and her family history. This discussion helps the therapist learn about the family's strengths and problem areas, as well as the mother's feelings about her relationship with her child. If either the mother or child is significantly traumatized or struggling with the effects of detox to the point where they cannot participate in routine activities, then we proceed at a slower pace.

After the initial assessment, there is a fifteen minute free play session in which the mother and child are asked to play as they would at home. The session is video taped for the mother and clinician to review together the following week.

During the review, the mother is asked to comment on what she observes and encouraged to share her thoughts. Often during this very first encounter, she sees aspects of her relationship with her child which she had not noticed before. This is the beginning of discovery, and a door into WWW.

How it Works

The mother and child then meet with the clinician for a 50 minute session that is divided into two parts—play and discussion. For the first 20 minutes the mother is instructed to settle onto the play mat...
with her child. She is asked to follow her child’s lead but not to direct or take over the play in any way. The mother is encouraged to respond to her child’s cues and to participate, but only if invited to do so. The clinician must foster a safe, secure environment so the work can unfold (Kurtz & Johanson, 1993), but she should not interfere with the process. When this sequence ends, pre-schoolers rejoin their classmates, while babies remain with their mothers.

During the 30 minute discussion sequence that follows, the mother is asked to make observations about her child’s activities. She is encouraged to share her thoughts and feelings. This can be slow and plodding at first, with moments of intense silence. However, the mother’s ability to talk about the session improves over time, and the observations expand in tone and texture. Sometimes the mother may grapple with something that took place during the session that bothered her. Careful inquiry may reveal a deep connection between the child’s behavior and other experiences the mother recalls.

As difficult as it can be for the mother to sit in the “silence” that often occurs during these sessions, it also can pose a challenge to the clinician who has to abide by the same instructions given to the mom. The clinician follows the mother’s lead without taking over the discussion or making interpretations of the child’s play. “When the setting is right the work will happen by itself” (Kurtz & Johanson, 1993). If the clinician takes over for the mother, interpreting the child’s activities, or directing the focus of the discussion, she not only deprives mom of making her own discoveries, but diminishes mom’s ability to do so (Minuchin, 1993). The comparison to an intrusive parent cannot be underestimated (Epstein, 1996). Rather than simply withdrawing, however, the therapist moves in accordance to what is taking place (Kurtz & Johanson, 1993). Questions such as, “What did you see?” “How did that make you feel?” and “Did that remind you of anything?” invite the mother to expand on her own observations.

Bonnie & Carla: A Case Study to Illustrate the Therapeutic Process:

The assessment and free play masked the struggle that was about to unfold between 21 year old Carla and her 3 year old daughter, Bonnie. Carla had been on her own since she was twelve, after running from an alcoholic, abusive mother. She had been using drugs for five years before giving birth to Bonnie. Bonnie’s arrival set in motion the relational dance of chaotic patterns that Carla had known as a child. Like Carla with her mother, Bonnie lived in constant fear of abandonment and her mother’s rage. Before beginning the WWW process, Carla reported that getting Bonnie to listen was difficult. “She does not have any patience, and everything is a struggle. We both do a lot of yelling.” Carla was, therefore, surprised at how well she and her daughter interacted during the initial session. They played in a relaxed, cooperative manner with genuine give and take—something Carla had never experienced with her own mother.

The following week, however, Bonnie’s behavior became aggressive. First it was directed toward the dolls, then it turned on her mother. She would modulate between yelling and throwing toys around the room, ordering her mother to “pick it up.” A few times without warning, Bonnie hit her mother. At one point she even asked permission to do so. This is a common pattern with chemically addicted mothers and their children. After a period of feeling safe and trusting of the staff, women often erupt—some quietly and others with more turbulence. This typically occurs with their children as well, and usually it comes sooner.

When the play sequence ended and Bonnie returned to her class, the therapist asked Carla what she noticed about the session. Carla noted, “the room is a mess,” and she expressed confusion as to why Bonnie behaved as she did. These comments offered the therapist two different leads: the “messy room” or Carla’s confusion. The therapist encouraged Carla to explore her sense of confusion and to note any thoughts or feelings that emerged. She sat quietly looking down at the floor. After minutes of mumbling about how messy the room was, obviously struggling with something, Carla looked up and commented, “This looks like our place. With Bonnie I used to yell, really yell, hit and throw crap when I was getting high. I would say ‘clean it up,’ ‘pick up this mess!’ I yelled all the time. Bonnie doesn’t know anything else. She must think it’s okay to yell.” Carla had made a direct connection between their recent life style and Bonnie’s behavior. She also recognized that it must have been confusing for Bonnie to see her mother out of control. Carla’s new found sensitivity to her daughter’s feelings was only the beginning of the shift necessary to contain the eruption that would come.

Between sessions, while Carla was participating in groups, working on her GED and receiving individual counseling, Bonnie attended therapeutic nursery preschool. There, given a predictable routine and consistent limits, she was becoming more secure about her surroundings. Slowly, she was learning to value her own and other’s feelings and ideas, as well as to express herself with words.

In session three, Bonnie was able to utilize these new skills to tell her mother that she had hurt her feelings. During a pretend phone conversation, Carla said she did not like it when her mom swore. This was a tender moment of communication between mother and daughter, but it did not last long. Within an instant, Bonnie attacked her mother with the phones. Carla responded by taking the phones away, insisting that Bonnie could no longer play with them and that there was to be no more hitting. Bonnie was stunned. She took three steps backward and stared at her mother. A standoff had begun and the next few moments were difficult to witness. After several minutes, Bonnie, not to be outdone, climbed up on the dollhouse and began spitting and cursing at her mother.

Bowley (1973) suggests that the most violently angry responses are elicited in children who have experienced repeated separations or live under a constant threat of abandonment. From experiencing such intense pain, it is only a short step to feeling brutally angry at the person who caused it. However, the fact that Bonnie felt safe enough with her mother to unleash her anger marked a turning point in their relationship.

What occurred next was critical. Without being instructed, Carla stood up.
promptly ended the session with “that’s it,” and returned Bonnie to the nursery. Carla asserted herself, set a limit and stuck with it. Experience has shown that as a mother starts to trust her observations and insights about her child, she begins to feel empowered. She becomes more secure in trying on new behaviors that otherwise would have eluded her. Though surprised with her competence, Carla remained concerned with Bonnie’s escalating behavior. She thought she was getting worse. However, other changes were occurring. Carla reported that during the past week she and Bonnie were playing games just before bed time (something new) and that they often laughed together.

Nevertheless, the play sequence in the fourth session lasted only seven minutes. Bonnie attacked her mother immediately, spitting and hitting her. When Carla could not get her to stop, she ended the session. Bonnie was shocked. Carla, however, was afraid. She could not understand why her daughter kept “abusing” her. The therapist asked Carla if Bonnie reminded her of anyone. “My mother.” Her voice grew shaky as tears bloomed in her eyes. She thought she was getting worse. However, other changes were occurring. Carla reported that during the past week she and Bonnie were playing games just before bed time (something new) and that they often laughed together.

Carla felt stronger in her ability to set limits and still enjoy her child.

Winnicott (1971) spoke about the “good enough mother,” who could survive her child’s fury without being destroyed or retaliating in kind. She could create a boundary and stand her ground while permitting the rage to exist. When met with a loving but firm mom, the child’s old way of relating gets frustrating, facilitating a shift in the relationship. Carla was starting to become this mother.

Although sessions five and six were not without incident, the disorganized play and Bonnie’s yelling and swearing were noticeably absent. Bonnie engaged her mother more by asking her questions, asking for help, and asking for permission. Bonnie was showing a tentative trust that her mother would meet her needs. The following week was characterized by Bonnie’s desire for nurturing from her mother. She took on an infant role asking to be fed, held, and rocked to sleep. Session eight brought a sense of comfort and security. Bonnie entered into dramatic play with the baby dolls. She held a baby close, rocking and singing, and gently stroking its hair. The nurturing exhibited was in marked contrast to the aggressive behavior played out with the dolls in earlier sessions. Later she asked her mother to help take the babies to the doctor and then to the video store.

During the following discussion, the therapist asked Carla, “What did you notice about today?” Carla could not help but smile. “She was so tender and thoughtful. It felt good. Bonnie has taught me how to be with her. I think she has changed me.”

**Conclusion**

As Carla gained insight into aspects of the relationship, perceptions created by her own experiences of being parented diminished. As Cramer (1992) said, “A turning point usually occurs when the child is discovered and the images from the past are banished.” For some mothers, simply having a space and a time to be with their child has made the difference. Very often this leads to a fresh start allowing the bond between mother and child to mend. As the mother learns to delight in the antics of her child, she begins healing ancient wounds. Without this basic modification in the primary relationship, the mother and child would remain emotionally unable to make behavioral adjustments, even with the teaching of cognitive skills. From here, mother and child can incorporate more positive techniques and ways of relating into their daily interactions.

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**REFERENCES**


In October 1993, Project Lagniappe, a four year demonstration project, was established to complement three existing Children's Hospital of New Orleans programs: The Pediatric AIDS Program (PAP), The Resources for Adolescents Program (RAP), and the Collaborative Approach to Nurturing (CAN). When Project Lagniappe was funded, each program provided case management in a community-based setting. However, unlike the other programs, the specific goal of Lagniappe is to prevent infant abandonment due to maternal substance use or HIV infection. In addition to case management, the project provides mental health, substance abuse, child development, and respite care services to families.

The Lagniappe Program

Lagniappe serves target infants and mothers as individuals and in infant-mother dyads. Interventions begin in the prenatal period and include group or individual counseling to address prenatal needs and the process of pregnancy, labor and delivery. Soon after birth, the developmentalist conducts a Brazelton Neonatal Behavior Assessment Scale (BNBAS) and discusses the caregiving implications with the mother. When the mother and baby arrive at home, the developmental specialist implements the Collaborative Approach to Nurturing (CAN) curriculum which focuses on caregiving in the first four postnatal weeks. This five session intervention addresses infant states, attachment, play, crying and handling. After this curriculum is completed, the BNBAS is repeated (at 4 weeks), and mother-infant interaction is assessed using the Nursing-Child Assessment (NCAST) Feeding and Teaching Scales. This procedure involves videotaping the dyad and coding the tapes using the NCAST protocol. The interventionist then provides the mother with feedback to enhance the quality of her interaction in feeding and teaching contexts. The NCAST is repeated at 4, 6, 12, 18 and 24 months, and the Bayley Scales of Infant Development is used to measure the infants' cognitive and motor development. This assessment is conducted in the presence of the caregiver in order to increase her understanding of her child's development.

Although most assessments are conducted in the home, center-based groups also convene twice a week. In order to increase participation in these groups, transportation, child care, meals and door prizes are provided. Groups begin with mother-infant circle time (songs, games, discussion). Then clients conduct their own NA group without staff participation. After this, a staff member rejoins the group to discuss parenting or women's issues. Simultaneously, the children enjoy structured child-focused activities or field trips facilitated by staff and volunteers. Mothers and children are reunited for lunch and door prize drawings.

Research Investigations

Since its inception, Project Lagniappe staff have endeavored to understand the needs of adults and children affected by maternal substance abuse and continue to refine and develop services to address these needs. Through data analysis and evaluation, we have learned a great deal about parenting and child development in cocaine-affected families. For instance, recent research conducted at Project Lagniappe and its predecessor, the CAN program, has provided information on the influence of maternal psychosocial factors on parenting and child development as well as caregiving risks in families headed by a substance-using mother. This research includes a longitudinal study that investigated mother-infant interaction over the first nine postnatal months (Blackwell, Lockman & Kaiser, 1996). Another study investigated the influence of maternal psychosocial factors on mother-infant interaction at one postnatal month (Blackwell, Kirkhart, Schmitt & Kaiser, 1996). A third project investigated the influence of active maternal drug use on the postnatal development of prenatally-exposed infants (Blackwell, Kirkhart, Schmitt & Kaiser, in press). The remainder of this article will review highlights of this research along with implications for programming and social policy decisions.

Mother-Infant Interaction

A substantial body of research demonstrates the relationship between the quality of maternal-infant interaction and developmental outcomes such as cognitive development and school performance (Crockenberg, 1983). Because we believed that interaction quality was likely to be compromised in cocaine affected dyads, we observed mother-infant interaction at 1, 4, 6, and 9 postnatal months. Clients were videotaped in their homes during a feeding and a teaching interaction with their infants. Home-based observations were favored over clinical assessments in order to capture mother-infant interaction in an ecologically valid context. These assessment videotapes were coded using the NCAST Feeding and Teaching Scales (developed by Katherine Barnard at the University of Washington). Twenty-five mother-infant dyads participated in this longitudinal study. As assessments were conducted prior to the full implementation of the CAN/Lagniappe early intervention component, these data may be regarded as a
baseline of mother-infant interaction for our population of cocaine-affected dyads. The results of this investigation revealed a substantial degree of impairment in mother-infant interaction at each age tested (Blackwell, Lockman & Kaiser, 1996). In order to evaluate the interaction quality of our sample, we compared it to a normative sample of intact African American dyads. On both the Feeding and Teaching scales, our sample of cocaine-affected mother and child subtotals, as well as scale totals at each testing, were at or below the tenth percentile cutoff for African American dyads described by Barnard (1990). Our sample also scored lower on both the Feeding and Teaching scales when compared to two other high risk samples: adolescent mothers and low education adults. Relative to these two other risk groups, cocaine-affected mothers in our sample scored particularly low on "cognitive growth fostering" on the feeding scale. We, therefore, concluded that mothers in our sample may not have been providing cognitive stimulation that is sensitive to the needs of their infants. This, in turn, may contribute to later developmental or school performance problems by their children.

Maternal Psychosocial Factors Related to Mother-Infant Interaction

Although all of the women enrolled in the CAN project reported an addiction to cocaine, participants were diverse in regard to psychosocial factors and drug use patterns. For this reason, we investigated the influence of three factors (in addition to cocaine use) that contributed to the quality of maternal interaction at one postnatal month (Blackwell, Kirkhart, Schmitt & Kaiser, 1996). These factors, assessed at the time of enrollment, included: maternal social support, years of cocaine use, and psychiatric status. The results revealed that the combination of years of maternal cocaine use with a woman's perceived social support or psychiatric status (measured during the prenatal period) had an important effect on the quality of maternal feeding interactions between cocaine-affected mothers and their prenatally-exposed one-month-old infants. The findings suggest that social support may be positively related to improved mother-infant interaction and, perhaps, mediate the effects of prolonged drug use. Consequently, assessment of parenting risk should include information regarding maternal drug use patterns as well as maternal psychosocial factors.

Influence of Active Maternal Substance Use on Child Development

As to date, researchers studying the effects of prenatal cocaine exposure have paid little attention to the influence of postnatal variables on child development. Results of our most recent research indicate that maternal postnatal drug use is associated both with poorer developmental outcomes and with impaired maternal-infant interaction (Blackwell, Kirkhart, Schmitt & Kaiser, in press).

In addition to observing mother-infant interaction, infant cognitive development was measured using the Bayley Scales of Infant Development (BSID) at four and six postnatal months. Post-hoc review of case management records of the 34 dyads who participated in the four month assessment provided information regarding maternal postnatal drug use. Participants were assigned to Group I if the mother returned to active substance use within the first four postnatal months, or to Group II if she remained drug free for the first four postnatal months. Differences were analyzed between Groups I and II on maternal characteristics such as years of cocaine use, psychological status, and social support at enrollment. Also compared were child development and the quality of mother-infant interaction for these two groups.

Mothers who relapsed in the first four postnatal months (Group I, n = 21) and those who remained drug free in the first four months (Group II, n = 13) were quite similar demographically. No significant differences were revealed between the two groups concerning years of drug use or psychiatric status. However, the measure of social support during pregnancy was significantly lower in the women who relapsed in the first few postnatal months (Group I) compared with the mothers who remained drug free (Group II).

Although all infants studied were exposed prenatally to cocaine, their cognitive development was in the average range at four and six months. However, maternal substance abuse in the postnatal period did have a significant effect on cognitive performance. T-test analyses of Bayley Mean Developmental Index (MDI) demonstrated that infant cognitive performance was significantly compromised in Group I.

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Conclusions and Implications

While our research has shown that maternal interaction is impaired in cocaine-affected dyads, maternal drug use history, per se, does not dictate quality of interaction. Perceived social support, duration of drug use, and psychiatric status also affect interaction quality. In particular, maternal postnatal substance use emerged as an important factor with regard to parenting and infant cognitive development. Higher quality interaction was associated with cessation of maternal substance use. Our data on the cognitive development of prenatally exposed infants showed that both interaction quality and maternal postnatal substance use may affect infant cognitive functioning. Here again, improved outcomes were associated with maternal sobriety. Therefore, interventions that focus on maternal postnatal substance use can have positive benefits on maternal-infant interaction and child development. Moreover, these data demonstrate that labeling of infants based solely on their prenatal exposure to drugs may be of limited value since postnatal factors also affect child development.

From a social policy standpoint, punitive approaches to maternal addiction, such as mandatory incarceration, do nothing to ameliorate the underlying problems that promote intergenerational cycles of addiction. Clinically and socially, more beneficial alternatives are programs such as Project Lagniappe, which assist the mother in obtaining drug treatment, provide support, promote personal goals, and enhance parenting skills. Our research indicates that interventions to enhance the quality of mother-infant interaction, in particular, may be important components of developmental services for drug-affected mother-infant dyads. As suggested by these findings, the benefits of programs such as Lagniappe are realized not only by mothers, but by children and society as well.

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Funding for CAN ended in 1995. However, services developed through this project have been replicated in Project Lagniappe. Funded by the Department of Health and Human Services, Project Lagniappe is based at Kingsley House in New Orleans and presently serves 164 children. Dr. Kaiser serves as the Principle Investigator on this project, with DeAnn Gruber, BCSW as the Project Coordinator and Pat Blackwell, Ph.D. as Project Supervisor.

REFERENCES
Sally & Annie:
A Success Story from Project Lagniappe

The following story describes a family currently enrolled in Project Lagniappe, Children's Hospital, New Orleans.

Sally was a thirty year old African-American female who, upon entering Project Lagniappe, stated that she had been an IV drug user for the past 13 years and had attempted suicide twice. When she enrolled in Lagniappe, Sally had three children and was six months pregnant with her fourth child, Annie. After the delivery, Sally learned that she was HIV-positive. Her case manager, in collaboration with the HIV Outpatient Clinic of The Medical Center of Louisiana (HOP), scheduled medical appointments for Sally and Annie. Unfortunately, due to Sally's drug use and chaotic lifestyle, she frequently missed scheduled appointments for herself and Annie. Eventually, due to medical neglect of Annie, Child Protective Services became involved.

In Lagniappe, Annie received regular testing which indicated that her development was declining. At the time, Annie's HIV status was indeterminate (P-O), therefore it was unclear whether the developmental deficits noted were due to her HIV status or to environmental factors. Sally occasionally attended Lagniappe parenting groups in an attempt to improve her parenting. During these meetings, however, she seemed to use disruptive behavior and inappropriate humor as a defense when parenting issues were broached.

As Sally continued to actively use drugs, her Lagniappe case manager and her CPS worker shared the belief that, in the best interest of her and her children, she should voluntarily relinquish custody of the children to the State and allow them to be placed in foster care while she sought help with her chemical dependency. The client agreed to this, with the understanding that her children would be returned to her if she followed specified guidelines including long-term drug treatment. She also had to demonstrate her ability to provide stable living conditions for the children.

After completing a 120-day treatment program arranged by her case manager, Sally returned to New Orleans and immediately renewed her involvement in Lagniappe. Her case manager, in conjunction with the CPS worker developed a treatment plan that included participation in weekly drug counseling sessions and weekly urine screens. She was required to attend N. A. meetings and select an N. A. sponsor, in addition to attending parenting, women's issues and recovery groups provided by Lagniappe twice weekly, Sally regained custody of her children after proving to the courts that she could maintain a drug-free lifestyle.

Sally's life seemed to have improved or stabilized in several ways since her enrollment in Lagniappe. However her need for case management and related services provided in the program continued. For instance, although Sally was still drug-free, she continued to participate in weekly relapse-prevention sessions with her case manager, as well as parenting groups. Her "middle" child, Caroline, had behavior problems for which she received counseling by a Lagniappe mental health specialist. Annie continued to receive developmental assessments in Lagniappe. Interestingly, her cognitive scores increased as her life stabilized and her mother became more involved with her and more nurturing. As both Sally and Annie had an AIDS diagnosis, they continued to benefit from assistance provided by the Lagniappe case manager who assisted Sally in negotiating AIDS-related health care and social service systems. Finally, although Sally became involved in a nurturing relationship, the support provided by Lagniappe staff remained an important aspect of her complex, challenging life.

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Project Lagniappe Supervisor
A Multi-Disciplinary Approach to Re-Parenting Chemically Dependent Women with Children

Flint Odyssey House, Inc., in Flint, MI, is a psychiatrically oriented therapeutic community for families. The community is strategically designed to foster the development of human potential and to help clients transcend the effects of chemical dependency, self-destructive behaviors, and other pathological behaviors. It is a microcosmic society in which the continuum of services is driven by the needs of individuals, families and the environment. Services, which continue to evolve as needs unfold, are provided through: residential and outpatient treatment, transitional housing, community health outreach and a child development center. Additionally, a newly acquired home for the aged provides resources to enrich the quality of interpersonal relationships and opportunities for trans-generational teaching.

The ultimate goal at Flint Odyssey House, Inc. is to interrupt intergenerational patterns of chemical dependency. When parents enter the program, it is clear that they are not adequately prepared to fulfill their parental obligations. They often are victims of neglect and abuse and, consequently, fall prey to patterns of abusing substances, themselves and, in some instances, their children. Yet, these parents are the key conduits to fostering change for the next generation. The therapeutic community at Odyssey House, therefore, simultaneously cradles the children as they grow and the mothers as they heal. Parents learn new ways of thinking and behaving so they can help create a new reality for their children. The extent to which parents benefit from the intervention directly influences the manner in which they relate to and care for their children.

At Odyssey House, cumulative staff experience and years of work with parents who have histories of chemical dependency repeatedly indicate that there is a negative correlation between chemical dependence and effective parenting. Because ineffective parenting may occur in the absence of drug use, however, it is inappropriate to assume that one factor causes the other. Effective parenting requires the adult to accept responsibility to nurture the developing child. In that children are initially dependent, the adult must be capable of, and willing to engage the child emotionally, cognitively, and physically. Effective parenting requires the adult to have sufficient self-knowledge, self-love, and self-respect. The anesthetized psychological state that results from chronic patterns of substance abuse stifles the individual’s psychological growth, level of self-awareness, and degree of maturity. Therefore, to increase parents’ ability to nurture and care for their children, parents must be parented. They must experience opportunities to understand and trust themselves in order to foster self-confidence and trust in their children. Odyssey House is designed to simultaneously address the parents’ chemical dependency and their parenting ability.

Structure of a Therapeutic Community that Parents the Parent

Women and their children are referred to Flint Odyssey House, Inc. by the Central Diagnostic and Referral Agency, the Courts, or other external agencies. The mothers have significant histories of chemical dependence. The primary drug of choice is crack/cocaine, and most of the women have experienced physical and psychological neglect and abuse, social isolation, and sexual abuse. For most, the trauma of these experiences has been sufficient to stifle or place significant strain on their psychological growth and development. Consequently, whereas the physical demeanor of these women appears to be that of adults, psychologically, most are egocentric, narcissistic, and immature. To reflect the women’s psychological stage, the therapeutic milieu at Odyssey House is based on traditional developmental theories. The treatment supports women as they progress through each stage of the development process. Simultaneously, children receive therapeutic and supportive services to promote their healthy development as their parents mature psychologically and learn how to effectively care for them.

Admission

The psychological characteristics of women entering the program are often similar, regardless of whether they are recidivists or initial intakes. These characteristics tend to mirror infancy gone awry. Infancy is a period during which healthy psychological growth occurs when the infant (birth-two years) is able to form attachments to caregivers, learn to trust, learn to express basic emotions and gradually develop a sense of independence. At intake the behavioral, emotional, cognitive, and social levels of functioning for mothers suggest that they have not mastered the tasks of infancy. Thus, mothers exhibit distrust, anger, obstinace, and impulsivity. They are neither prepared to emotionally invest in their own healing, nor foster healthy growth and development in their children. Like newborns, these women must first learn to trust. This trust is fostered through nurturing caregivers in the therapeutic community who help women begin to understand the significance of healthy emotional attachments and learn to acknowledge their emotions as they grow into an elementary level of self awareness.
Children, at the point of admission, often are angry, bewildered, fearful, dejected, and confused. Having witnessed and/or experienced violence, physical, mental and emotional abuse, neglect, poverty and despair, the children are inclined to view Flint Odyssey House as just another pause in an accelerated spiral that has taken them from one house to another, one school to another, and one community to another without sufficient time to anchor as a person. Children feel the effects of their chaotic histories and often assume responsibility for it. Thus, caregivers at Flint Odyssey House are careful to receive the family as a unit, ensuring that children are not separated from their mothers during the first seventy-two hours and providing each family with individual living quarters.

As soon as a family enters the program, caregivers begin to establish a relationship with them. Comparable to the role of healthy adults in a parent-child relationship, caregivers in the Odyssey community initiate contacts, orient the mother to the community, and act as teacher for the mother. The same caregivers provide limits and structure by making the mother aware of established rules. They also observe and evaluate the women to determine their level of self-awareness and motivation for change.

Within thirty days of admittance, each mother is assessed in the areas of self esteem, mood, parenting, addiction and psychological functioning. Assessment tools used include: The Adult Adolescent Parenting Inventory (AAPI), The Profile Of Mood State (POMS), The Index of Self Esteem (ISE), and The Social Support Questionnaire (SSQ). During this same time period, The Kaufman ABC, the Achenbauch Child Behavior Checklist, the Vineland and other tools are used to assess children in the areas of language, physical, educational, social/emotional, mental and behavioral development. The data obtained assists the multi-disciplinary team in formulating individualized treatment plans and prevention strategies for the entire family’s recovery. Children are then enrolled in appropriate childhood programs, e.g., the Child Development Center, Pre-Kindergarten Program, or public school.

Women participate in individual and group therapy. Confrontational, interpersonal interactions are used to inspire and motivate the mothers to invest in their own healing. The objective is to help the mother to recognize, acknowledge and clarify her own self-destructive feelings and behavior. This is imperative to the process of helping the mother to understand her needs and the needs of her children. It also is critical at this stage of “infancy” to help a women develop the ability to trust. To foster rudiments of trust, Odyssey uses a process called a “probe.” In the probe, the client is encouraged to genuinely confront significant events in her history (e.g., peer pressure, experimentation, acts of abuse, neglect, sexual abuse, lack of personal fulfillment) that may have affected her feelings of self-worth. Through this supportive process, the mother is expected to face the realities of herself and accept responsibility for change. At this point, she begins to develop trust as she emotionally attaches to the community, much as an infant bonds with a parent. As a member of the therapeutic community, the mother may progress through four interrelated levels of psychological development. However, her success at the “infancy” stage will invariably affect the mother’s growth and parenting abilities throughout the remaining stages of treatment.

**Level I**

*Early childhood (3-5 years)* is a period during which healthy psychological growth manifests in a child’s ability to successfully employ developing motor skills, language skills, and mental abilities. During early childhood, these tasks tend to be narcissistic in nature. Symbolic of unhealthy experiences during early childhood, mothers at Level I often show self-initiated fantasies that reflect unrealistic expectations of themselves and their children. At this stage they tend to be manipulative, irresponsible, and inconsistent. To address these issues, caregivers in the therapeutic community employ behavior modification strategies, a method frequently used with young children. The objective is to encourage the client to manage her behaviors and learn to appropriately express her emotions. The mother’s ability to effectively teach her children to manage their behaviors and appropriately express their emotions is predicated upon her success at Level I.

Also during this stage, caregivers work with parents and children together to help stabilize the family and strengthen the parent-child relationship. The primary tactics used include: specialized bonding time, experiential activities, supervised play time and structured meal times. This structure and consistency create an opportunity for children to begin to trust the environment, their mothers and themselves.

**Level II**

*Middle childhood (6-11 years)* represents a period during which advancement in children’s ability to read, write, and think logically paves the way for them to successfully gain recognition and social status. Often reflective of middle childhood gone awry, mothers may approach Level II uncertain of their ability to manage stress and simultaneously adapt to the demands of life. Not unlike the traditional family system, the community is structured in a way that encourages mothers to accept increased responsibility for specific community-related tasks while remaining responsible for their children. Women at this level are confronted with added responsibilities (e.g., procuring donations, conducting inventories of household needs, or ordering supplies for the facility), challenging them to function in a stabilized fashion. This stability tends to
predictably, as children develop increased feelings of security, however, they may act out, exhibiting behaviors that tend to be inconsistent with the mother’s unrealistic expectations. Subsequently, within the family, the attention is directed toward the child and the mother’s ability to understand the dynamics at play. Mothers are expected to become the authoritative figures in the restructured family unit. They begin to test their mother’s sincerity, demanding more attention and constantly seeking reassurance from her and from the community. The ongoing struggle is to appropriately balance her needs and her children’s needs so that each is sufficiently nurtured.

At this level, the children struggle to find their appropriate place within the restructured family unit. They begin to test their mother’s sincerity, demanding more attention and constantly seeking reassurance from her and from the community. To address the children’s confusion and insecurity, and its impact on the family, interventions at this point may include child and family therapy, enriched parent-teacher conferences, individualized parenting sessions, play therapy, and individualized child care.

Additionally, parents at this level often experience significant guilt which stimulates a desire to be reunited with children who are not currently residing with the family. The multi-disciplinary team, including the mother, develops reunification plans based upon the strengths of the family and the mother’s demonstrated ability to effectively parent her children. Although these plans often result in adolescents joining their families at Flint Odyssey House, the mother’s perception of her readiness frequently is not accurate. She may fail to realize the challenge of reestablishing herself as a parent in the lives of children from whom she has been separated. Therefore, in making decisions regarding reunification, the team gives careful and equal consideration to the needs of the children and the mother, and the stability of the family. They help the mother understand issues around reunification and prepare for challenges that may arise in the process.

Level IV

Minimally 90-180 days after admission into Odyssey, the “adolescent” mother transitions into adulthood. Healthy adults function independently with the capacity for reciprocal relationships. Attaining vocational success and contributing as a member of society are the ultimate measures of success. Evidence of unhealthy functioning may be expressed in continued dependency, reluctance, timidity, and passive-aggressive tendencies. Not unlike the healthy parent, caregivers within the community must encourage independence. Much is invested, from intake to graduation, to facilitate changes in cognition that will lead to productive, drug-free, mainstream living. At this level, a mother is expected to be a positive role model to her children and negotiate systems on behalf of her children.

Despite a mother’s increased readiness to parent her children, however, the children (particularly adolescents) may continue to be resistant, mistrusting and rebellious. At this point, support for the family focuses more on referral and connection to other community agencies. Support from the community provides a stronger foundation for family maturity and prepares a family to leave Odyssey House.

Outcomes

Historically, the multi-disciplinary team approach has proven to be highly effective with single adults. Federal funds from the U.S. Department of Health and Human Services’ Center for Substance Abuse Treatment (CSAT) and the Substance Abuse and Mental Health Services Administration (SAMHSA) paved the way to more fully develop a program specifically designed to address the needs of families. A team from Wayne State University in Detroit, MI, is evaluating this program to determine the effectiveness of the multi-disciplinary team approach for treating families. Spearheaded by Dr. Marilyn Laken, the evaluation team also includes Dr. Rivka Greenberg and Dr. Judith Fry-McComish.

Based on anecdotal evidence and individual case studies, there is reason to believe that this approach can be equally effective with families. By enabling families to live together and simultaneously addressing individual and family system issues, it has the potential for intergenerational impact. Thus far, the data collected has been clinically useful, but it is not yet complete enough to make any conclusive statements. The staff at Flint Odyssey House, however, strongly believe that effective parenting is critical in promoting healthy development in children, and that when a woman is encouraged and supported to address her own needs as an individual, she is likely to become a more effective parent.

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their own documents. Each journal becomes a unique creation that may also include artwork, photographs, favorite poems, and letters to and from children and other family members. Everyone can participate. One mother who was embarrassed by her literacy skills dictated every journal entry. She was surprised and pleased to find that she could, in fact, read what she had dictated. One of her writings illustrates how her journal helped her reflect upon herself as a parent.

BEING CORA LEE'S MOTHER

I feel like we are getting bonded. It seems like a cloud has been lifted, like I can see now.

I couldn't see the wrong. I thought I was doing everything right. I have a baby, you know. I feel good inside. I really do.

I feel like a mother and that's a good feeling. I know why I feel like that because I'm detoxing and I'm changing. She's more happier. I feel like mom and daughter.

At first I thought she was happy, but she was a sad little baby.

I feel like a different person with her. I feel like I'm really taking care of her.

Her diapers are being changed, her bottles are being sterilized, and she's eating good. I feel a lot better.

She's touching her feet, she tries to roll over, and she's teething.

This journal entry, printed fittingly on blue cloud paper, documents the client's progress in parenting over several months in treatment. In the entry, this client eloquently describes the process of building a stronger relationship with her daughter and connects her own growth and satisfaction as a parent, positive changes in her daughter's affect, and finally, the baby's developmental progress.

Conclusion

Working with recovering parents and their children is always challenging and sometimes frustrating and discouraging. It is difficult to simultaneously address addiction and the parent-child relationship. But the parents and their children possess amazing reservoirs of strength and have an unlimited potential for growth. Addictions treatment staff are themselves strong, resilient, hard-working, and dedicated to helping these families succeed. Optimal development for parent and child is possible when interventions focus on each family's unique circumstances, goals, and strengths.

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