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Shining a Light on the Impact of Parental ADM Disorders and Trauma on Children

Editorial Staff

Considering that children may be affected by parental ADM disorders in conjunction with their mother's history of violence/trauma, and the multifaceted and long-term problems that may result, it appears that many still do not receive the services and support they need to help them with their problems. (SAMHSA, 2000)

With this observation the Substance Abuse and Mental Health Services Administration (SAMHSA) launched the Women, Co-Occurring Disorders and Violence Children's Subset Study. This multi-site initiative is evaluating the effectiveness of trauma-informed, culturally relevant and age specific intervention service models for children exposed to parental substance abuse and mental health problems and histories of violence.

Over 6 million children in the United States live in households where at least one parent suffers from a substance abuse disorder (Wilens, et al., 1995). Research also shows that over 60 percent of substance abusing women suffer co-occurring mental health problems (Alexander, 1996; Helzer, 1994). Violence and abuse are also common in the lives of women with ADM disorders (Kilpatrick et al., 1998). Fifty-five to 99 percent of women substance abusers report being victimized at some point in their lives (Fullilove et al., 1993; Najavits, et al., 1998; Yandow, 1989). Many children are being raised by mothers dealing with these complex issues.

Each year an estimated 3.3 million children witness violent assaults against their mothers by

their fathers or mother's intimate partners. (Jaffe, Wilson & Wolfe, 1988). In 60 to 75 percent of families where a woman is assaulted, children are also physically abused (Bowker, 1998; Straus, Gelles & Steinmetz, 1980). Studies have shown that in families where domestic violence is present, half of the children who

were physically abused were caught in the middle of an inter-parental argument and 77 percent of children in high-violence families are abused over their lifetime (Unite for Kids, 2001).

Although research on the outcomes for children exposed to parental substance abuse, mental illness and violence is relatively recent, the harmful physical and psychological effects are clear. Children whose mothers have

co-occurring disorders and experiences of violence may suffer harmful consequences that can include:

- Emotional and/or physical abuse
- Physical injury
- Attachment disorders
- Learning difficulties and impaired school performance
- Developmental delays
- Post-traumatic stress disorder
- Depression/anxiety
- Aggression
- Behavior patterns similar to their parents (Knitzer, 2000; Young Glade & Belsky, 1990; Lamphear, 1985).

Meeting the needs of children exposed to this constellation of experiences poses great

The Children's Subset Study is working to address...service gaps through innovative programs dedicated to meeting the needs of children...

The resources featured in this issue of *The Tapestry* include literature, web-sites and organizations focused on responding to the needs of children affected by substance abuse, mental illness and violence. Space limitations preclude exhaustive coverage here, but we welcome readers' suggestions for future resource columns.

Promoting Resilience: Helping Young Children and Parents Affected by Substance Abuse, Domestic Violence, and Depression in the Context of Welfare Reform

J. Knitzer
New York: National Center for Children in Poverty, 2000
<http://cpmcnet.columbia.edu/dept/nccp>

This brief addresses the needs of families affected by welfare reform, whose parental risk factors increase the likelihood that their children will have developmental or behavioral problems. The brief highlights service, policy, and funding strategies to promote resilience, social competence, and school readiness and discusses ways to prevent or repair damaged parent-child relationships.

Children of Battered Women
P.G. Jaffee, D.A. Wolfe & S. K. Wilson
Newbury Park, CA: Sage Publications, 1990

This book addresses the impact of family violence on children including effects on development, clinical dysfunction and children's views of violence. It addresses assessment, identification, the roles of institutions and services, and strategies for intervention and prevention.

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challenges for service providers. Programs targeted towards young children and families (childcare, preschool, kindergarten) are typically not equipped to offer the types of services needed. They lack proper training and have limited access to community agencies that serve adults with substance abuse, domestic violence and mental health problems and their children (Knitzer, 2000). Misdiagnosis of children due to inadequate assessment instruments, lack of understanding among practitioners, and limited access to appropriate interventions and services also decreases the likelihood of children receiving the attention they need (SAMHSA, 2000). Nationally, there are also long waiting lists for mental health services for children. In fact, the Children's Defense Fund named the lack of mental health services for children as one of the top three

service gaps for children in the nation (CDF, 1995).

The Children's Subset Study is working to address these service gaps through innovative programs dedicated to meeting the needs of children whose mothers have co-occurring disorders and histories of violence. This issue of *The Tapestry* highlights those efforts.

Let us hear from you. You can email us at Dawn.Moses@tbhf.org or send a fax or letter to Dawn Jahn Moses, The Better Homes Fund, 181 Wells Avenue, Newton Centre, MA 02459; Fax number 617-244-1758. ■

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The SAMHSA Women Co-Occurring Disorders and Violence Children's Subset Study

Brandy Jablonski
The Better Homes Fund

The Women Co-Occurring Disorders and Violence Children's Subset Study is evaluating the effectiveness of trauma-informed, culturally relevant, and age-specific service models for children of women with co-occurring substance abuse and mental health disorders who have histories of trauma. The study seeks to identify models of care that will prevent or reduce intergenerational perpetuation of violence, substance abuse and mental health problems, reduce the impact of violence in the lives of these children, increase resiliency, and improve emotional and behavioral health (SAMHSA, 2000).

This SAMHSA-funded initiative was launched as a Subset Study of the Phase II Women, Co-Occurring Disorders and Violence Study to meet the needs of children who are likely to have witnessed family violence and/or experienced abuse or neglect. Utilizing a multi-site framework, the study is implementing a cross-site process and outcome evaluation with non-random comparison groups. Each program provides:

- A uniform clinical assessment including parent and child interviews.
- Ongoing case management (including service coordination and advocacy and individualized family service planning in individual therapy, crisis intervention, childcare/daycare/learning center, family therapy, family trust-building, multi-family group therapy, psychiatric intervention, medication management, recreation, and school/medical/social services referral and follow-up).
- A skills-building group intervention (modified version of the curriculum outlined in *Groupwork with Children of Battered Women* [Peled & Davis, 1995]) that offers safety plan development, establishment of boundaries, improved self-care and enhanced identity.

Each site is also creating opportunities for consumer/survivor/recovering (C/S/R) women's involvement in the design, operation, management and evaluation of the project.

Four sites were awarded cooperative agreements to implement and evaluate the Children's Subset Study:

- **PROTOTYPES** is a large multi-service agency providing residential, outpatient, and day treatment

services to women and children in Los Angeles County for substance abuse, mental health, HIV/AIDS, and domestic violence.

- **Allies**, located in northern California, is a collaboration between ETR Associates, an evaluation and research organization, and the Departments of Health and Human Services of two counties, as substance abuse and mental health service providers.
- **Arapahoe House, New Directions for Families (NDF)** is a comprehensive residential and outpatient substance abuse treatment program serving women and children in metropolitan Denver.
- **The Women Embracing Life and Living (WELL)** project is housed in eastern Massachusetts within three dually licensed mental health and substance abuse providers (two of which are participating in the Children's Study) serving women with co-occurring disorders and their children.

Program Components and Operation

The Children's Study enrollment procedures are similar across sites. Women learn about the study and are asked to participate during an initial baseline interview they complete for participation in the women's study. Some sites have tried alternative tactics to encourage involvement. **Allies** has found that introducing the Children's Study to the mothers a few times before asking for their participation has worked well. Because women are provided with an abundance of information and paperwork upon entering the program, a gradual introduction to the Children's Study seems less overwhelming. At the **WELL** project, women are encouraged to complete the children's baseline interview whether they have decided to participate or not. Even though they may withdraw, their participation is facilitated by this initial step.

Once a woman agrees to enroll her child, a clinical assessment is conducted to determine the most appropriate service plan. The child is then paired with a case manager who handles service coordination and advocacy, and is responsible for ensuring that each child receives all needed services. In collaboration with the mother, this person designs an appropriate service package.

Each site provides a range of services to children as needed. Individual therapy, children's group therapy and family therapy involving joint sessions between the mother and child are available.

RESOURCES

**Witness to Violence:
The Child Interview**
R.S. Pynoos
Journal of the American
Academy of Child Psychiatry,
25(3), 306-319, May, 1986

This article presents a technique for interviewing children recently exposed to acts of violence. It offers a 3-stage approach for interviewing which allows for exploration, support and closure within a 90 minute timeframe.

**Children's Witnessing of
Adult Domestic Violence**
J.L. Edleson
Journal of Interpersonal
Violence, 14(8), 839-870,
August, 1999

This research review explores how witnessing adult domestic violence affects children. It suggests that various social, behavioral, emotional and cognitive functioning problems are connected to exposure to domestic violence.

**Child Abuse and Trauma:
Theory and Treatment of the
Lasting Effects**
J. Briere
In *Interpersonal Violence:
The Practical Series, No. 2*
Thousand Oaks, CA: Sage
Publications, 1992

This book discusses the overlapping effects of all forms of child abuse and neglect including maltreatment by an alcohol or drug-addicted parent. It outlines the complex ways abuse impacts psychosocial functioning and offers treatment approaches for post-traumatic stress disorder, interpersonal dysfunction, self-destructive behavior, impaired self-reference and borderline personality disorder.

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The SAMHSA Women... (continued on page 4)

RESOURCES

Juvenile Justice Bulletin: Blueprints for Violence Prevention

U.S. Department of Justice,
Office of Juvenile Justice
and Delinquency Programs
Center for the Study and
Prevention of Violence
(303) 492-8465
www.colorado.edu/cspv/
blueprints

This issue brief highlights various violence prevention and intervention initiatives that have been proven to be effective. It features programs that have demonstrated effectiveness in reducing adolescent violent crime, aggression, substance abuse and conduct disorders.

Interventions with Parents and Caregivers of Children Who are Exposed to Violence

B.M. Groves and
B. Zuckerman
In J.D. Osofsky (Ed.),
Children in a Violent Society
New York: The Guilford
Press, 1997

This piece offers information to parents, teachers and health providers about strategies for supporting children who have been exposed to violence. It uses case examples to illustrate methods for responding to the needs of children affected by violence.

Violence Against Children in the Family and the Community

P.K. Trickett & C.J.
Schellenbach (Eds.)
Washington DC: American
Psychological Association,
1998

This book brings together the latest research on violence against children in the family and in the community. It presents interventions that have helped children traumatized by violence and offers strategies for preventing violence before it occurs.

RESOURCES...
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The SAMHSA Women... (continued from page 3)

Psychiatric intervention services including crisis intervention are also offered. Case management, referral and follow-up are ongoing. In addition to mental health services, sites also provide or make referrals for childcare, recreational activities and school-related assistance. Primary health care services are also available including medical treatment and medication management. Children also take part in a common cross-site skills building group intervention. (For a more detailed description of the children's skills building group intervention see *Group Intervention for Children of Mothers with Co-Occurring Disorders and Histories of Violence* on page 7).

Sites also offer specialized parenting programs that focus on increasing awareness of the impact of co-occurring disorders and trauma on children; expanding knowledge of child development needs; and strengthening mother-child bonds. These efforts include one-on-one mentoring; parenting groups with women; and therapy with the mother and child. The **WELL** Project offers a modified version of their published program, Nurturing Program for Families in Substance Abuse and Recovery that incorporates issues of mental illness, trauma and structured parent-child activities. **Allies** also provides a modified version of this program geared specifically towards women with co-occurring disorders who have histories of trauma and are in the process of regaining custody of their children. **NDF** implements an intensive parenting intervention aimed at repairing and nurturing the parent/child relationship by focusing on establishing parenting goals, teaching behavior modification techniques, and understanding the needs of the child. **PROTOTYPES** teaches parenting skills and techniques during individual and group therapy sessions and offers experiential classes focused on mother/child bonding and relationship building.

In addition to these required services, each site offers services that are unique to their particular program. For example:

- **PROTOTYPES** operates an on-site Children's Center—a licensed after-school program that offers tutoring, recreation, and weekly parent/child activities. The program is geared towards addressing children's individual academic needs while teaching parents to take active roles in meeting those needs. Early Head Start and Head Start are also offered on-site.
- **NDF** offers experiential play therapy and talk therapy sessions. These groups provide a safe environment for children where they can interact and develop interpersonal skills.
- The **WELL** Project develops service plans for children that concentrate not only on mental health and trauma treatment, but also include recreation, sports and after-school activities.

- **Allies** utilizes an integrated strengths-based case management approach whereby services for both the mother and the child are coordinated by a single case manager.

Services are coordinated by a person or team of people that provide case management. All sites also rely on case conferencing to formulate the most appropriate service delivery plans. In addition to providing extensive services while children are enrolled in the study, each site offers services after children complete the skills-building group intervention.

Although only one child per family is eligible to participate in the study, many sites note that other children within a participating family can receive services provided by the study without being measured. For example, **NDF** and **Allies** focus on the entire family unit and work to ensure that the needs of the whole family are adequately met.

From a research perspective, it is important to understand which of the study's broad array of services are especially helpful. Although it is too early to draw definitive conclusions, each site acknowledges that certain components seem to be making a difference.

- At **Allies**, mothers seem happy to have services available which are geared specifically for their children, such as the skills building group intervention and trauma-informed counseling. Children are enthusiastic about being together in their group. Some mothers have expressed their appreciation for the level of support and advocacy they receive through the family model of case management.
- At **PROTOTYPES**, families are responding well to a "one-stop shopping" model. This framework is particularly helpful in Los Angeles County where accessing geographically spread-out services is often burdensome for families with limited transportation.
- **NDF** reports the parenting curriculum is working well. The program's focus on rebuilding parent/child relationships and the ongoing structure it offers is helpful to parents trying to regain custody of their children.
- At **WELL**, engaging children in recreational activities in addition to meeting their mental health needs has been beneficial.

C/S/R Integration

The study places strong emphasis on involving C/S/R women in all aspects of the initiative. All sites offer opportunities for C/S/R participation in program design, management, service delivery, and research activities. All sites have C/S/R representation on their project planning committees, and feature Advisory Councils made up exclusively of C/S/Rs with

responsibilities ranging from providing input into all key project decisions, to meeting regularly with project staff, to serving as group support.

All sites have C/S/Rs serving in various paid or volunteer project positions, including community outreach workers, case managers, counselors, group co-facilitators, educators/trainers, research interviewers and peer support counselors to the mothers around various study issues. Some sites have C/S/R coordinators responsible for coordinating all consumer activities within the project and advocating for consumers. C/S/Rs are also available to families for ongoing support. They orient parents and children entering the program and remain available throughout to address any concerns that may arise. C/S/Rs have been pivotal in recruitment and retention efforts.

All sites have also developed collaborative processes to involve women in the design of their children's treatment plans, allowing them to work directly with case managers to develop care coordination packages that best fit their children's needs.

Coordination Between the Women's and Children's Intervention

All sites acknowledge the importance of ensuring coordination between the mothers' and the children's study, and the services that each are receiving. Each site has developed strategies to keep the two interventions synchronized.

Mothers at all sites participate actively in developing their child's treatment plan by working closely with case managers and/or treatment staff to identify services. At the **WELL** Project, the mother's Integrated Care Facilitator and the child's Child Clinician Advocate work together on-site and convene regular meetings. At **Allies**, mothers and children who are both enrolled in the study share the same case manager to facilitate smooth coordination between both interventions.

Sites hold regular meetings between the mothers' staff and the children's staff. Nancy VanDeMark from **NDF** notes that "very rarely are there on-site meetings that involve only women's services staff or children's services staff." This allows consideration of issues as they pertain to the entire family, rather than just to the woman or the child. Cross-training with the children's and the mothers' staff keeps each in tune to the issues of both the women and children.

Some sites also conduct joint family therapy sessions. At **PROTOTYPES**, a mother and child meet together with the child's mental health therapist to process multiple issues concerning family dynamics. Extended family members are welcome to participate in these sessions if relevant to the child's mental health. **NDF** also engages other family members, typically a father or grandparent, in conversations about the needs of the child.

Evaluation

The Children's Study sites are participating in a multi-site process and outcome evaluation. The process evaluation is designed to document the process involved in implementing this type of project and will assess the nature and scope of service delivery within the two study conditions: experimental and usual care. The outcome evaluation is examining the effects of a trauma-informed intervention on intermediate and long-term clinical outcomes of children exposed to parental mental health and substance abuse problems and histories of violence. It will measure whether children in the experimental condition show greater clinical improvement over children receiving services as usual. Outcomes of interest include improved relationships, personal safety, self-care, and identity (SAMHSA, 2000).

Challenges

Like any complex project, the Children's Subset Study has encountered issues that affect its implementation. Although some of these circumstances are universal among sites, others reflect treatment settings, service arrangements, and program structures unique to a given site.

All sites face challenges around recruiting children. Some sites struggle with the lack of eligible children. For example, the most recent influx of women into the women's study do not have children within the required age bracket, or do not have children at all.

Hesitancy among mothers about enrolling their children into the study has also limited participation. Past negative experiences make some women mistrustful of service programs and reluctant to enroll their children. Others fear they will be viewed as inadequate parents and lose their children to the foster care system. Furthermore, many women entering these programs have just begun to deal with their own issues and are not ready to confront their children's situations. Though all sites agree that mothers are very interested in getting trauma-informed services for their children, immediate solicitation of their children's involvement can be overwhelming.

Outpatient settings present challenges around keeping families engaged in the intervention. Women are coming in and out of treatment, making it difficult to secure their continued involvement and the involvement of their children. In addition, the frequency and timing of groups presents a challenge. Mothers themselves have so many groups to attend for their own recovery and balancing these with their children's treatment and groups is difficult. In residential environments, the closed group requirement has been an obstacle. Children in this setting interact regularly and form relationships with one another, presenting issues of fairness when only certain children are selected to participate in the

RESOURCES

The Overlap Between Child Maltreatment and Women Battering

J.L. Edleson
Violence Against Women, 5(2), 134-154, February, 1999

This article examines the possible overlap between child maltreatment and women battering. It reviews 35 studies that discuss the connection between child maltreatment and domestic violence. The studies are reviewed and their strengths and weaknesses identified.

Children Exposed to Marital Violence: Theory, Research and Applied Issues

G.W. Holden, R. Geffner and E. Jouriles
Washington, DC: American Psychological Association, 1998

This book examines issues related to children exposed to violence and analyzes the interactions that influence children's outcomes. It discusses why some children are more affected by marital violence, what features of a hostile environment children react to, and childhood and parental characteristics that mediate or exacerbate behavioral problems.

Growing Up in a Violent World: The Impact of Family and Community Violence on Young Children and Their Families

B. Groves
Topics In Early Childhood Special Education, 17(1), 74-102, Spring, 1997

This article discusses the impact of violence on young children with special focus on children who witness violence and whose scars remain hidden. Topics include prevalence of exposure to violence, research on violence and young children and impact of exposure to violence.

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The SAMHSA Women... (continued on page 6)

RESOURCES

National Center for Children Exposed to Violence

Child Study Center
Yale University
School of Medicine
230 South Frontage Road
New Haven, CT 06520
(877) 49-NCCEV
www.nccev.org

The National Center for Children Exposed to Violence works to enhance public and professional awareness about the effects of violence on children. It provides training and technical assistance to organizations focused on responding to the needs of children and families. It also offers access to publications on children's exposure to violence.

Family Violence Prevention Fund

383 Rhode Island Street,
Suite #304
San Francisco, CA 94103
(415) 252-8900
www.fvpf.org

The Family Violence Prevention Fund works to end domestic violence and help women and children whose lives are affected by abuse. Its focus is mobilizing concerned individuals to help carry out its mission through public education, public policy reform, training, advocacy and organizing.

RESOURCES...
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The SAMHSA Women... (continued from page 5)

group. In both settings, tracking children for follow-up interviews has been difficult. This affects outpatient settings more strongly than residential settings. In residential programs this issue becomes more difficult after mothers and children have left the residential portion of the program. Logistical issues have also been a challenge. Childcare and transportation needs, along with the frequency and timing of group activities can be burdensome for families.

Although certain issues—like the age requirement for participation—are difficult to resolve, the sites have developed various strategies for overcoming challenges. The hesitancy of mothers to enroll their children has been addressed in several ways. In residential settings, communication among participating women helps to boost involvement of those who might be unsure. Generally, women and children are pleased with the treatment and services the study is providing. Once this information spreads, it peaks the interest of families who might be initially hesitant. In outpatient settings, where interaction among women is less frequent, it is helpful to have C/S/Rs on-site to offer support. The **WELL** project has established roles for consumers to serve as C/S/R Assistants. These individuals are paid to do outreach with other women whose children are in the study and offer support and encouragement. Similarly, at **Allies**, paid peer support staff have been essential for recruiting women and their children within substance abuse treatment programs, providing support around emerging issues or concerns, and arranging/providing transportation for appointments and group sessions.

Tracking children for follow-up interviews and meeting logistical challenges have been alleviated by flexibility among staff members. This has involved hours spent on case management, providing outreach, helping families access or providing transportation and rearranging the scheduling of groups. **Allies** hopes to begin running

either a parenting or women's trauma group simultaneously with one of the children's groups to help alleviate scheduling issues for mothers.

Lessons Learned

Although still early in the process, the Children's Study sites have learned valuable lessons about implementing a project of this kind. As Norma Finkelstein of the **WELL** project explains, "It is important to think through how to get families involved in a study of this nature. Methods need to be in place for conducting outreach and engagement that engage families more gradually." All aspects of the project design must be well thought out before children are enrolled.

All sites acknowledge the importance of providing children and families with comprehensive service delivery plans that accurately reflect their individualized needs. Keeping families engaged is a challenge that requires tremendous flexibility and dedication among staff members in terms of reaching out to children and families to ensure they receive the services they need.

Sites have struggled with the complex task of implementing both the Women and Children's Studies simultaneously. Sites have learned to deal with issues such as sharing staff and balancing their time spent on both the Women's and Children's Studies so that work for each is completed in a timely manner. This has been particularly important in outpatient settings where employees are spread-out geographically.

Perhaps most importantly, the study is shedding new light on the needs of children affected by parental substance abuse, mental illness, and histories of trauma. As Elke

Rechberger from **PROTOTYPES** concludes, "It has increased public awareness of the urgent need for coordinated services for children and families." As sites continue to work through the implementation phase, the field can look forward to new strategies for helping families live healthier lives. ■

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Group Intervention for Children of Mothers with Co-Occurring Disorders and Histories of Violence

Jessie Casey

Women and Violence Coordinating Center

The Women, Co-Occurring Disorders and Violence Children's Subset Study has at its center a structured children's skills-building group intervention. The purpose of the group is to strengthen the children's ability to cope with experiences that can threaten their safety and self-esteem. Each child who becomes involved in the study will participate in the psycho-educational group program that meets once each week over a ten week period.

The group intervention has been modified from Einat Peled and Diane Davis' *Groupwork with Children of Battered Women: A Practitioner's Manual* to include a broader range of topics and apply to children who may or may not have witnessed violence and/or a parent's substance abuse or mental illness. The group, with its focus on education, attempts to accomplish four major group goals:

- To understand that it is okay to feel and express feelings
- To learn to protect oneself
- To experience the group as a positive and safe environment
- To strengthen self-esteem

Each session is designed to achieve one or more of these goals.

As a child enters the study, he or she becomes a participant in one of two groups depending on his or her age. Although the goals and desired outcomes for each session are the same for both the 5-7 year old and 8-10 year old age groups, each group participates in age appropriate activities.

The program consists of an orientation, nine core group sessions and two booster sessions. Each session follows a specific outline that is included in the Groupwork Manual provided to each group facilitator. The groups are conducted by a facilitator and a co-facilitator and in many cases the co-facilitator is a consumer/survivor/recovering (C/S/R) woman.

Both the mother and the child are introduced to the program together at orientation. This hour long session is meant to explain to both the parent and the child what the group is about and what they can expect over the next ten weeks. It is during this session that a short letter written by several C/S/R women is read to the mothers in an effort to explain to them what their child will be participating in and the potential effects this may have on themselves, their child, and the rest of their families. A C/S/R woman is also available after this session to answer any questions the mothers may have.

Each subsequent session follows an explicit outline and many of the activities remain constant throughout

the sessions. The sessions tackle complex issues such as a parent's substance abuse, being exposed to violence, appropriate touch, expressing anger and having the right to be safe. The sessions begin with a check-in which allows each child to discuss any feelings they have about the last session or anything that has been going on in their lives throughout the last week. In addition, each session has a feeling of the day. This activity is designed to legitimize the feelings the child experiences and helps them to understand appropriate expressions of those feelings. Several of the sessions include books chosen specifically for each age group. The books chosen include *The Monster Boy* by Christine M. Winn with David Walsh, *Don't Rant and Rave on Wednesdays* by Adolph Moser, *My Body is Private* by Linda Walvoord Girard and *The Mouse, the Monster and Me* Written by P. Palmer. For the session that addresses substance abuse, "Coping With A Parent that Drinks or Abuses Drugs" will be shown to both age groups. Each session also includes a snack and each child is given a small reinforcement such as a sticker or a pencil to take home with them.

The sessions build on each other and culminate in the creation of a safety plan designed specifically by each child. The plan contains phone numbers and safe places the child can go if they are in a situation that feels unsafe. This activity is repeated in one of the two booster sessions that occur 30 days and 60 days after Session Nine. The safety plan is then laminated and the children are encouraged to take the plan home with them as a reminder of what they learned in the group over the last few months. ■

GROUP SESSIONS

Orientation for Parents and Children

Week One:	Getting To Know Each Other
Week Two:	What Hands Can Do
Week Three:	Anger
Week Four:	Drug Abuse
Week Five:	Sharing Personal Experiences With Violence
Week Six:	Touch
Week Seven:	Assertiveness
Week Eight:	Protection Planning
Week Nine:	Review and Good-Bye
Booster Session One:	Review of What Hands Can Do <i>From Session Two</i>
Booster Session Two:	Review of Safety Protection Plan <i>From Session Eight</i>

REFERENCE:

Peled, E. & Davis, D. (1995). *Groupwork with children of battered women: A practitioner's guide*, Thousand Oaks, CA: Sage Publications, Inc.

RESOURCES

The International Society for Prevention of Child Abuse and Neglect
200 North Michigan Avenue, Suite 500
Chicago, IL 60601
(312) 578-1401
www.ispcan.org

The International Society for the Prevention of Child Abuse and Neglect is committed to increasing public awareness, developing activities to prevent violence, and promoting rights for children.

Child Trauma Academy
www.bcm.tmc.edu/cta/

The Child Trauma Academy is a research, service and training organization that focuses on the maltreatment of children. Its mission is to improve the systems that educate, nurture, protect and enrich children by developing innovative, measurable, and replicable solutions for working with traumatized children.

Child Witness to Violence Project
Boston Medical Center
Department of Pediatrics
91 East Concord Street,
5th Floor
Boston, MA 02118
(617) 414-4244
www.bostonchildhealth.org/
[childwitnessstoviolence](http://childwitnessstoviolence.org/)

The Child Witness to Violence Project is a counseling, advocacy, consultation and training program that serves young children who witness violence in their families. Its goals are to identify children who witness acts of violence, to help children heal and to provide training to caregivers of children exposed to violence.

RESOURCES...
(continued on page 8)

Nurturing Families Affected by Substance Abuse, Mental Illness and Trauma
 Institute for Health and Recovery
 349 Broadway
 Cambridge, MA 02139
 (617) 661-3991
 www.healthrecovery.org
 Cost: \$35 (\$8 shipping)

This parenting curriculum is designed to address the needs of families affected by substance abuse, mental illness and trauma. It includes three modules that can be used separately or in conjunction: two one-on-one mentoring sessions, 14 psycho-educational parenting sessions for parents and four parent-child activity sessions.

Building Family Recovery
 Institute for Health and Recovery
 349 Broadway
 Cambridge, MA 02139
 (617) 661-3991
 www.healthrecovery.org
 Cost: \$20 (\$5 shipping)

This is a psycho-educational, group-based program for families who have experienced separation and disruption as a result of parental substance abuse. The program is aimed at supporting families in getting to know one another in a new, sober lifestyle. Particular attention is paid to the needs of school-aged children.

RESOURCES...
 (continued on page 9)

Children of Mothers Who Have Dual Disorders: The Barriers They Face

Gloria Grijalva-Gonzales
 C/S/R Representative
 The Allies Project

Barriers in obtaining services for children affected by parental co-occurring disorders and trauma are many. These children face problems very similar to those that mothers often face in getting services for them. Barriers for children come from many different sources, the system (our society), those who deliver the services, and supposedly from consumers themselves.

In working with women with multiple issues, who have children, I have seen and continue to see numerous barriers. As a recovering consumer I have also experienced an array of these same barriers while trying to get services for my children or shall I say that I did not get. I sometimes still experience barriers that hinder my now grown children in obtaining help.

The how and why of barriers that block children from services may be viewed differently in comparison with that of a consumer's point of view and that of a service provider's view. The idea and thoughts that will be expressed within this article are views and conclusions I have come to while walking through my journey of recovery and from working as a service provider. The story I tell and yes I say "story" because some of it may be over exaggerated, but most of it is told in truths, about the way I see and feel about the obstacles children face in getting services. I truly do not intend to offend anyone because working in services I see change happening slowly, but surely they are on their way.

First off let's take a look at the barriers that supposedly come from the consumers themselves in getting services for their children. I'll start with the barrier called "**Denial**". Denial is thought to be a normal part of the recovery process for substance abusers and other related issues. To deny is to say we have no problems so we need no services, which goes down as us refusing services and neglecting our children (the bad people). How come we, consumers, cannot see the wrecking ball of drug use, mental illness or abuse and the impact it has on our children? (Are we crazy?) I think the only way anyone could miss that ball is if they were taught to miss it. Taught to "deny" problems.

Denial stems from the biggest barrier called "**Culture**" (social conditioning). Culture is the root that triggers most, if not all the barriers I will discuss. Social conditioning teaches us certain ways to live. It teaches us what is acceptable and what is not and it has also conditioned us on how we respond accordingly, so we deny. Society teaches us not to talk about problems, rather "not to have problems" especially in regards to problems of substance abuse, mental illness or other abuses. So with all that said it is really very hard to

overcome these barriers when the world is saying "NO PROBLEMS". Culture uses a subculture called "family culture" to reinforce what has been taught to them. They (our families) say similar types of messages like, "don't air your dirty laundry" and "there's nothing wrong" etc. Yes culture has us strapped in pretty tight into keeping quiet and staying in "denial." For if we speak, the punishment of more barriers will be laid upon us such as the barriers

of "**Shame and Guilt**".

So now we try and bare your crosses of Denial, Culture (societal, family), Shame and Guilt and follow your new message to reach out for help to save our children. We have tried your system, a system that has reassured me that conditioning has happened to us all because now I face the barrier of "**Stigma**" meaning our world says we are lazy, crazy or bad because we have resorted to illicit substances and mental illness to be able to cope. We had to do this in order to survive since we are not allowed to have problems or ask for help. To ask for help is hard but it is especially hard when you have problems that are even more taboo to speak about, such as substance abuse and mental illness. These types of problems we have are totally unacceptable in our society. Stigma keeps them that way.

The world's helper now see us with eyes of stigma because all they see us as are labels (disorders, diseases, borderline, hostile, etc.). With labels the world can no longer relate to us as people because labels take away our identity. If I do not have an identity, who or what will they be treating, the labels? So how will they ever help "me" if they

"To ask for help is hard but it is especially hard when you have problems that are even more taboo to speak about..."

no longer know I exist? The barriers of **“Labels”** are keeping us from getting the real services we need.

I really do want help for my children but the barrier of **“Fear”** from all that I’ve discussed is so thick now that it often stops me from going to you for help. I am afraid my children will be removed, retained, restrained and labeled like I was. I am afraid of the system that has imprisoned with so many barriers.

Now with the barrier of having no **“Trust”** how will I ever unlock the latch on my prison gate? I do want to trust and I know I have to trust or I may lose my children. What makes it so hard is that I’ve seen other women who have tried your system that were set up to fail. Maybe you didn’t really plan it that way, but it sure looked like it. When they submitted or were forced into your services another whole gambit of barriers started to hit them. First the system forgot we came with children and many times with quite a few. The women with children had to deal with the barrier of **“Child Care”**. The child care services available had all kinds of requirements to create other hardships for women getting to services for their children. There were all kinds of rules and guidelines of age limits, which most likely

meant our children had to be separated and had to go to all kinds of different child cares (now remember I have trust issues). Then came the next barriers of **“Transportation”** and **“Finances”** in getting our children to services. Bus tickets are not the answer when you have more than one child, have time schedules, different services at different locations, child protective services waiting to drop the axe and your hands are full with diaper bags, stroller, two or three children which require the holding of a hand. Yes I started to feel overwhelmed, tired and then depressed. The wall was getting higher, wider and thicker. The barriers of not having **“Integrated”** services were making it to hard for me to run from here to there. Once I do get to a service the barrier of **“Criteria”** is something alone that can finish one off. The number of children you have, the ages of those children, the right (wrong) disorders, their culture, repetitious questions and paper work, the amount of income, the kind of insurance and what ever else programs make their boxes out were hard to fit. I was so “bent out of shape” from trying to fit in box after box that I just had to quit because my illness was continuously progressing through the process of trying to get help.

Boy, the frustration in just telling this story has been trying! Trying to put it to words is still hard because I still get angry knowing that things haven’t changed much. With all the money coming in for our clients you’d think things like integration would be in place. Yes the story makes me want to shout, wake up! Get it together!

Not having adequate services for women and their children is in great part what is causing our children to show off on the five o’clock news almost daily now. I know that sounds ugly, but what is worse is the fear if what I am saying is the truth and we are still moving so slow to break the barriers that can bring change.

It may seem that I am over reacting, but most of my life I have kept my mouth shut because I had lost hope, and a lot of bad things happened because I never spoke, but today I learned truths that have made it possible for me to speak. I have learned truths like “a mouth that never opens doesn’t get fed”. So I speak because I have come to realize that I have a voice and I need to use it in order to help. So I have and will use it whenever and wherever I can to help women and children learn that it is ok to ask for help.

So I will continue to tell my stories in hopes that it will bring about change for the next woman and her children to have it a little easier. That goes especially for my own children because they are starting to raise children and I plan for them to start a new and healthier generation. One that permits the realization that they do have problems and were affected by problems and that it is ok to get help so that they can help to alleviate these problems for our next generations.

Many thanks to *The Tapestry* for allowing me (us) to share our hardships and our voices, (voices of consumers) so that those who are in power may hear our cries and help us to remove the barriers that get in the way of us reaching recoveries and in stopping the intergenerational plagues that bind us. ■

*“I will continue
to tell my stories
in hopes that it
will bring
about change.”*

RESOURCES

Family Activities to Nurture Parents and Children
Institute for Health and Recovery
349 Broadway
Cambridge, MA 02139
(617) 661-3991
www.healthrecovery.org
Cost: \$13 (\$5 shipping)

This easy to read book describes playful, creative activities for parents and children, ages 2-12 to enjoy together. A guide identifies activities age range appeal, capacity to energize or calm and supervisory level needed.

Child Abuse Prevention Network
www.child-abuse.com

The Child Abuse Prevention Network is an online resource that provides tools for workers to support the identification, investigation, treatment, adjudication and prevention of child abuse and neglect.

Minnesota Center Against Violence
www.mincava.umn.edu

This electronic clearing-house, developed by Jeffery Edleson offers access to extensive resources on the topic of violence and abuse including, domestic violence and children that are available online.

A Family-Centered Approach to Women Trauma Survivors with Co-Occurring Disorders

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Nurturing is central in the lives of many women, who typically do so in their capacity as mothers. Motherhood may carry even more significance for women living with mental health and substance use disorders as it is a life role that is often assumed to be unavailable. There is, however, increasing awareness that women with these diagnoses are bearing and caring for children (Nicholson et al., 2001).

Given this reality and the strong relationship between maternal and child well being, it seems appropriate to borrow the concept of “family-centered,” developed in the children’s services arena, to elaborate a set of principles for working with women and their children. The basic tenants of family-centered care are derived from an ecological view of children with disabilities in the context of their families and the greater community (Hunter & Friesen, 1996), and are consistent with the values formulated by SAMHSA Women and Violence site participants. The family defines needs; the focus is on strengths; interventions are broadly conceived; families have choices; and services and systems are flexible and responsive. Family-centered services enhance feelings of personal control and family empowerment (e.g., Trivette et al., 1996; Thompson et al., 1997); may prevent out-of-home placements and reunify families (e.g., Heneghan, Horwitz, & Leventhal, 1996; Nelson, Landsman, & Deutelbaum, 1990); and benefit both children and parents (e.g., Evans et al., 1996; Evans et al., 1994).

The application of family-centered principles to adult services stretches both our perception of adults with disabilities, and our definition of family-centered. Principles of family-centered care have not been routinely applied when an adult is the “identified patient.”

The following are suggested as basic guidelines.

- ***Women trauma survivors with co-occurring disorders have the capacity to nurture and many are mothers who desire “normal” family lives.***

While women’s ability to nurture may be compromised by inadequate role models, negative life experiences, and a consequent lack of motivation, women can be supported in recognizing and enhancing their capacity to care for others. Forming healthy relationships, including relationships with children, is an essential step in healing the trauma of abuse (Copeland & Harris, 2000).

- ***Women provide their own definitions of family.***

Women must be asked about their children; where they are living; who is caring for them; and the extent or nature of involvement with them (Nicholson et al., 2001). Women may be caring for adopted children, stepchildren, or the children of others in informal arrangements. They may have goals for pregnancy, parenting, or family reunification yet to be achieved. Mothers may have ambivalent relationships with individuals traditionally defined as family members and may feel disempowered by them. A woman may be supported best by those she defines as family members, who may include individuals from her church or spiritual group, clubhouse, or treatment community.

- ***Parental and child well being are intertwined, whether parents and children live together or apart, and regardless of age or stage of development.***

Children who have a parent with mental illness are at significantly greater risk than children in the general population for multiple psychosocial problems (Beardslee et al., 1996; Canino, Bird, Rubio-Stipec, Bravo, & Algeria, 1990; Oyserman, Mowbray, Meares & Firminger, 2000). Despite these risks, many children of parents with mental illness are resilient and appear to avoid significant problems (Beardslee & Puderofsky, 1988). While as many as 30

to 50% of children may develop problems, an equal or greater percent do not (Nicholson et al., 2001).

Mediating variables in the relationship between parental mental illness and children’s functioning include genetic/biological influences, illness characteristics, and aspects of the family environment related to parental functioning. Moderating variables include the sociopolitical climate, spouse/partner characteristics, minority status, education level, poverty, and child characteristics such as temperament and intelligence.

Parents with mental illness worry about the impact of their illness on their children (Nicholson et al., 1998a). They may be concerned that any signs of misbehavior or distress on their children’s parts are indications of developing emotional disturbance.

Family-centered services enhance feelings of personal control and family empowerment.

- ***Most children are better off at home if possible.***

Safety is the ultimate concern when mothers have difficulty meeting children's needs. Other caregivers may be required to provide support or primary care, temporarily or long-term. Home-based treatment models may be in the best interest of mothers and children, as there are costs as well as benefits to disrupting the parent-child relationship. Relieving mothers of their parenting responsibilities does not necessarily make a positive contribution to their recoveries (Finkelstein, 1994). Poorly planned or mismanaged visits are stressful and contribute to trauma for both women and children. While separations may seem positive in the short-run, there are long-term sequelae, with repercussions for women and children at every age and life stage.

When it is not desirable or possible for children to live at home, mothers can be engaged in planning arrangements and supported in making choices that optimize outcomes. Women who reasonably choose alternatives to 24-hour-a-day parenting must be respected for their choices rather than viewed as failing. Mothers can continue to be involved in making decisions about their children, unless prohibited by adoption laws.

- ***Recovery builds on strengths rather than deficits.***

Parents have a wide range of skill levels, regardless of psychiatric diagnosis. Unfortunately, mothers with mental illness and/or substance abuse may have doubts and fears about their own skills, reinforced by the negative assumptions of providers and family members. Parenting services are often accessed via the child welfare system where failure, i.e., demonstrated child abuse and neglect, is an eligibility requirement.

The opportunity to identify strengths may be a new experience for many mothers, and may actually be difficult for those mired in poor self-esteem and feelings of powerlessness. The identification of strengths offers hope; without hope there can be no rehabilitation or recovery. Mothers must identify strengths in children, to implement effective behavior management strategies and enhance parent-child relationships. Children need to know their parents have strengths as well. Even in situations in which children and providers have no contact with birth parents, mothers' strengths must be identified and highlighted, as children's perceptions of their mothers are an integral component of their own identities.

- ***Parents and providers are partners rather than adversaries.***

In the past, professionals, parents, and the public commonly held the belief that children's disorders were solely the result of poor parenting (Friesen & Koroloff, 1990). Parents were blamed for their children's problems. In fact, parental characteristics are one factor among many

affecting children. A programmatic or provider focus only on parental inadequacies contributes to a parent's view of the helping relationship as adversarial (Hearle et al., 1999; Nicholson, 1996).

Proceedings in the legal system are often adversarial, with child advocates pitted against parents, or "well" parents against those with psychiatric diagnoses. A family-centered approach requires a non-blaming stance, engaging parents as consultants regarding their children's problems and supporting them in sharing responsibility for solutions.

Services for women with co-occurring disorders may be family-centered but not necessarily include direct services to children. Women may not be mothers, either by choice or lack of opportunity, or may have no contact with their children. Support may be provided for reproductive decision-making, or grieving and coping with loss. Women may be encouraged to develop alternative avenues for nurturing, forming positive relationships with other young relatives or friends, or even caring for pets. Acknowledgment of the importance of nurturing and motherhood does not take away from an emphasis on the centrality of trauma in women's lives. Rather, it provides an avenue for recovery, a motivation and context within which we can partner with women.

Services for children require the participation of adults. Treatment cannot proceed without the permission of a parent or designated parental figure. Providers typically understand that, while it is possible to work with individual children in treatment, unless caring adults are engaged in supporting change, children's progress will not be sustained in the natural environment.

The effectiveness of a family-centered approach to services for women trauma survivors with co-occurring disorders and their children has yet to be empirically proven. However, these principles can be applied and tested on a case-by-case basis, recognizing that the integrity of women's recoveries and the safety of children must not be compromised. Attention must be paid to the impact of nurturing and parenting experiences on women's lives, in addition to the effects of women's life experiences on their capacity to nurture and parent. Mothers' and children's well being cannot be

separated. To promote recovery and optimize outcomes for both, we must recognize the contribution of each to the other. ■

Joanne Nicholson, Ph.D. serves as a consultant for the Women, Co-Occurring Disorders and Violence Coordinating Center and recently published a new book entitled Parenting Well When You're Depressed.

*Acknowledgment of
the importance of
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The Women, Co-Occurring Disorders and Violence Study is generating knowledge on the development of integrated services approaches for women with co-occurring substance abuse and mental health disorders who also have histories of physical and/or sexual abuse.

The Tapestry is a product of the Women, Co-Occurring Disorders and Violence Coordinating Center which is operated by Policy Research Associates, in partnership with The Better Homes Fund and the Cecil G. Sheps Center for Health Services Research. The Coordinating Center provides technical assistance to program sites, conducts cross-site process and outcome evaluations, and develops a range of application products from the study sites. This publication was developed by The Better Homes Fund.

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For more information on this Initiative, please contact
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Delmar, NY, 12054
518-439-7415
e-mail: wvcc.prainc.com
web: www.prainc.com/wcdvs

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