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'Bringing you up to Speed' Challenges of a Mother Using Amphetamines : A Case Study

Derek Bilton
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‘Bringing You Up to Speed’
Challenges of a Mother Using Amphetamines: A Case Study

By Derek Bilton

A Report Submitted in Partial Fulfilment of the Requirements for the Award of Bachelor
of Arts (Psychology) Honours
Faculty of Community Studies, Education and Social Sciences
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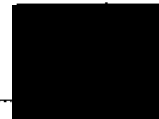
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'Bringing You Up to Speed' Challenges of a Mother Using Amphetamines: A Case Study

Abstract

The purpose of the current study was to explore the challenges of parenting from the perspective of a woman who uses amphetamines. The types of parenting challenge that arise as a direct result of both intoxication and a drug using lifestyle were examined. The study also investigated the types of coping strategies that the participant adopted in meeting her parenting challenges in conjunction with the factors that aided and impeded her preferred method of responding. The study extends onto the existing literature by drawing a participant from a non-clinical setting. The participant was recruited from word of mouth field recruitment. An open response format interview was used to assess the themes of parenting challenges, relationship to drug use and coping strategies. Furthermore, data were collected from the participant's children in order to gauge their current level of functioning. Responses were analysed using a thematic approach. The data indicates a complexity of interactions among the various parenting challenges, coping resources, and life circumstances. Preferred methods of coping were impeded by the participant's intoxication, a drug using lifestyle, domestic violence and a number of complicating life factors. Results are discussed in terms of a harm reduction paradigm in forming hypotheses to guide future programs that aim to reduce the harm to children of amphetamine users. It is concluded that future methods of service delivery need to focus on placing drug use within a social context. Specifically targeting the harm experienced by family members and providing a more holistic approach to intervention that gains the consumer's trust.

Author: Derek Bilton
Supervisor: Greg Dear
Submitted: October, 2002

Declaration

I certify that this thesis does not incorporate, without acknowledgement, any material previously submitted for a degree or diploma in any institution of higher education and that, to the best of my knowledge and belief, it does not contain any material previously published or written by another person except where reference is made in the text; or contain any defamatory information.

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Date: October 30, 2002

USE OF THESIS

The Use of Thesis statement is not included in this version of the thesis.

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Introduction

Current literature on the topic of substance using parents has predominantly focused on two areas: the positive and negative implications of parental alcohol and other drug use, and the experiences of the parent who is also a drug user. Each of these areas is reviewed separately below prior to presenting.

Parental alcohol use

There has been extensive research on the negative impact of parental alcohol misuse on children (Bijur, Kurson, Overpeck & Scheidt, 1992; Johnson & Jacob, 1995; Johnson & Leff, 1999; Jones & Smith, 1973; Kandel, Kessler, & Margulies, 1978; Kondanaram, 1995; Lieb et al., 2002; Swain, 1991). Children of parents who misuse alcohol (COPMA) are more likely to develop their own substance use problems than are children from randomly selected samples (Swain, 1991). Due to the presence of a number of combined risk factors, COPMA are especially vulnerable to an increased risk of later emotional and behavioural problems (Kondanaram, 1995; Nylander & Rydelius, 1982; Mutzell, 1995). Current research on COPMA has predominantly focused on their developmental outcomes and the possible teratogenic effects of in utero exposure to alcohol (Eyler & Behnke, 1999; Sher, 1997).

Families with a history of alcohol abuse report higher levels of conflict than other families (Moos & Billings, 1982), and the environment of COPMA has been characterised by a lack of parenting and family communication skills (US Dept of Health and Human Services, 1993), increased family conflict and mismanagement, emotional or physical violence, decreased family cohesion and organisation, increased family isolation, health, employment and financial problems, and numerous family relocations (Wolin, Bennett & Noonan, 1979; Harter, 2000; Jacobson & Jacobson, 2001; Johnson & Jacob, 1995; Leonard

et al., 2000; Puttler, Zucker, Fitzgerald & Bingham, 1998; Swain, 1991; Velleman & Orford, 1999). Furthermore, COPMA have been found to be at an increased risk of injury (Bijur et al., 1992), display lowered academic functioning, neuro-psychological deficits in perceptual motor ability, memory and language processing, auditory and visual attention impairments and a lower level of achievement in reading comprehension (Tarter, 84). COPMA display psychological and interpersonal difficulties such as aggressiveness and anti social behaviour (Harter, 2000), have problems with adjustment in the home, health, emotional and social domains, (Kondanaram, 1995), and display impaired emotional development; (Moos & Billings, 1982, Johnson & Jacob, 1995).

Overall the research has indicated that parental alcohol abuse can have a negative effect on children. However, the research also indicates that there is significant heterogeneity amongst the population of the COPMA studied in terms of psycho-social functioning, interpersonal and family stability, drug related impairments, and concomitant psychopathology (Chassin, Rogosch, & Barrera, 1991; Tweed & Ryff, 1991). Furthermore, most COPMA may be indistinguishable from non-COPMA in regard to both drinking and non-drinking characteristics (Sher, 1991). This observation might be attributable to the difference in the number of risk factors present at any given time and/or the cumulative effect of multiple risk factors on the measurement of behavioural outcomes (Johnson & Leff, 1999).

Parental Drug Use

An overview of the research findings revealed an abundance of information relating to COPMA. In contrast, the literature pertaining to the children of parents with problematic drug use is meagre in comparison. Relatively little is known about the children of parents

who have problematic heroin, cocaine and polydrug use (Johnson, Boney and Brown, 1990-91). Nonetheless, many researchers suggest that the children of parents with problematic drug use are at greater risk of later dysfunctional behaviours and deserve significant investigation to prevent transmission of drug abuse from one generation to the next (Swain, 1991).

The illegal nature of these drugs and the subsequent secretive nature of user conduct is one of the main factors that divides it from alcohol in terms of the public image it creates and the subsequent public reaction it receives. Complicating this issue further, are the associated health risks and the risk of additional criminal activity (Hogan, 1998).

The relationship between parental drug misuse and the negative impact it has on their offspring has been documented through a number of studies primarily concentrating on the illegal drugs of heroin and cocaine (Barnard, 1999; Hawley, Halle, Drasin & Thomas, 1996; Hogan, 1998; Inciardi, 1993; Johnson et al., 1990-91; Keen & Alison, 2001; Kelley, 1998; Mayes, 1995; Stanger, et al., 1998; Swain, 1991; Wilens, Biederman, Kiely, Bresidin & Spencer, 1995). The areas of foetal exposure, psychological, social, emotional and cognitive development and family factors are reviewed below.

Foetal Exposure

Most research on children of parents with substance use problems examines foetal exposure to maternal drug misuse. Because most drugs cross the placenta, there is a risk of passive drug dependency in the foetus. (Calabrese & Gullledge, 1985). Prenatal drug withdrawal, by a pregnant woman can inhibit foetal oxygen consumption, resulting in hypoxia or death. In contrast, postnatal drug withdrawal is characterised by the neonatal abstinence syndrome.

Infants of opiate users are generally of lower birth weight and are at increased risk of intrauterine death (Sparey & Walkinshaw, 1995). They are also at risk from elevated tension and poor concentration (Berstein, Jeremy, Hans & Marcus, 1994). However, it is difficult to gauge what effect the mother's health has on current infant outcomes. An improvement in antenatal care may be a determining factor in improving outcomes for the infants of opiate dependant women (Broekhuizen, Utrie & Van Mullem, 1992; Siney & Walkinshaw, 1995). An improvement in health related care and its effects on infant outcomes is potentially reinforced through the research findings that infants of methadone maintained mothers have more positive outcomes than untreated mothers who use heroin (Rosner, Keith & Chasnoff, 1982).

In regard to cocaine use, prenatal exposure to cocaine is associated with a variety of physical problems including low birth weight and gestational age (Chouteau, Namerow & Leppert, 1988), vasoconstriction of the placenta vessels, and an increased risk of maternal hypertension and spontaneous abortion (Bays, 1990).

A retrospective study by Furara Carriek and Armstrong (1999) of 30 cases of pregnancy associated with maternal amphetamine use revealed that the risk of pre-maturity was 286% higher than in the general obstetric population with birth weights being 25% lower than the cases who ceased amphetamine use during pregnancy.

The existing literature does not address the issue of the interaction between foetal exposure to maternal drug misuse and the conditions in the postnatal environment. It is difficult to distinguish postnatal environmental effects from genetic effects (Wilson, Desmond, Verniaud, 1973). However, "even if children are not exposed to chemicals in

utero, they are potentially at a greater psychological, social, emotional and cognitive risk if their parents are involved in the drug culture” (Johnson & Leff, 1999).

Psychological, social and emotional development

Findings from studies comparing children of substance misusing and non substance misusing parents revealed that children of substance misusing parents had difficulties in the area of social-emotional development and were more immature, impulsive and irresponsible than children of non drug users (Bauman & Levine, 78). These children performed more poorly on intelligence tests (Sowder & Burt, 1980), had attention problems, impulsivity, and higher rates of internalising and externalising problems, (Chassin et al., 1991; Hawley et al., 1995; Jansen et al., 1995; Moss et al., 1994,1995,1997; Wilens et al., 1995). Children of substance misusing parents displayed substance misuse, delinquency, academic problems (Stanger et al., 1998) and an increase in learning problems and behavioural disturbances (Wilson, McCreary & Kean, 1979). Such comparisons had shown that children were more likely to experience greater social isolation, socio-economic disadvantage and reported higher levels of stress than non misusing comparison groups (Kumpfer and DeMarsh, 1986; Sowder and Burt, 1980). Higher maternal drug involvement was associated with an increase in children assessed as aggressive, withdrawn, detached and disobedient (Kandel, 1990). Furthermore, children of parents with substance use problems were found to be at significant disadvantage on measures of depression, trait anxiety and standard scores of arithmetic when compared to other children (Johnson et al., 1991).

Cognitive development

In terms of cognitive development, findings from studies focusing on children of parents with problematic heroin use revealed that they were at greater risk of poor school

performance, in the areas of learning, IQ, and perceptual motor performance. They displayed more truancy and behavioural problems, had a need for remedial reading (Nichtern, 1973; Sowder & Burt, 1980) and showed delays in language development (Sardemann, Madsen & Hansen, 1976). However, findings from a study by Fanshel (1975) revealed no evidence of poorer cognitive performance between children of drug users and other children in care, but teacher ratings indicated poorer school adjustments.

Family factors

Recent studies that have focused on the family have shown that substance misusing parents are at increased risk of abusing and neglecting their children (Casado-Flores, Bano-Rodrigo, & Romero, 1990; Chaffin, Kelleher, & Hollenberg, 1996; Famularo et al., 1992; Wasserman & Levanthal, 1993). Child abuse or neglect is also a significant concern for infants of substance misusers (Black & Mayes, 1980; Famularo et al., 1992; Jaues, Ekwo & Van Voorhis, 1995; Reagan & Ehrlich, 1982). Children of parents with substance use problems are more likely to be taken into care (Fraser & Cavanagh, 1991; Kelley, 1992;) and their parents have difficulty providing a safe environment (Bijur et al., 1992). Furthermore, drug using families appear to have poorer bonding and attachment (Kumpfer and Turner, 1990-1991); whilst the parent's need to acquire drugs at times supersedes the child's need for love, attention, supervision, food and clothing (Rosenbaum, 1981). Chronic dependence can result in much time being focused on accessing, using and supplying drugs rather than parenting. Rosenbaum (1979) stated that these conflicting behaviours might be heightened in low income households where there is limited support from relatives and friends. Furthermore, the household of drug using parents has been characterised as poor and unstable, involving drug use, criminal activity and drug induced violence (Inciardi et

al., 1993). Children within these families may be exposed to drug related activities and associated crime (Hogan, 1998).

There is a strong correlation between parents' and adolescents' use of illicit substances. Adolescents who use drugs are more likely to have one or more parents who also use drugs (Kumpfer & De Marsh, 1986; Pickens, Svikis, & McGueetal, 1991; Sowder & Burt, 1980), and their attitudes to their children's drug-taking behaviours may be as important as actual drug misuse among the parents. If children perceive that their parents attitude is permissive about drug use, then they will be more likely to use drugs themselves (Barnes & Windle, 1987). Furthermore, key factors that predict later substance misuse in children include parental modelling of substance use and a family history of substance misuse (Swain 1991).

The behaviour of children may be constrained by their exposure to criminal activity and the secretive environment that an illegal drug using lifestyle creates. (Hogan, 1998). The route of administering the drug poses further risks of injecting equipment and the transmission of blood borne diseases. Furthermore, drug-using families may experience limited interaction in certain areas of social life, reporting few to no friendships with supportive persons who are not also substance abusers in addition to often describing long standing social detachment (Tucker, 1979).

The negative impact of illegal drug use on children is well-documented incorporating environmental, biologic, and psychologic risk factors. These factors are believed to increase the likelihood of future dysfunctional behaviour and to have an increased risk of elevating parent levels of stress and maladaptive coping behaviours

(Kelley, 1998; Kettinger, Nair and Schuler, 2000). Evidence points to the fact that children who grow up within a drug dependant household are at increased risk of a wide range of negative outcomes.

The question of Heterogeneity

A high-risk paradigm has been used to study children at risk for a variety of problems. Reviews on the risk factors associated with drug and alcohol misuse in children, indicate numerous contributing factors including, childhood personality, antisocial traits, stress, hyperactivity, low academic achievement and commitment, and relationships with substance-using peers (Catalano et al., 1991; Swain, 1991). According to Johnson and Leff (1999) the single most potent risk factor is their parent's substance misusing behaviour placing the child at biologic, psychologic, and environmental risk.

However, children of substance misusing parents consistently had fewer problems than children who were referred to mental health clinics (Stanger et al., 1998). This finding is consistent with research on children of parents with alcohol problems showing that many children in these groups do not show elevated rates of mental health problems but that those with elevated problems tend to show both internalising and externalising problems (Chassin et al., 1991; Moss et al., 1994; Wilens et al., 1995). Parental drug misuse is associated with adverse outcomes for children, including an increased risk of substance misuse during adolescence, however, many children with family histories of drug misuse never exhibit maladaptive behaviours in childhood or adulthood (Garnezy, 1985).

Anthony (1974) stated that children of substance users can not be considered as a single entity but may be a heterogeneous group of individuals. Similar experiences affect children differently as a result of individual differences in factors such as temperament, intelligence and environmental resources. Research on children of substance users needs to

take into account that there is probably no single profile of children of substance users. Johnson and Leff (1999) proposed that most importantly against the odds, there actually might be a subgroup of children whose parents are substance users and who are healthy, experience a favourable home life and develop into well adjusted individuals. Some individuals may be more resilient to and competent at adapting to the stressful living environments than others (Rutter, 1990; Hogan, 1998). This view has encouraged the search for individual, family and community attributes that protect children from high-risk environments (Jessor, Vandebos, Vanderryn, Costa, & Turbin, 1997). To date, research has focused on child and family protective factors including, supportive family environments, highly organised families and positive family qualities (Richter & Bammer, 2000), the school context, major life events and community and cultural factors (Hawkins, Catalano, Morrison, O'Donnell, Abbott & Day, 1992; National Crime Prevention, 1999). However, current studies have not attempted to identify the positive impact of parental substance use but have noted positive effects simply as an absence of negative impacts.

Experiences of Parents who are also Drug Users

Past research in this area, has predominantly involved the experiences of women within a clinical setting who have presented with a variety of personal issues relating to opiate, and cocaine use. (Bauman & Dougherty, 1983; Colten, 1980; Hawley, Halle, Drasin & Thomas, 1996; Wellisch and Tseinberg, 1980).

Clinical Studies

A study by Colten (1980) used a semi-structured interview to compare parenting attitudes, experiences and self-perceptions of 170 women in treatment for opiate use to a matched control group. Findings revealed no differences between the two groups in relation to their perceptions and expectations regarding the rearing of their children. Both groups

shared similar experiences, had similar relationships and expressed similar attitudes toward their children. Women in both groups believed that motherhood was a central focus in their lives. However, women in treatment had greater concerns with regard to their adequacy in fulfilling the mothering role and expressed doubts about their ability to influence their children. Willis and Steinberg (1980) administered a parenting attitudes measure to 25 heroin using mothers within a clinical treatment setting, 25 non-heroin using mothers, 25 non-mothers and 25 non-heroin using non-mothers. Findings revealed that heroin using mothers received higher scores on a factor called authoritarian over-involvement than did non-using mothers. This factor incorporated the behaviours of controlling the child and excluding the child from external influences. Furthermore, a study by Bauman & Dougherty (1983) compared observations of parent child interactions between 15 mothers in a methadone maintenance clinic and 15 drug free mothers. Methadone maintained mothers were more likely to use a provoking, threatening and commanding approach to discipline in comparison to control group participants. Whilst, differences were found for parenting behaviour, no differences were found between groups for parenting attitudes.

Hawley et al., (1996) examined the care giving environments, drug use, resources, depression and social supports of 25 mothers in treatment for problematic substance use and 25 non substance using mothers recruited from community Head Start programs. Participants were interviewed at the site where they were recruited and questions focused on the participant's oldest child who was under six years of age. Results revealed a high incidence of crack cocaine usage, emotional and physical neglect and a tendency toward depression among the treatment group. The child-rearing environment was typified by a higher rate of foster placement, less father contact, less adequate total resources and frequent family relocations.

The majority of participants are recruited from drug treatment facilities. However, drug treatment facilities only represent a minority of illegal drug users, the poorest, most visible and most problematic users. (Waldorf et al., 1991). Only small percentages (i.e. < 10%) of substance abusers receive formal treatment for alcohol and or other drug problems (Narrow et al., 1993). A study by Carroll and Rounsaville (1992) directly compared cocaine and opiate using participants with community members. Findings revealed that treatment participants had more mood disorders, greater negative consequences, poorer social functioning and more family problems. The extent to which these parents and their children can be considered to be representative of those not connected to the drug treatment facilities is questionable. Families of drug users have rarely been studied in general population samples. Most of the existing research has dealt with clinical samples of alcohol or heroin users (Kumpfer & De Marsh 1986). The majority of drug users in the community do not access mainstream treatment services, however, those that do on a voluntary basis have the potential to acknowledge and identify areas of personal concern and are undertaking the first steps in addressing these concerns. Non clinical studies that document the experiences of parents who are also drug users are reviewed after the section relating to harm reduction policies. Why then do most mothers who use drugs not present for treatment?

Barriers to Treatment

The question of which factors prevent women from seeking treatment was addressed at the "Women Healing Restoring Connection" conferences in Philadelphia and Palm Springs California in 2001. Four hundred women were surveyed in regard to their top three barriers to treatment. The group comprised 32 percent of women in recovery, 22 percent of professionals involved in the chemical dependency field and 46 percent of

woman who were both professionals and women in recovery. Results revealed that shame, a lack of emotional support from family members, the inability to admit that a problem was severe enough, the thinking that addiction was a symptom of an emotional problem and seeking psychiatric or mental health therapy instead of drug treatment were all barriers to treatment (Barriers to Treatment, 2001). In providing a possible alternative to the aforementioned barriers attention can be turned to the topic of self-change and the ability of the drug user to recover naturally.

Natural Recovery

Self-change or the ability to recover naturally is a relatively new field of research. Previous studies suggest that natural recovery is a common route to recovery for cigarette smokers (Marlatt, Curry & Gordon, 1988; US Department of Health and Human Services, 1988). Findings from several alcohol studies reveal that harm reduction is practised by many respondents who considered themselves to be reformed drinkers (Ludwig, 1985; Sobell et al., 1992). A survey by Dawson (1996) reported that 25 percent of problem drinkers had resumed low-risk drinking. Natural recoveries have also been reported for problems other than substance abuse such as neurosis (Eysenck & Rachman, 1973). In addition, the majority of people who face psychological issues don't seek support from mental health professionals (Totto, 1986).

The area of natural recovery is acquiring acceptance with professional bodies such as the Institute of Medicine (1990) and the American Psychiatric Association (1994) acknowledging it as a legitimate means of recovery. In contrast, numerous professionals and lay people alike believe that substance misusers can not change their behaviour on their own (Cunningham, Sobell & Sobell, 1998; Klingermann, 2000).

Sobell, Ellingstad and Sobell (2000) reviewed 38 articles relating to individuals who recovered from an alcohol or other drug problem without formal help or treatment. Findings revealed that most of the natural recovery studies with alcohol and drug misusers were methodologically weak and that future natural recovery studies should; (1) report participant's demographic characteristics at the time of their recovery; (2) describe participant's pre-recovery problem severity; (3) explore the self-change process; (4) provide corroboration of self-reports; (5) examine factors related to the maintenance of recoveries (6) include a second interview; and (7) require a minimum 5 year recovery time frame.

Longitudinal studies involving naturally recovered participants can be used to explore how changes in alcohol and drug use are related to changes in other behaviour. In particular, changes in the use of other substances needs to be explored as there have been reports of participants stopping one drug but increasing the use of another (Sobell et al., 1994). Toneatto et al., (1999) assessed respondents who had naturally recovered from a cocaine problem before and after recovery. Findings revealed that participants reported that they continued to use alcohol at levels deemed as high risk. There have also been studies that have found competing behaviours in the form of food and non alcoholic drinks (Sobell et al., 1995). Furthermore, findings from Saunders and Kershaw (1979) found that maintenance of change in ex-problem drinkers was associated with changes in relationships, employment and residence or the onset of ill health, which precluded continued problem drinking.

The natural recovery literature also questions the traditional concept that recovery can only occur through abstinence. For example, studies of participants who recovered from alcohol problems reported some recoveries as involving low risk drinking (Rosenberg,

1993). In addition, studies of natural recoveries from opiate (Shewan et al., 1998; Zinberg & Jacobson, 1976) and cocaine use (Mugford, 1995; Waldorf, Reinerman & Murphy, 1991) have also reported low risk use. Taking this evidence into consideration Marlatt (1998) proposed that a concept should be developed that accommodates discontinuity of drug use over time incorporating multiple pathways to recovery including moderation and harm reduction. However, conceptualisations in regard to Bandura's (1977) social learning theory help explain the processes involved.

Harm Reduction Policy

The national policy of Australia incorporates a range of strategies including supply-reduction, demand-reduction, and harm-reduction that work towards reducing drug-related harm. According to Single (1995) harm minimisation aims to provide an alternative to other treatment and preventative approaches by reducing the harmful outcomes of drug use both legal and illegal to the user, the user's family and the wider community, without necessarily stopping drug use. The harm minimisation philosophy accepts that we live in a drug using society and acknowledges that drug use is functional for many people. In contrast, the Western Australian Government prefers the term harm reduction and its policy is - "first and foremost, opposition to drug abuse, encompassing strategies to reduce demand for drugs and the supply of drugs; and second, harm reduction, recognising the need for strategies to reduce the risks and harm to those continuing to use drugs and the wider community, whilst taking care that such strategies do not encourage or normalise drug abuse" (Drug Abuse Strategy Office, 1999,p.2). Heather, Wodak, Nadelmann and O'Hare (1993) referred to harm reduction as a range of strategies by which the goal of harm minimisation might be achieved.

Harm reduction strategies include providing information, education, learning safer ways to use, needle exchange programs, counselling, psychotherapy, pharmacotherapy, welfare advocate and linkage support, and home detoxification. These strategies are offered as services and are delivered through individual case-management, outreach, group work programs, residential withdrawal services, outpatient services, parenting, women centred and peer based substance user support and advocacy programs which aim to ensure a safer and supporting environment. Harm reduction strategies recognise that drug use can have a wide spread effect beyond individual concerns within a clinical setting and are therefore also targeted at parents and children within substance using families who reside in the community (Copello, Orford, Vellerman, Templeton, & Krishnan, 2000; Dear, 1996)

Non-Clinical Studies

Rosenbaum (1979) reported the first study of non-institutionalised heroin users. One hundred women who were heroin users, seventy of whom were mothers, were recruited by leaflet drops and snowballing techniques. Participants were interviewed in depth about their life histories in relation to motherhood. Findings revealed that participants accepted the dominant cultural role prescription of motherhood as being central to a woman's purpose and being one of women's central work and social roles. Heroin using mothers felt extreme remorse and guilt over neglect issues involving their children and wanted to leave the heroin lifestyle when their children and their role of mother were in jeopardy.

Richter and Bammer (2000) also conducted a study focusing on heroin using mothers. Twenty two mothers aged 20-38 were recruited through word of mouth, field recruitment, and flyers. Semi structured interviews were used to collect participants' views on parenting and heroin use. Findings revealed a hierarchy of seven strategies heroin-using mothers' employ to reduce harm to their children. They included, (1) stop using, (2) go into

treatment, (3) maintain a stable small habit, (4) shield children from drug related activities, (5) keep the home environment stable, safe and secure, (6) stay out of jail, and (7) if the children's needs are still not met, place them with a trusted caregiver and maintain as active a parental role as possible.

Sixty eight mothers who used crack cocaine were recruited through a field based approach and interviewed about their life histories in regard to their views on motherhood, the strategies they used to manage mothering while on cocaine and the contextual influences on mothering outcomes (Kearney, Murphy & Rosenbaum, 1994). Findings like Rosenbaum's (1979) earlier study of heroin users, supported the centrality of motherhood to their identity, a commitment to parenting responsibilities and the emotional despair faced when they failed to meet their mothering goals. Mothers were concerned about the possible risks to their children and used a process of defensive compensation to protect themselves and their children from the influences of crack cocaine. When unable to fulfil their roles, mothers placed their children with family members, whilst others lost custody of their children. When the children were removed forcibly, mothers often used drugs to cope the emotional stress this caused.

A study by Kandel (1990) examined the relationship between drug use and parenting styles. A longitudinal cohort design was used to follow 1222 high school adolescents from age 15-16 to age 28-29. The study focused on 222 parents whose oldest child was 2 or more years old. Many of the questions were centred on the rearing practices and the level of functioning of any children 6 years of age or older. Data included measures of drug using behaviour, children's and parent's behaviour, and self-reported parenting styles. Typically, families that are involved in drug use are characterised by poor parenting skills, unreasonable high expectations for their children, lack of supervision, extreme

disciplinary techniques, social isolation, lack of cohesion, psychological problems, family stress, conflict and antisocial behaviour. Findings revealed that mothers who were more heavily involved in drugs report more control problems with their children. The implications of these findings relate to conduct problems in childhood and their power in predicting future adolescent drug use and delinquency.

Past non-clinical research has tended to focus on the experiences of the mother who is also a user of heroin and/or cocaine. Currently, there is limited research involving women in the general community who are amphetamine users documenting experiences from their own point of view.

The only studies that have been focused on the views and experiences of mothers who are users of amphetamines have studied women in residential programs. For example, a study by Baker and Carson (1999) examined the perceptions of 17 crack cocaine and crystal meth-amphetamine using women through in depth, semi-structured interviews and behavioural observations. The study covered mothering practices, describing participants' experience of parenting and their sense of the difficulty that they had integrating substance use with parenting. Participants were recruited via residential substance abuse treatment program for pregnant women. Findings from the study revealed that mothers described how their drug use had a negative impact on their children. They recognised and felt guilty about the times wherein they failed to be good parents and when they were emotionally unavailable for their children. The women openly described the trouble they had integrating substance use with good parenting. The mothers also detailed practices that illustrated that they felt capable as parents exhibiting behaviours associated with socially acceptable, intensive parenting. Motherhood emerged as a fundamental part of their lives. However, those mothers in the community who use amphetamines regularly, who do not access

treatment programs and who might not experience problematic drug use, are not represented in Baker and Carlson's study. It is likely that mothers who are drug users living in the community have very different needs and concerns than those who present for treatment. To date, there have been no published studies in which the needs of these women are identified. Neither have researchers documented the experiences of these mothers and the challenges that they face and cope with. However, there are, at present, individual excerpts from mothers who use amphetamines in the literature presented by the Western Australian Substance Users Association (WASUA, 2001).

Research has looked at unique challenges that women face, in the work force, within migrant families and within sexual minority groups. It might be that women who are regular drug users face challenges specific and unique to their situation. Children of drug using parents are raised in a social context that may differ from children of non-drug users in a number of ways. "It is essential to take into consideration the social context as well as individual influences which bring together issues in relation to parenting, child development and child care with those of drug use" (Hogan, 1988). Apart from the parenting challenges that all parents face (e.g., supervision of children, responding to a child's illness, toilet training, managing inter-sibling conflict, costs of child care) users of illegal drugs are likely to face other challenges that are related to their drug using lifestyle (e.g., needing to find child care while the parent goes to score drugs).

Currently, in Western Australia, there is an increase in the number of clients presenting with amphetamine related issues to hospitals and drug treatment programs (A. Bartu, Next Step, personal communication, May 20, 2002).

Purpose of the current study

The purpose of the current study was to explore the parenting challenges faced by a woman who uses amphetamines. Data were collected from a mother who is a former dependent and current recreational user of amphetamines through addressing the following eight research questions:

- 1) What were the types of parenting challenges that arise as a direct result of intoxication?
- 2) What were the types of parenting challenges that arise as a direct result of a drug using lifestyle?
- 3) What types of coping strategies were adopted to help meet parenting challenges?
- 4) What factors aided coping?
- 5) What were the positive implications of parental drug use?
- 6) What were the negative implications of parental drug use?
- 7) What were the factors that influenced a change in drug using behaviour? and
- 8) What were the barriers to seeking support from external based drug treatment agencies?

Furthermore, data were collected from the participant's children in order to gauge their current level of functioning. This study will extend the existing literature by drawing the participant from a non-clinical setting and incorporate the participant's drug use within a social context. It is anticipated that the findings will provide an insight into the social realities of the parental challenges faced by this relatively under-researched section of the community.

A case study approach was adopted as it is useful in providing insights into the complex interactions of drug related lifestyle factors and non-drug related events facilitating or frustrating the drug using mother's attempt to care for her children.

The data will be discussed in terms of a harm reduction paradigm. Currently the mainstream message from residential treatment settings is that drug-using mothers require parenting skills programs (Mejta & Lavin, 1996; Nye, Zucker & Fitzgerald, 1991). Whilst this might be a major need for some women, it is likely that many drug-using mothers have parenting skills as good as non drug users but have other needs in relation to their parenting role. A number of studies have suggested alternative focal points of intervention including; behavioural training programs for mothers instead of parenting programs (Heller, Sobel & Tanaka-Matsumi, 1996), an ecological approach to parenting support targeting a variety of social contexts e.g., Triple P Positive Parenting Program (Sanders, 2001), improving the ability of the parents to supervise and discipline their children, children's pro-social skills and the family's communication and relationship skills e.g., the Strengthening Families Program (Kumpfer & Turner, 1990-1991), and gender specific and family centred programs (Metsch, Rivers, Miller & Bohs, 1995). Additional approaches include, a women centred model of care (Brindis, Berkowitz, Clayson & Lamb, 1997; Magura & Laudet, 1996), a co-ordinated care approach encompassing health, social and mental health care (Merrick, 1985; Keen & Alison, 2001) and a peer based support and advocacy group (Byrne, Bedford, Richter & Bammer, 2000).

"There are few good studies of the effect of interventions on the children of drug users. However, there is a mass of evidence that interventions aimed at treating the parental drug problem can have a dramatically stabilising effect in terms of harm

reduction to the individual, which by extrapolation might be expected to improve family functioning" (Keen & Alison, 2001, p. 298).

Interventions that targeted children of parents who use drugs focused upon improving both family and school climate, improving self efficacy, school bonding and peer relations (Kumpfer & Turner, 1990-91), providing information, problem and emotion focused coping skills, and social and emotional support (Emshoff & Price, 1999). It is anticipated that the data from this study will assist in clarifying issues relating to parenting interventions and thereby guide the development of programs that meet the real needs of these women and their children.

Method

Recruitment of participant

The present study was advertised through word of mouth field recruitment and informal drug using networks. The participant was selected on the basis of being a mother who had one or more children that lived with her permanently and was a former dependant user of amphetamines. Two women who met these criteria were identified within a one week period, one of whom consented to an in depth analysis of her parenting experiences and the participation of her children in the study. The participant was offered an inducement of \$20 for expenses for each interview completed.

Participant profile

The participant was 36 years of age at the time of the interview. At 18 years of age, the participant conceived her son with her first partner. The relationship ended when she was aged 19. She met her second partner at the age of 21 and, at the age of 23 and 25 years, conceived her daughters. Her relationship with the father of her daughters ended 7 years ago. The family is currently comprised of a boy aged 16, two girls aged 11 and 13 and the interviewee's partner of 5 years. The children lived with her permanently and attended Education Department of Western Australia (EDWA) schools. Currently the participant has an extended family support network comprising her parents, her partner's parents, several close friends, her neighbours and work colleagues of both herself and her partner.

The participant is currently a recreational user of meth-amphetamine (1.0 gram 3-4 times a year), she uses cannabis (5-10 cones every 1-2 days e.g., a cone is a cylindrical thimble like device that holds roughly 0.2 grams of cannabis and is attached to a water filled cooling implement called a 'bong' that is used to smoke cannabis), and smokes

approximately 15 cigarettes a day. She occasionally uses alcohol (1-5 standard drinks, 1-2 times a year). In regard to legal infringements involving drug use, the participant has eight prior convictions for possession of marijuana, with no convictions recorded in the last 8 years.

The participant is currently in full time work in the human services industry and is undertaking tertiary studies. She is currently in good physical and psychological health and takes no prescribed medications. Her husband is employed in the building industry.

Instrument

An open response format schedule was used to guide the participant's interview and assess the major content areas of: 1) the type of parenting challenges as described by the participant, 2) the relationship between drug use and parenting challenges. The second content area was further subdivided into three categories of interaction including:

- a) those parenting challenges that are directly drug related (DDR) e.g., intoxication,
- b) those challenges that are related to a drug using lifestyle (DUL) e.g., purchasing drugs, and
- c) those challenges that are non drug-related (NDR),

3) the type of coping strategies that the participant has utilised, 4) the factors that aided coping, 5) the positive impacts of parental drug use on children, 6) the negative impact of parental drug use on children, 7) the factors that influenced a change in drug using behaviour and 8) the barriers to seeking support from external based drug treatment agencies. A copy of the schedule is attached in (Appendix A). In order to gauge the children's current level of functioning, an open ended clinical interview was used to assess the functioning in four major life areas:

- a) school life,

- b) hobbies and interests,
- c) peer relationships and
- d) self-concept.

A copy of the information and consent forms for the children's participation is attached in (Appendix E and F).

In addition to the interview, the Child Behavior Checklist (CBCL) comprising the Parent and Teacher Report Form and the Youth Self Report were used. The participant completed the Parent Report Form (PRF) for ages 4-18 (CBCL/4-18) to obtain ratings of 20 competence items, 118 specific behavioral and emotional problem items, and 2 open-ended problem items. (Achenbach, 1991a). Furthermore, the teacher of each child completed the Teachers Report Form (TRF) for ages 11-18 (TRF/11-18) with the sum of the four adaptive characteristics comprising academic performance, working hard, behaving appropriately and learning. (Achenbach, 1991b). A copy of the authorisation for completion of the Teacher Report Form is attached in (Appendix G). Each child completed the Youth Self Report (YSR) for ages 11-18 with the total competence score comprising the sum of the two scale scores, activities and social, plus the mean of the youths' self-rating for academic performance. (YSR/11-18) (Achenbach, 1991c). Items that were found in the analogous core syndromes from at least two of the three instruments were used to form a cross informant syndrome construct. The following eight cross informant syndromes are displayed on the TRF and the YSR profile: Withdrawn, Somatic Complaints, Anxious/Depressed, Social Problems, Thought Problems, Attention Problems, Delinquent Behavior and Aggressive Behavior. Scores are displayed for every problem item, as well as raw scores and T scores for the syndrome scales, Internalising, Externalising and Total problem score. All scores are compared to normative data with normal, borderline and clinical ranges designated for the scaled scores. The test-retest reliability for PRF, TRF and

the YSR has been clearly demonstrated, as has the validity with respect to discrimination between referred and non-referred samples. (Achenbach, 1991 a, b, c; Vignoe and Achenbach, 1997).

Ethical Considerations

The participant was provided with an information form outlining the purpose of the investigation. This form included the estimated duration of the interview, the possible benefits of the study and the conditions that relate to participant acceptance, withdrawal and confidentiality. A copy of the information forms (consent and canvassing) and consent form is included, as Appendix B, C and D. The name of the participant is known only to the researcher. The anonymous transcribed records are secured at Edith Cowan University. The Participant was informed that she could obtain a copy of her individual interviews on request. Due to the potential of bringing up painful memories when recalling personal experiences the participant was made aware of this prior to the interview, and she informed the researcher that she had someone available to call or visit later if in need of emotional support. The participant's data was regarded as strictly confidential. However, the participant was informed of the limits of confidentiality that extended to those cases where there is a risk of participant self-harm and/or danger to others. In addition, the participant was informed that prior arrangements of professional support had been made at a government welfare agency.

Procedure

Data were collected through semi-structured interviews that were tape-recorded with the participant's written consent. The participant was informed regarding the confidentiality of the study and her prerogative to abstain from responding to any or all of the questions. A venue to conduct the interviews was provided by a non-government

welfare agency that met the following criteria: A central location for the participant, access to professional assistance, and adequate privacy. Interviews were conducted during the July and August 2002. Interviews lasted from 50 minutes to 2 hours. All interviews were tape recorded and transcribed. Following transcribing all tape recordings were erased.

The children's interviews were tape-recorded and lasted approximately 15- 20 minutes. All tape recordings were transcribed and then erased following transcribing. The Participant's were informed that their names would not be identified on any of the transcripts, nor would there be any way of linking their names to any of the transcripts. Participants were informed regarding confidentiality and the circumstances that would warrant a breach in procedures. Participants were also informed of the voluntary nature of the study and their option to withdraw from the interview at any time. All participants' completed the relevant checklists and the teacher of each child completed the Teachers Report Form. The PRF and the YSF checklist were completed in front of the researcher and all questions were clarified as they arose. The TRF was handed to each of the children's teachers with a signed parent consent form attached. Completed forms were then collected via returned mail. Participant interview responses were then analysed using a thematic approach.

Analysis

Themes were identified within the data for the content area parenting challenge. Similar challenges were then grouped together and themes were generated. Each parenting challenge was then assigned to three levels of interaction and categorised under the headings,

- a) Intoxication (I), including the challenges directly influenced by the physical, psychological and emotional effects of amphetamine use,

- b) Drug Using Lifestyle (DUL), including the challenges directly influenced by a drug using lifestyle. For example, safety and legal issues and,
- c) Non-Drug Related (NDK), including the parenting challenges that are specifically not related to drug use. For example, toilet training.

A further analysis of the content area parenting challenges, revealed a number of themes relating to

- d) the factors that further complicated the task of parenting and,
- e) the type of coping strategies adopted. Sub themes were then generated.

Text units were then examined in relation to the content areas, implications of drug use, the factors that aided coping, the factors that influenced a change in drug using behaviour, and the barriers to seeking professional support. Guided by these definitions themes and sub-themes were identified and labelled.

In relation to the children's interview text units were examined to determine which of the following four areas they applied to: 1) School life 2) Peer relationships 3) Hobbies/Interests, and 4) Self-concept. Guided by these definitions themes and sub-themes were identified and labelled.

Results

The data are reported in five sections.

First, a timeline of events is presented incorporating nine areas: age-relationships; drug use; family; children; social supports; legal; education; physical health; psychological health; and employment (see Table 1). Data pertaining to the mother's current level of functioning and her three children's current functioning are presented. Second, the raw data are organised and summarised into 16 themes incorporating parenting challenges, relationship to drug use, complicating factors and coping strategies (see Table 2). Data pertaining to the types of parenting challenges that the mother faced during the period of regular heavy amphetamine use (aged 21 to 31), the types of coping strategies adopted and the complicating factors that she faced are reported and discussed separately using quotes. An example of a commonly faced parenting challenge and the mother's coping responses are described in detail, so as to illustrate the complexity of the interactions among the various parenting challenges, coping resources, and life circumstances. The positive and negative implications of parental drug use are then presented. Third, the higher order theme of resilience is then reported and discussed. The complex interaction faced by the mother involved in taking care of her children whilst maintaining her drug use is then illustrated (see Figure 1). Fourth, data pertaining to the factors that assisted the mother in coping with the parenting challenges that she faced, the types of services that would have been useful to her, the barriers to seeking these services and her reasons for not seeking professional assistance are reported and discussed. Fifth, the main implications for harm reduction that emerged have been summarised from the data presented in the first four sections.

Section 1-Timeline

The timeline is structured into six periods of time defined by the significant relationships in the participant's life and her corresponding age. Detailed accounts of the major events in the participant's relationship during these periods of time are illustrated in the eight life areas. A dependant pattern of amphetamine use exists between the fourth and fifth periods of time. This period of time represents the focus of the current study. In regard to drug use it can be seen that there is an escalation of amphetamine, alcohol and cannabis use during this focal period. The birth of the participant's two daughters, legal convictions regarding drug use, physical abuse of the participant's son and the subsequent withdrawal of family support also mark this period of time. During this same time frame the participant attempted suicide on two occasions.

Family Functioning

Data, pertaining to the perceptions of the mother and her children's interviews, behavioural observation from both the parent and child interviews and scores obtained from the completion of the Child Behaviour Checklist, encompassing the Parent Report Form, Teachers Report Form and the Youth Self Report are reported and discussed below.

Mother's Perception of Family Climate

The participant described the current family life as being calmer, easier, less stressful and more tolerant than family life in both her previous relationships. Her current partner provides emotional support and stability and she has renewed self-confidence. Furthermore, her partner abstains from using amphetamines. There is no underlying feeling

Table 1
Time line of events placing the participant's drug use within a social context

Age/ Relationship	Drug use	Family	Children	Legal	Education	Health	Jobs
>16 Single	Alcohol: 2 cans beer/ day Cannabis: Twice/ week Amphetamines: no usage Other: cigarettes	Supportive Extended family	No children	No legal infringements	Year 10 lever		Myers Sales assistant
17-20 First partner- non supportive	Alcohol: 2-3 cans beer/day Cannabis: 3-4 times/ week Amphetamines: 1 gram/ month Other: cigarettes	Supportive Extended family	1 st child aged 18 limited parenting challenges prenatal exposure alcohol ,cannabis, cigarettes	No legal infringements	Tafe course- Interior Design 18 months		Home duties
20-21 Single-casual relationship	Alcohol: 3-4 cans beer/day Cannabis: 3-4 cones /day Amphetamines: 1 gram month Other: cigarettes	Family child care available during work /weekends	Limited parenting challenges	No legal infringements	Nil		Dancer night club Home duties
21-28 2 nd partner- abusive, violent, non supportive	Alcohol: 5-6 cans beer day Cannabis:daily 12-15 cones Amphetamines:2-3grams week Other: cigarettes Partner:2-3 grams daily	Withdrawal of family support at age 25 due to physical abuse to participants son	2 nd child aged 23 prenatal exposure to cigarettes 3 rd child aged 25 prenatal exposure to all drugs used Numerous parenting challenges	8 convictions for possession of cannabis Partner imprisoned for 2 years for armed robbery 1994 participant aged 26	Nil	Counselling for weight loss. Twice self admitted for attempted suicide	Dancer until aged 22 Home duties
28-31 Single-casual relationship	Alcohol: twice per year Cannabis:5-10 cones /1-2 days Amphetamines: daily 6-8 grams per week) Other: cigarettes	Family support returned when 2 nd partner went to prison	Limited parenting challenges	No legal infringements	nil	Visited GP concern HBP	Bar maid Home duties
31-36 Husband Supportive	Alcohol: 1-2 times a year Cannabis: 5-10 cones every one to two days, Amphetamines: 1 gram 3-4 times year Other: cigarettes 15/day	Supportive extended family	Children aged 11, 13 and 16. Limited parenting challenges	No legal infringements	Tafe course Completed Enrolled in University studies		Full time position human Services Industry

of fear and there is a healthier psychological space within the home environment. Both adults in the household are employed and are financially secure. The family has greater financial, social, familial, employment and educational options available to them in comparison to previous relationships. Decisions in the family are made by negotiation and explanation, with freedom to express ideas and opinions. The participant stated that more time is given to dealing with problems than was the case with her previous partner. Strengths within the family are reported to be the prevailing openness and the acknowledgement that all the children are loved. Family functioning would be improved by increasing the time spent at home, which could be catered for by a reduction in work hours.

Mother's Perception of her Children

The participant described her children as currently being more open and not so dependent on the environment for cues on how they should behave. There is less rigidity in the family environment and the children have the freedom to be themselves. There is greater grandparent involvement, which has increased the social support available to the family. The children are free to express their concerns and are listened to. Previously the children were more conscious of their behaviour due to the potential of physical and verbal abuse from their mother's partner. The children were described as fairing poorly in situations involving conflict, a carry-over from the participant's past relationship.

An assessment of the participant's current level of functioning was based on the researcher's observations during the interviews. The participant provided candid accounts of her life experiences and was receptive to further questioning. She used humour to cope when revealing potentially distressing issues and displayed sensitivity throughout the interview (e.g., asking the interviewer about his level of comfort in discussing certain topics). The participant also displayed a great deal of insight into her own limitations in dealing with her abusive husband. In conclusion, the participant presented as being assertive, sensitive, confident, intuitive and approachable.

In relation to her drug use the participant reported low risk use of alcohol (e.g., 2-5 standard drinks, 1-2 times a year) and low risk amphetamine use (e.g., 1.0 grams 3-4 times per year). Her current pattern of cannabis use is moderate to regular reporting smoking 5-10 cones every 1-2 days. She stated that her cannabis use is dependent on home and work commitments, as on some days she doesn't use. While the participant is a regular user of cannabis her drug use does not reach a dependent pattern of use. Personal and family obligations take precedence over drug use. This judgement of non-dependence is based on the dependence syndrome within the ICD-10 criteria. Although there is evidence of tolerance (e.g., self reports from the participant describing having increased amounts to achieve the desired effect), there is no evidence of harmful consequences, the participant is not preoccupied with substance use, displays no cravings or compulsion, has no impaired control and displays no withdrawal symptoms.

Behavioural Observations of Children

The following behavioural observations were made during a 20-minute semi structured interview conducted with each of the participant's three children. A summary of the children's responses is shown in Table 2.

Table 2
Summary of Children's Responses from Clinical Screening Interview

Boy aged 16		
Education	Likes-	Workshop, all types of welding, machining and work experience
	Dislikes	Non supportive work place bosses, pressure to use expensive machinery and wood work
Peer relationships		Most friends reside out of school, but he still has social contacts at school. Likes to hang out with friends or by himself, likes to play on computers, enjoys playing the guitar and welding, learns skills from other friends fathers.
Hobbies/interests		Computer games, skateboarding and welding
Self concept		Describes him self as trustworthy. He likes being himself. He feels older than his friends. He feels he needs to get fitter and feels fortunate for what he owns and where he lives. He sees his step dad as a friend.
Girl aged 11		
Education	Likes	English, LOTE, reading and hanging out with friends
	dislikes	No apparent dislikes of school
Peer relationships	Positive	Likes friends that achieve good grades, are funny and supportive
	negative	Doesn't like selfish friends
Hobbies/interests		Wants to be a lawyer. Her school and her school grades are important to her. She likes dancing, swimming, tennis and the play station. She feels that by having interests children feel happy about themselves
Self concept	likes	Describes herself as being funny and different to her friends, happy generous and nice to people. She thinks of people's feelings.
	dislikes	Laziness and getting hyped up over things that are small
Girl aged 13		
Education	likes	Socialising, agriculture and media She feels safe at school and enjoys mathematics and projects that you can choose yourself
	dislikes	Back-stabbing friends, some teachers and science subjects
Peer relationships	positive	Likes helping friends
	negative	Doesn't like rudeness, hanging out late with boys and back stabbing friends
Hobbies interests		Movies, hanging out with friends, looking after animals and young babies
Self concept	likes	Helping people sort out problems, cheer up people, cool
	Dislikes	Not liking schooling that much, failing subjects I like.

The participant's son, a boy aged 16 can be described as having the attributes of being shy, analytical and introverted with a high level of social comparison to his friends who have a natural father. He has passive leisure interests, positive peer relations and limited verbal communication with his mother. He is sensitive, independent yet withdrawn. He is a recreational user of cannabis and, has borderline academic functioning but finds meaning in some aspects of school.

The participant's youngest daughter a girl, aged 11 can be described as having the characteristics of being confident, articulate and honest. She has an extensive vocabulary and a positive self-concept. She is empathetic, insightful, moralistic, career oriented and anxious. She has positive leisure pursuits, is a high achiever at school and is task oriented. She has positive peer relations, is high self-monitoring, communicates well with all family members and finds meaning in many aspects of school.

The participant's oldest daughter a girl aged 13 can be described as having the characteristics of being extroverted, vivacious, energetic, caring and sociable. She has positive peer relations, and a positive self-concept. She is loyal but competes academically with her younger sister. She is involved in passive recreational pursuits, communicates well with her family, is humorous, and finds meaning in certain aspects of school.

Checklists and Report Forms

The Child Behaviour Checklist, encompassing the Parent and Teacher Report Form and the Youth Self Report, provided standardised descriptions of behaviour for each of the participant's three children. The results are as follows:

The participant's son, a boy aged 16 received the following results for the PRF, TRF and YSR:

- PRF- Normal

- TRF- The adaptive functioning items of academic performance and learning fall in the borderline clinical range.
- YSR-The competence scale total score encompassing the items of activity, social and academic fell just inside the normal range.

Taking into consideration the participant's responses in the clinical screening interview, behavioural observations of the current researcher and scores on each of the PRF, TRF and the YSR, the borderline clinical range scores for the item academic represents an accurate assessment of the participant's current level of academic functioning. At the time of the interview, the participant had changed his academic focus from a metals trade to an interest in computers. This lack of interest was evident through a review of his teacher's comments. However, the participant is functioning well in all problem scales of the TRF, PRF and TSR, has positive hobbies and interests, positive peer relations and displays adaptive functioning within the family unit. Therefore, his overall current level of functioning is considered to be within the normal range.

The participant's daughter, a girl aged 13 received the following results for the PRF, TRF and the YSR:

- PRF- The total T competence score fell into the borderline clinical range.
- TRF- The adaptive functioning score and the items of academic performance, working hard and learning, scored a borderline academic range.
- YSR-Normal range

The total T competence score for the PRF fell into the borderline clinical range. Score comprised the competence scales of activities, social and school. All three individual scores fell within the normal range, with activities recording the lowest score of 4.0. The participant is not involved in active sports and is not a member in any organisation.

However, through behavioural observation during the child interview and through the completion of the YSR, the child presented as being very happy, energetic, self confident and highly sociable, she has positive peer relations and passive leisure pursuits. The item of happy on the adaptive functioning scale of the TRF scored well into the normal range, in addition to her teacher's comments that detailed her socialising at school tended to be the main point of distraction keeping her from further academic progress. Observations at the time of the interview reinforce the point that the participant is a very happy, sociable and friendly individual who places more emphasis on the social aspects of schooling. Her interests in passive recreational pursuits and informal social networks have a direct impact on her ability to score higher on the PRF competence scales, in addition to her socialising that focuses attention away from a more academic pursuit. Therefore, her overall current level of functioning is considered to be within the normal range.

The participant's youngest daughter, a girl aged 11 received the following results for the PRF, TRF and the YSR:

- PRF-Normal
- TRF- Normal
- YSR-Problem scale, item aggressive behaviour, externalising encompassing delinquent and aggressive behaviour and total T score = borderline clinical.

A normal range was recorded for the adaptive functioning, problem scales items and total scores for the TRF, the participant recorded scores of over 5.0 for the adaptive functioning areas of academic performance, working hard, behaving appropriately, learning and happy. Teacher comments reflected no academic concerns and positive remarks in relation to her diligence, manners and maturity. Normal range scores were recorded for the

competence and problem scores for the PRF. The compatibility between the TRF and the PRF must be taken into account when gauging this child's current level of functioning. Furthermore, behavioural observations indicate a task-oriented, high achiever who is high self-monitoring and provided an extremely honest personal account throughout the interview. Externalising scores for the problem scale aggressiveness were recorded for the following behaviours; argues, jealous, fights, teases and is loud. A healthy rivalry exists between the participant and her older sister especially in regard to academic performance. These scores may represent pressure that is generated internally and is driven by the pursuit of success and / or the on going sibling rivalry. Therefore, the participant's current level of functioning is considered within normal range.

Summary

A multi-axial assessment, incorporating behavioural observations, transcribed verbatim from parent and child interviews and standardised descriptions from the PRF, TRF and the YSR, were used to gauge the current level of family functioning. The results of these assessment items were then combined, placing the participant's drug use within the social context of her life. The participant's current level of functioning is considered adaptive in all of the observed areas. In regard to the participant's current illegal drug use, placing it within the context of the family environment, it is considered that her use of cannabis is classified as non-dependent as determined by the ICD-10 criteria. All children fall within the normal range of functioning.

Section 2-Parenting challenges

In examining the data for the category parenting challenges, 16 themes emerged. These included: 1) toilet training, 2) tantrums, 3) health issues, 4) child waking during the night, 5) getting children to school, 6) lying to children, family and friends, 7) disruption of children's routine, 8) moral dilemma of drug use, 9) finding child care when scoring, 10) only leave child with a competent and trusted care giver, 11) safety of children 12) legal implications, 13) financial problems, 14) finding private time for self, 15) transport issues, 16) self concept of being a mother and a drug user. Content analysis of the theme parenting challenges revealed a number of sub themes including relationship to drug use, complicating factors and coping strategies. Through further content analysis there, emerged a number of categories. A complete list of the themes, sub themes and categories can be viewed in Table 3.

Data pertaining to the three parenting challenges of toilet training, tantrums and finding a competent and trusted care giver when scoring are discussed below. They represent two parenting challenges that are traditionally non-drug related and one challenge that is directly drug related. The data pertains to the period of regular heavy amphetamine use in the participant's life (aged 21 to 31, see Table 1). Each theme is described with quotes from the participant's experiences. They relates to the types of coping strategies that the participant used to manage the parenting challenges that she faced and the factors that complicated her preferred method of coping. In each of the various quotes the partner being referred to is not the participant's current partner.

Table 3

List of the Categories, Themes and Sub Themes Emerging from the Content Analysis of Transcripts from the Case Study exploring Parenting Challenges Faced by a Mother Using Amphetamines.

Parenting challenges	Drug Relationship Intoxication, (I) Drug related lifestyle(DRL), Non Drug related (N)	Complicating Factors	Coping Strategies
Toilet training	(N) but routine effected by (DRL)	Participants drug use Going outside of house to score Partners drug use Non supportive partner Partners abusive behaviour	Rewards Modelling Compliance Establishing a routine
Tantrums	(N) Participants reaction determined partially by level of drug use	Level of participant intoxication Non supportive partner	Parent behaviour modification Child needs assessment Timing of outing Compliance Amphetamine use Compliance
Physical health issues General physical complaints Physical abuse	(N) (N) (I)	Participant drug use Partners drug use Partners abusive behaviour Non supportive partner	Amphetamine use Compliance
Child wakes during night Difficulty in sleep Sleep walking	(N) and (DRL)(I) (N)	Participants and partners drug use Partners abusive behaviour	Amphetamine use Compliance
Getting children to school Lie to children, family and friends Accountability by grandparents Questions from children Feeling guilty	(N) (DRL) (I) (N) (N) (DRL)	Non supportive partner Participants and partners drug use	Lie to children, family and friends
Lying Accountability by grandparents Questions from children Feeling guilty Feeling frustrated /angry	(DRL) (N) (N) (N) (DRL)	Participants and partners drug use	Lie to children, family and friends

Disruption of children's routine	(DRL) (I)	Level of intoxication Going out of the house to score Drug related social group within house	Tolerance Compliance Avoidance
Moral dilemma of drug use Feelings of guilt, anger, frustration Routine disruption School attendance Children witnessing criminal activity Children speaking about criminal activity Prioritising of finances e.g., on children's food Inquisition from children and family Lie to children, family, friends	(DRL)	Partners criminal activity Participants legal infringements	Avoidance
Finding child care when scoring Only leave child with a competent and trusted care giver	(DRL)	Transport Non supportive partner	Accessing social network
Only leave child with a competent and trusted care giver	(DRL)	Non supportive partner Partners and participants criminal activity Family support denied from age >25-28	Accessing social network Accessing family support Screen others behaviour
Screen children via observations Non judgmental care giver No excessive use of drugs Limited questions asked No safety issues e.g., needles Child satisfaction with care giver Care givers children screened (Satisfied that children will be well looked after)			

Safety of children	(DRL) (I)	Partner Social group Route of administration Criminal activity to obtain drugs/money	Avoidance Shield child from drug using Trusted care giver Segregate from social group Limit time of drug use Limit amount of drug use Reduce exposure to violence Keep home environment safe
Safety from drug use Safety from criminal activity Safety from partner Safety from social group Safety during scoring			Score when kids are at school or times of the day when the children are not around
			Lie to children
Legal implications	(DRL)	Partners dealing Partners criminal social network	
Explaining it to children			
Financial problems	(DRL)	Level of dependence	Access social network
Finding private time for self	(N)	Availability of family support	Access social network
Transport issues	Both (N) and (DRL)	Availability of public and private transport Financial situation	Access closest alternative scoring options
Factors influencing self concept in relation to being a mother and a drug user	(DRL)	Ambivalence between the role of drug user and mother	Avoidance of situations involving external validation
Friends judging Self fulfilling prophecies			

1) Toilet Training

Examination of the data for the parenting challenge of toilet training indicated a non-drug relationship. Sub themes within the category complicating factors and coping strategies are illustrated below (see table 4).

Table 4

Themes and Sub Themes Generated for the Parenting Challenge of Toilet Training

Drug Relationship	Complicating Factors	Coping Strategies
(N) but routine affected by (DRL)	Participants drug use	Rewards
	Going outside of home to score	Modelling
	Partner's drug use	Compliance to partner
	Non supportive partner	Establishing a routine
	Partner's abusive behaviour	

This challenge was not directly caused by a drug using lifestyle, however, the establishment of a toilet training routine was effected by a number of complicating factors.

Complicating factors.

One of the main complicating factors from the participant's drug use was the difficulty this created for establishing and maintaining routines around toilet training with the participant reporting the following comments:

...and say you're using that, your routine can go right out the window you know...(163)

...and bringing drug use in intermittently throws that routine. (223)

However, drug use was reported to have both positive and negative effects. For example, being awake at night could ease the pressure of the routine. Evident in the comment:

When I used it's easy because you're already awake and your're a bit more tolerant, you know, cool (9)

An example of a negative impact includes:

... but fuck when I was frying, fuck it's hard to get up you know because you might not have slept for three days so...(10) (frying refers to the coming down period after the effect of the drug is worn off).

The toilet training routine was also disrupted by the necessity to leave the home environment and purchase drugs. Evident in the comment:

...it can go either way. I mean when you're using at your home you need to have a base to teach this skill so if you're going out of the house then that routine is upset in anyway which by bringing drug and drug use in to your routine it throws it all out. (164-166)

One of the principal complicating factors effecting the establishment of any routine was the negative effect caused by her partner's drug use and non-supportive behaviour. Disruptions to the household were evident at times when her partner was not using amphetamines.

...If you've got that person in the house then they influence the whole house, you know like, go back to the toilet training one. If he was firing on that day right, that day you just wouldn't be bothered with the toilet training because you've already got him and his shit, and like keeping a child quiet is another thing and you need to

have that balance in the house, so depending on where he is at or what space he's in depends on what you do within your day...(217-221)

However, her partner also offered limited support during the times when he was using amphetamines. Evident in the comments:

...mean if he's(partner)speeding he's a bit more tolerant but he still doesn't want to do it, it still becomes my responsibility you know... (151)

He doesn't take any responsibility for the kids, he doesn't at anytime (22)

The establishment of a toilet training routine was complicated further by her partner's abusive behaviour toward the participant and their children. This resulted in compliant behaviour. Comments supporting this include:

He basically would use everything possible to keep me down. It was easier not to be noticed, so no routine is better than a punch in the head. (222a)

He'll start yelling and screaming and throwing things round and yelling at the kids and ranting and raving "shut those fucken kids up "(13)

Coping strategies.

A number of coping strategies were attempted by the participant to establish a toilet training routine. The participant reported the following:

You get your child a potty right and before you start the toilet training they're in nappies so you get the child to start to wear the training pants and learns that they go to the toilet or they sit in the potty. You work out with your child what its routine is... (152)

The participant accessed role models to act out situations in an attempt to generate the desired toileting behaviour. Evident by the comment:

... another one if you got a male in the house you take them to the toilet and they see by watching yeah. That's how I did it and my partner would take them to the toilet and show them that's what had to go in the toilet. That's the progression.
(157)

Combinations of behavioural techniques were utilised by the participant including the provision of positive reinforcement and rewards. Comments include:

You then take that potty and you waltz it to the toilet and then the reward is they get to flush the toilet you know ...you do the reward system for doing it in there and then reward is the flush and the child believes like it's a game or eventually the child recognises it a good thing to do its business in the potty and then go to the toilet and flush it or (153-156)

However, any attempts by the participant to establish and maintain a toilet training routine were directly influenced by her partner's behaviour and resulted in the coping strategy of compliance. The participant responded:

...like you know, if the kids are distressed and it doesn't need to be yelled and screamed at, it's easier for me and the kids if we get them back to bed and out of the way.
(16-21)

Her partner's behaviour was influenced by his drug use and subsequently affected the participant's preferred method of responding to the parenting challenge of toilet training. Reports include:

... depending on whether he's frying or he's awake. If he's awake he'll wake me up so I will get up and see what's going on or if he's frying then fuck look out you just don't want to wake him up...(11)

so you gotta keep the house as quiet as possible and that's hard (12)

...you try to do every thing so you don't wake them (children) up ... (14)

Although the participant adopted a compliant approach to this particular parenting challenge, it is evident in her comments that she perceived the role of primary care giver to be her responsibility at all times including when she used drugs.

...even when I'm using or not, or if I'm ok, or not whether I'm fucked or not, it's still my responsibility. You just do it, you know, you just deal with it, you know, get it done. You just get it done as quickly as possible, you know, so you don't upset the apple cart if you know what I mean. It's fucked. (16-20)

2) Tantrums

Examination of the data for the parenting challenge of tantrums produced a non-drug relationship. Sub themes within the categories complicating factors and coping strategies are illustrated below (See Table 5).

Table 5

Themes and Sub Themes Generated for the Parenting Challenge of Tantrums

Drug Relationship	Complicating Factors	Coping Strategies
(N) Participants reaction determined partially by level of drug use	Level of participant intoxication Parent emotional state Situational context Level of forward planning Non supportive partner	Situational analysis-forward planning Knowing your child's needs and pattern of behaviour Compliance

This challenge was not directly caused by a drug using lifestyle, however, the reaction of the participant to this particular challenge was influenced by a number of complicating factors.

Complicating factors.

One of the main complicating factors from the participant's drug use was the indecision it created in her emotional response to her children's tantrums. At times the participant would comply with their requests. The participant recounted:

That time if I was using I'd be really cool and it would be all good and probably just end up giving the child the bag of Tim Tams to shut them up (183)

...you just may be a bit more tolerant when you're using. (210)

However, on other occasions she displayed limited tolerance and recalled:

...depending on if you're off your head or whether you're not depends on your reaction to that parenting challenge. You might not be as tolerant (192)

The effect of drug use on her reactions is further highlighted with the comments:

...you know you're using you're happy. If your not using then you might smack the child or go 'no!' (190)

...it depends whether you're using or not, if you're straight or if you're stoned (186)

However, the participant also placed her drug use within a situational context, which highlighted a number of interacting factors. The participant's current emotional and behavioral states were seen as determining factors in complicating the challenge of responding to her children's tantrums. Evident in the comments:

...whether you're using or not, your reaction is the same, you know, your behaviour prior to going into the situation will impact on that situation depending on whether or not you used or what's happening before (211-212)

I think it depends on your frame of mind (187)

...if you're in a really good mood then you will give the child what they want regardless of whether or not you're on drugs you know, (189)

The level of insight into the current situation, a sound knowledge of your children's routine, personality and behaviour, and the ability to effectively plan ahead were viewed as essential skills in dealing with tantrums. The participant recounted:

...you'd still have the same awareness of what the reaction of other people would be regardless of if you're using drugs (207)

...it depends on the time of day so if I wasn't using right, yet you plan to go to the shops at one o'clock and you're completely straight on this day the kids slept all good, the chances are you aren't going to cop that parenting challenge on that day if you're going to the shopping centre. (201)

...and as a mother, knowing your child you know, you are aware of all these things before you put yourself into that parenting challenge (213)

... it's knowing your own child and the situation you put them in. (194)

...but generally you can gauge that if you know your child's cranky so you deal with it ... (199)

The participant also alluded to the fact that parenting challenges are never exactly the same and that individuals tend to have a standard methods of coping irrespective of their drug use. An example follows:

I mean, if that happened to you all the time, your drug use may or may not impact on it because you still have the same way of dealing with it regardless whether your using or not (209)

An awareness of the situational context also allowed the participant to predict future parenting challenges that subsequently provided her with a greater insight into her own level of responsibility. The participant responded:

On the other side of the coin, you been up all night and the kids been disturbed, they might be teething, in your head you got it that you could be faced with that parenting challenge because you know your had some part in the possibility of the parenting challenge you know. (212)

Number one, you might of delayed the shopping trip, the child might not of slept, you might set yourself up for it, if they're feeding or if you're using, you have to tolerate that situation or possibly not you know, it depends (203)

Similar to the above findings of the parenting challenge toilet training, the participant's partner complicated the traditionally non-drug related challenge of tantrums further by restricting the participant's preferred method of responding.

Coping strategies.

The participant utilised a number of coping strategies in order to manage her children's tantrums. An emphasis was placed on analysing the situation and making changes to her routine. Indications of these coping techniques were evident in the following comments:

Say you need to do a whole shop, a food shop you wouldn't do it because you'll go to the deli you know. You'll take the child or leave the child in the car or you'll leave the child at home. (215)

...it depends on the time of the day. So if I wasn't using right, yet you plan to go to the shops at one o'clock and you're completely straight on this day, the kids slept all good, the chances are you aren't to cop that parenting challenge that day if your going to the centre right. (201)

Furthermore, the participant acknowledged the necessity of knowing her child's needs and patterns of behaviour and her own ability in coping with the parenting challenge.

...but you'll minimise the parenting challenge based on your own ability to deal with it plus the children where that child is at that time (211)

...and as a mother, knowing your child you know, you are aware of all these things before you put yourself into that parenting challenge (216)

The partner's abusive behavior restricted the participant's preferred methods of responding to her children and resulted in her adopting the strategy of compliance. The participant commented:

You know, sometimes it's so fucked up. The kids are chucking a wobbly and he's yelling shut them fucken up and I'm thinking shit, just get them out of this space, you know. So you change how you deal with shit all the time, just to avoid him and all his shit....(181b)

3) Only leave Child with a Competent and Trusted Care Giver

Examination of the data for the parenting challenge 'Finding child care when scoring' revealed the additional theme 'Only leave child with a competent and trusted carer', which produced the relationship of a drug-related lifestyle. Sub themes within the categories complicating factors and coping strategies are illustrated below (see Table 6).

A number of sub themes emerged from the parenting challenge ' Finding child care when scoring'. The main issues centred on finding a competent and trusted caregiver to mind the children during the time when the participant went to score drugs.

Safety issues were a determining factor to where the participant left her children. Evident in the comment:

...there is unsafe conditions for the kids and you know, cause to me some of them use to much and there not places that I want to leave my kids. You know some of them use needles, like you know, like there might be needles (101-102)

Table 6

Themes and Sub Themes Generated for the Parenting Challenge of Only Leave Child with a Competent and Trusted Care Giver

Sub themes	Drug Relationship	Complicating Factors	Coping Strategies
Screen children via (DRL) observations		Non supportive partner	Accessing social network
Non judgmental care giver		Partners and participants criminal activity	Accessing family support
No excessive use of drugs		Family support denied	Screen others behaviour toward their children before
Limited questions asked		from age >25-28	accessing social network
No safety issues e.g., needles			
Child satisfaction with care giver			
Care givers children screened			
(Satisfied that children will be well looked after)			

The participant also observed the other parent's behaviour towards their children and evaluated them by her own standards. The following comments include:

The kids were well looked after you know, the kids were always clean, um they were fed you know, they went to bed all that stuff. If I take my kids anywhere I watch like how the other operates, if I want to leave my kids (262-267)

However, sometimes the childcare options didn't go to plan, which created further difficulties with the children. At these times the participant accessed family support. The participant responded:

but then if you take the kids there they'll start winging I don't want to go there because I'm going to fight with such and such ,this and that so they ask why are you going? Cant we come with you...(268)

so you choose that spot because your going to get the least questions and the kids are actually happy to be going to nanna's you know (256-257)

During her relationship with her partner there was a period of time when her parents withdrew their support over physical abuse issues. This resulted in the participant having to find alternative arrangements. Participants' were chosen on criteria relating to safety issues, competency, children satisfaction, least questions asked, non-judgmental nature and limited use of drugs in the household. Compounding the issue further was the increased selling and purchasing of drugs by her partner, which placed additional stress on the participant in terms of finding competent care. The increased frequency of needing to find childcare meant that the participant had difficulty in explaining why she had to leave the children so often and why they could not come with her. Her chosen alternatives were drug using social networks that she trusted.

It is evident from the three examples above that a number of complicating factors influenced the participant's preferred method of responding. Intoxication, a drug using lifestyle and the partner's non-supportive and abusive manner effected these everyday parenting challenges. Through the use of a narrative detailing the complexities involved in responding to the challenge of 'getting the children to school' the remaining parenting challenges will be addressed.

4) Detailed account of the parenting challenge 'Getting the children to school'

The commonly faced parenting challenge of “getting the children to school” poses a number of tasks for any parent. There are issues relating to organisation of family members, self discipline in getting up in the morning, transport arrangements and bus time-tabling to name a few. However, the complexities of this parenting challenge amplify when drug use, a drug using lifestyle and domestic violence are introduced into the family household. A detailed example including quotes from the participant is used to illustrate the complexity of the interactions among the various parenting challenges, coping resources, and life circumstances.

An exploration of the parenting challenge “getting children to school “ revealed that a number of complicating factors were at play in influencing parenting behaviour. The general role of delivering children to their place of schooling is non-drug related. However, the participant's and her partner's drug use, incorporating both intoxication and the factors that relate to a drug using lifestyle influenced the participant's behaviour towards her children. Subsequently, this created further parenting challenges.

The effects of coming down from amphetamines on the participant's ability to deliver her children to school was evident in the following comment:

... if you're not using and you're frying you might sleep through and you wont get up on time to get the kids to school you know. (35) (frying refers to the period of time following a binge on amphetamines)

... but fuck if I'm frying fuck its hard to get up you know because you know because you might not have slept for three days so Well, then you're all over the joint and you can't wake up when the child wants you to get up. (10)

The participant's physical and emotional response to her children varied depending on whether the participant was taking amphetamines or in a coming down period following binges. These changes were described through the following comment:

If I hadn't been using then I was a cranky cunt but you know if I wasn't using I might not be as tolerant. (28)

They get yelled at a lot more than they would when I was using. (31)

These quotes highlighted the inconsistencies in the participant's emotions and behaviour. As a result, the children often missed school. The participant would usually drive her children to primary school. However, at times when the household awoke late due to her partner or herself staying up at night on the effects of amphetamines, she would keep them at home rather than take them to school late. Her reasoning was based on the premise that the fewer questions asked the better. If the children arrived late they still had to explain themselves to their teachers. This provided the basis for a new parenting challenge to develop, taking the form of accountability from her parents. This is evident through the following participant's comments:

My mum queries me all the time you know. (42)

... if she (participant's mother) comes around to visit during the day and the kids are meant to be at school and she wants to know why, why they aren't at school or why this or why that. (43)

The participant was then faced with the new dilemma of explaining to her mother why the children were not at school. The following comments explain her reaction to this dilemma:

Everyone can go, what the fuck, why are you doing this? Why are you doing that? You know, so it's catch 22, six of one and half a dozen of the other. If you come up and tell people that you're using, they're going to say you've got a fucking problem. (124)

Just bullshitting hey, to the kids, to everyone, cause if you told them the truth, you cant go down to the school cause you were up all night wizzing you know. (55)

The participant did not see telling the truth as an option as it would reveal her use of illegal drugs. Alternatively, she chose the coping strategy of lying to her children, family and friends. This was evident in the following comments:

... then you gotta bullshit why the kids aren't at school, or you know, and if anyone comes around you gotta bullshit why you kept the kids home from school. (36-37)

You lie to your parents, you lie to your kids. (120)

I actually feel like to get what you want, and to do what you want, you've got to bullshit you know, you gotta bullshit about it and have secrets, and keep things from the children, and from your parents, and your friends and everybody else. (64-66)

Examples of the type of lies adopted include:

You tell her I've been up for a couple of days or like you've had a fight...(49)

I haven't been eating properly or you don't feel right. (50)

Haven't been sleeping properly you haven't slept well and you feel like shit. (51)

I fucked up you know, I didn't get up. (52)

...or we haven't got any petrol in the car or you cant go out to day you know, you just bullshit. (53-54)

...like you know one of them were sick , just couldn't get there, you know. (55)

Lying created personal challenges for the participant including feelings of frustration and anger.

I was sick of bullshitting, I was pissed off really because you know, I didn't want to lie. (117-118)

I'd been doing it for a long time you know. You just get pissed off with having to lie... (121-122)

The parenting challenge of lying also created a moral dilemma for the participant through the associated feelings of frustration, anger and guilt produced as a result of not telling the truth. The participant described her feelings as:

Ah pissed off that you know that their not old enough to understand the truth about what's going on in the house, but I also know that you cant tell them the truth. It's horrible hey. (62-63)

...and then your got the guilt's that go along with that because you know that number one, your child should be at school each day. That gave me the shits. (69)

... you just don't want to find out why your going that's the moral issue, yeah, because then you have got to tell your mum your using drugs. Angry in a way because you'd like to tell your mum the truth you know, but then also you want to spare your mum from that you know. Ah, pissed off because you want to tell her the truth and angry at yourself because you lie to your mother (242-246)

This moral theme ran parallel to all the parenting challenges faced by the participant. There was the underlying belief that what she was doing was wrong and that her mother and her children should be protected from the whole drug-using scenario. This

moral question of "what is the right thing to do for my children?" prevailed throughout the participant's story. An analysis of her relationship with her partner provides greater insight into the complicating factors that faced the participant in getting her children to school and the resulting ambivalence experienced by the participant in being a mother who uses amphetamines and who also lives in an abusive relationship.

The following quotes highlight the frustration of a mother who has the sole responsibility for raising her children and transporting them to school with limited support from her partner at that time. Often her behaviour and the children's schedule would be affected by the unpredictable nature of her partner.

He didn't take any responsibility for the kids, he didn't at anytime. (41)

so he's not involved so getting them to school and getting them up, its all my responsibility so he didn't feel he needs to do that... (22)

I basically had fuck all support from him for ten years. (222)

...If your got that person in the house then they influence the whole house you know, you've already got him and his shit, and like keeping a child quite is another thing and you need to have that balance in the house. So depending on where he is at or what space he's in depends on what you do within your day...(217-221)

This last quote captures the extent of the partner's influence on the participant's behaviour. The participant complied to the demands of her partner to safe guard herself and her children and to maintain the status quo in the household. Her partner's influence extended past the challenge of getting her children to school. It also effected the participant's preferred method of coping to the challenges of when her children awoke in the middle of the night and when they were making a noise. This is apparent in the following remark:

Oh when their screaming, I'm thinking fuck, just to shut them up, shut the baby up, because he's going to go off his head you know. Well if he's yelling at me about the baby being awake he's a fucken cunt, so like this is your child as well you know, like that sought of shit, like at the time you just do the best you can, so you don't have to deal with it, not really with the child but with him. If it needs a bottle or changing I normally do it as quickly as you possibly can and get the baby back to sleep, and so its not going to wake the rest of the house up, so the other kids don't get up, so you don't want them all up in the middle of the night and have him on your back. (5-8)

In this particular example, the participant was limited in the options available to her in dealing with the parenting challenge of a screaming child. She was forced to adopt the method of getting them to sleep as quickly as possible. Present day methods of control crying would not have been an option. Therefore, escalating the parenting challenge further by making the child less resilient in learning to go to sleep by themselves. This solitary example emphasises the compounding effect that the participant's relationship had on the type of coping strategy adopted irrespective of drug use. When questioned about her partner's drug use, the participant responded:

Well sometimes my other kids wake up, if my boyfriends speeding then he'll be awake or if he's not and if the kids are wake there in his space, then he's all pissed there in his time (5)

...mean if he's speeding he's a bit more tolerant but he still doesn't want to do it, it still becomes my responsibility you know... (151)

Furthermore the participant commented on her partners abusive behaviour:

He basically would use everything possible to keep me down, it was easier not to be noticed, and so no routine is better than a punch in the head. (222a)

Generally what happened in the house is that he would argue with me or be abusive verbally abusive or physically abusive to me or my son (327)

In one situation he (my son) got thrown off the roof and we had to go to hospital and stuff (340)

The partner exerted a controlling effect over the family and, in particular on the participant's preferred method of responding to parenting challenges. Compliance, avoidance and lying were the predominant coping strategies adopted. Based on the participant's fear of her partner, compliance was used as a protective mechanism for herself and her children. These two methods also served the dual purpose of maintaining the participant's current supply of amphetamines whilst providing an ongoing moral dilemma. This resulted in ambivalence over being a drug user, a mother and a woman living in an abusive relationship.

The parenting challenge of "getting the children to school" was also influenced by factors associated with a drug using lifestyle. The necessity to go out of the home environment to buy and sell amphetamines also contributed to the children missing school and created the additional parenting challenges of providing a disruption to the children's routine, creating a moral dilemma and compromising the children's safety.

The parenting challenge of "disruption of children's routine" was apparent in the following comments:

...maybe if you had that routine and a constant supply of drugs, I mean, if your routine is set then your child's routine is going to be more stable. (119)

Yeah and bringing drug use in intermittently throws that routine. (123)

The participant's level of intoxication contributed further to the subsequent disruption to the child's routine. Examples include

You know, like depending on what day of the week it is, and depending on whether or not I'm using or not using, or if I'm frying or I'm coming down, it really fucks up their routine. (68)

...and if your routine is out the door, if your coming on and off then of course your child's routine is unstable. (180)

Furthermore, the participant described the effect of scoring on the family's routine.

...which by bringing drugs and drug use in to your routine, it throws it all out you see what I mean, its that fact you have to go out to score or that you may have drugs one day and then you don't have drugs the next, there's no routine in your own life. (166)

By the participant not sending her children to school, she feels pressure in justifying to her parent's questions regarding accountability. Subsequently, she lies to cope with the situation. Her children's routine is disrupted and she feels a sense of guilt regarding her actions and the resulting effect it has on her children. A moral dilemma ensued, which was further complicated by her drug using lifestyle and her domineering partner.

The secretive nature of illegal drug use, in combination with the children witnessing drug related crime, posed further reasons for preventing the children from going to school. Comments relating to this include:

...then you run the risk of the kids going to school and say that we had the police over and that sought of fucken shit and the kids ask why the police were in the house. You know he did a armed robbery, you know, and I had the armed robbery

squad in my house pulling my whole house to pieces and you know, you've got kids there running around going what's going on? (141-142)

...you just don't want them to find out why you're going, that's the moral issue, (242)

Furthermore, the witnessing of criminal activity posed an additional moral dilemma for the participant in respect to the potential harm to her children associated with being exposed to deviant models of behaviour. This is evident in the comment:

They knew he was in jail, coz I took them to the jail and they saw him in the back of the paddy wagon and the kids were quite disturbed by that seeing there dad in the wagon (322)

The participant's drug using lifestyle presented the issue of child safety surrounding actual drug use, criminal activity, drug related social networks and safety during scoring. More time was spent buying, selling and using drugs, which meant the possibility of further disruption to the children's routine with school comprising an active component. The participant used the coping strategy of lying and compliance, which in turn posed greater moral dilemmas. Compounding this whole situation further was the relationship the participant had with her partner.

The participant responded to her role whilst being in a drug using environment:

Cos I'm still there you know. I know what's going on. I'm responsible for these kids right. I will take care of them. (104-105)

When exposed to situations involving drug use and related drug social networks the participant adopted the coping strategy of defensive compensation (Kearney, Murphy & Rosenbaum, 1994) that reduced the harm to her children: Examples included:

Limiting the amount of drug use.

Then I go, yours first, and then I come out make sure all the syringes and the fit packs are ok. (111)

Shielding the children from drug using

If you feel that there are some people there that you're not really too sure of, I try to keep my kids away. (115)

I try to keep my kids away. Send them to their room to play. Like outside or to their mate's house. You want to hide it from them, to hide the kids from that. (127)

Providing supervision for the children.

I would become more with the children so that you are sure they weren't where they weren't meant to be (286)

Finding a trusted care giver.

...you'd choose an allie in the group and if you needed to go into the group you'd choose an allie within the group that you know you could trust (287)

...to come out and look after the kid, so with that group there would be people you did like and didn't like so you could actually gage whom you could trust (288)

It is evident from this example that a drug using lifestyle in combination with domestic violence further complicates even the most common of parenting challenges. This example illustrates the complexity of interactions among various parenting challenges, the coping strategies used by the participant and their relationship to a number of complicating factors. The challenge of 'Getting the children to school' is diagrammatically represented in Figure 1.

Drug use plays a significant role in the participant's life. Currently she is very candid about her cannabis use, speaking openly about it to her three children, family and friends. The period in her life (ages 21 to 31, see Table 1) represented a time of regular and very heavy amphetamine use. During this time the participant recollected both positive and negative implications of her illegal drug use. An example follows:

Positive Implication of Drug Use

Drug use afforded the participant the positive effect of increased alertness and high energy levels allowing her to stay awake for long periods of time. During this time the participant described the beneficial effects of her drug use to specific parenting challenges. Evident in the following comments:

...the drug use can also assist you in the parenting challenges cause one I thought of the other day is when my youngest child used to sleep walk and that was one that was influenced by drug use because if she's sleep walking and your speeding your awake. Yeah, because if your awake you can immediately put the child back, like because, you know if you were a sleep you don't know what that child is going through. (172-174)

Furthermore, it provided a method of coping to the demands of parenting.

Comments include:

Well if I'm using it's easy because your already awake ands I'm a bit more tolerant, you know cool (9)

The participant's experience with drug use is currently seen as a tool for educating her children. Drawing on her life's experiences the participant believes she provides a learning environment for her children. The participant recounted:

I've a good knowledge of drugs and knowing you have control over your use and your not a dependant person on a substance. I know that I feel like if my kids came home and they used drugs that I have a better understanding than if I didn't use. The education I suppose, like if my kid came home now it wouldn't spin me out if she said she had five dexies at school or she did a line at a party, though it would concern me about their age and stuff like that, but you know like the relationship I have with my kids, I think they could talk to me and tell me that. (453-458)

Negative Implication of Drug Use

The participant's drug use posed a negative effect on her physical and emotional condition that subsequently impacted on her children. Examples include:

If I'm not using then I'm a cranky cunt but you know if you weren't using you might not be as tolerant, so when your tolerance is less you may decide you're just going to smack, like it depends, it depends whether you're using or not if you're straight or if you're stoned. (28-30)

you may be a bit more tolerant if you're on it. (184-187)

They get yelled at, a lot more then they would when I was using. (31)

Furthermore, it had wide-ranging effect on the lives of her children. It created a

disruption to their routine in regard to when they slept, ate, socialised and went to school. The children were also exposed to their parent's lies and issues relating to a drug using lifestyle. Subsequently, it created a number of safety issues. They comprised exposure to violence, criminal activity, drug-using social networks and the health risks associated with amphetamine use. The children were exposed to a range of counter productive coping mechanisms in conjunction with their parent's modelling of a drug using lifestyle. Evident in the comments:

They knew because they were there, when the police raided, and they knew he was gone and he stole drugs and that he did an armed robbery (309-310)

...they know about the IV use, they know that he stuck needle up his arms. (319)

They knew he was in jail, coz I took them there and they saw him in the back of the paddy wagon (322)

... my oldest daughter has seen him abusive to my son and me, she's formed an opinion...(354)

Section 3-Resilience

The super- ordinate theme of resilience ran concurrently throughout the participant's life story. The participant's perseverance, determination, commitment and will to maintain her protective role of mother in guarding her children is salient in the following areas. These included, a) separating her children from many aspects of a drug using lifestyle, b) limiting their exposure to an abusive partner, c) changing her own drug using behaviour, d) managing to cope after a drug overdose and two suicide attempts, and e) maintaining the goal of a better life for herself and her children. The participant possessed the self-efficacy to reach the current extended roles of mother, human services employee,

university student and wife. Furthermore, the participant delivered a candid account of her relationships, acknowledging her limited insight concerning what life would be like away from an abusive relationship. She also commented on the disabling effects of fear.

An example of the participant's resilience is illustrated below:

I explained to him (son) why it was happening, that it s not his (son) fault, like he hasn't been naughty, because he (partner) would tell him (son) that he a cunt or he's this and that, but we would have that window of opportunity to reverse that, so to put the blame back on to him.(partner) But I didn't want him (son) to come out of any of that to think that he(son) was the cause of that. (343-348)

Through her actions to comfort and reiterate to her son that the physical abuse he had encountered was of no fault of his own, she placed herself at greater physical risk.

The participant's resilience was also described when she was awaiting the return of her partner from jail. When asked how she managed to cope with the fear of his return, she responded:

I needed to be alert and I needed to be ok, and it came to a point where you can fuck yourself up, or you and pick yourself up from here and go the other way, it was a conscious choice. (374-375)

You just do it you know, you just deal with it, you know get it done. (17)

The underlying motivation to survive an abusive relationship, a drug dependence two suicide attempts and the challenges of parenting were based on the participant's internal belief in herself and the importance that her life experiences might provide for someone else. The participant recounted:

I looked back and thought how can I best use that space in my life to use the skills I gain to effect change in other people. Also, for other people to look at me and say

she's ok. For someone to say you're ok it's got to have something behind it, some sort of conviction. If someone can stand there and say there's something similar in my life this is how I did it, then you can do this and then they realise that, that's a real thing. I think it holds more weight than if you get it out of a book. (372-376)

Furthermore, knowing inevitably what you want in combination with the courage and an internal resilience to achieve it enabled the participant to cope with the many challenges she faced. Evident in the comment:

Ah, cause fuck all of yous right, cause I'm going to show yous that I'm not fucked up you know, I know I have a brain, I can be more than just someone's wife or mother and for me personally because I needed more. Since I'd had my son you know, that was a point in my life that that's stopped your track, now your going off the track but ultimately you will come back to where you started to pick up and be where you wanted to be (376-378)

Ah the want, the want for a better life the will to do it (372)

The participant was also insightful of the reasons why she complied with her partner. She acknowledged that fear was the main factor. The participant responded:

...all the things I like about myself now but back then your not so aware, you know there, there but your not aloud to come out, you know, underneath the skin your still the same person. It would of caused more trouble to come out and be yourself because living with a full on drug user within the house and their up and down, and your running in going don't fucken worry about it and it is all ok, your probably going to get a punch in the head, so that's why they couldn't come out. (438-442)

A crisis point was reached in the participant's life where her capacity to cope was at its limits. Fearing for her life and feeling trapped, she made an attempt at her own life. Resilience played a key factor in the participant's survival and her subsequent behavior change in regard to every aspects of her life. When asked for a retrospective account of the role amphetamine use performed in her life? She replied:

It performed a function for me to cope, it's just the fact I didn't want to die. you've gotta do more than that, just die, just the shit I told you pretty much (477)

After living in fear, surviving amphetamine dependence, a drug overdose, two attempted suicides, a 10 -year abusive relationship and the complex challenges of being a mother to three children, the question was asked. What are you currently afraid of? The participant responded:

Nothing really besides you know, someone like hurting my kids. ah, that's the only one I really care about (374)

The theme of resilience is connected to every aspect of the participant's story, telling how she managed to cope with the challenges of being a mother and a drug user. This complex series of interactions is illustrated as Figure 1.

Section 4-Harm Reduction

The participant's story reflects a life consumed with a number of interacting and complicating factors that created a great deal of stress and potential harm for her and her three children. A drug using lifestyle posed safety, health and legal issues for the whole family, whilst her abusive relationship with her partner created massive uncertainty, fear and impeded her preferred method of coping. Throughout this period of time in her life the participant minimised harm to her children by making all decisions with the safety of her children in mind. Subsequently, this minimised the harm to her children in regard to domestic violence and the risks associated with illegal drug use. However, crisis point was

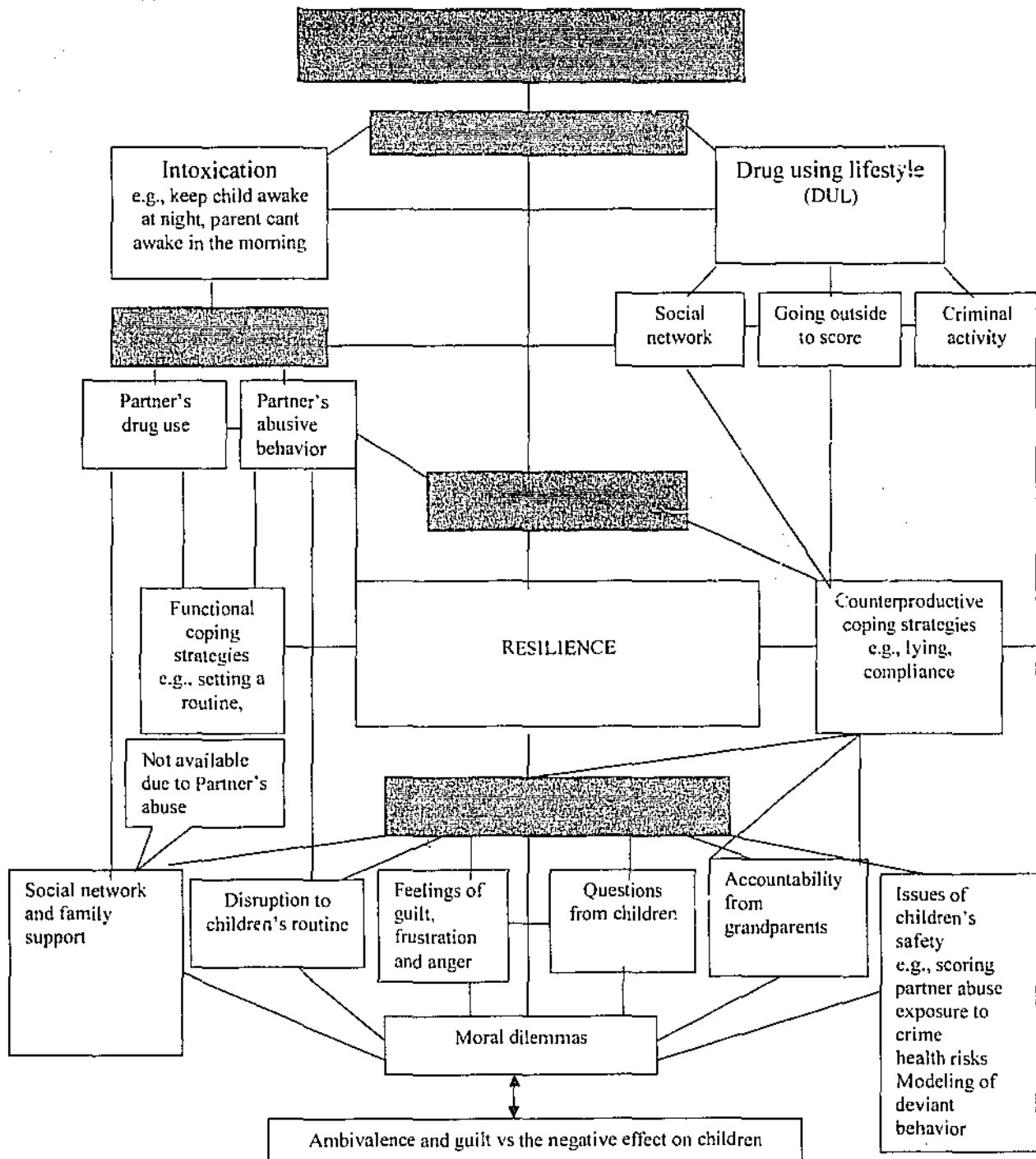


Figure 1. Flow chart illustrating the complexity of interactions involved in the parenting challenge "getting the children to school".

reached when the participant, feeling like she would not survive the physical abuse inflicted on her by her partner, attempted suicide on two occasions. On reflection, the participant described her attempts at her life as the result of feeling trapped, with a sense of no way out of the problem. Her subsequent survival provided the basis of a renewed sense of resilience to protect her children and to keep fighting. This particular time in her life and how drug use played a supporting role is captured in the following comments:

It performed a function for me to cope, it's just the fact I didn't want to die. You've gotta do more than that, just die, just the shit I told you pretty much (477)

It is interesting to note that the participant minimised the impact of her drug use on her children differently in the 10 years during her relationship with her partner than compared to the two years following his departure from the family. The relationship period marked a time where the participant used the coping mechanisms of compliance and avoidance to minimise the harm to her children. Examples include, moving the children away from her partner when they are throwing tantrums, crying to be fed, to be changed or wanting affection. The participant changed her preferred method of coping to protect herself and the children from the verbal and physical repercussions from her partner. In relation to a drug using lifestyle the participant adopted what Kearney et al. (1994) termed 'Defensive compensation' to protect her children from harm. Examples include, limiting the amount of drug use, shielding the children from drug using, supervising the children, finding a trusted care giver, segregate the children from drug related social group, reduce and limit exposure to violence, and scoring drugs when kids are at school or times of the day when the children are not around. A specific example of how the participant shielded her children from actual drug using involved the relocation of her children to a safer location. Evident in the comment:

I try to keep my kids away. Send them to their room to play. Like outside or to their mate's house. You want to hide it from them, to hide the kids from that. (127)

The participant minimised the impact of both her drug using lifestyle and her abusive relationship on her children by primarily having their best interests placed first and foremost in her mind when making decisions. Naturally, a conflict arose between the competing behaviours of taking care of her children whilst at the same time using amphetamines. The ensuring ambivalence was catered for by the participant's resilience in providing a loving, caring and supportive relationship with her children while at the same time shielding them from both a drug-using lifestyle and her abusive relationship. The attribute of resilience, which included the characteristics of perseverance, determination and tolerance, were seen as the key factors enabling the participant to take care of her children. The participant and her children were constantly subjected to a life of fear, physical abuse and crime from her partner. Subsequently, this created complex problems for the participant in terms of how she coped. However, the two years marking the departure of her partner signifies a change in the participant's methods of coping. The participant had an internal desire to further herself. This factor was a driving force that moved the participant forward in relation to her self-esteem. Education and employment were used as the tools to implement this change. Evident in the comments:

...its so different now , I'm working, I think self confidence plays a big part in it...(402)

Work has given me some clarity of where my life has come from and why, (411)

Furthermore, employment and education provided an avenue for the participant to feel valued and connected to the mainstream community. She recounted:

...and it also made me know that I'm not loopy because somewhere along the

line I've fitted into something (410)

an explanation for why and it gives you the skills that you can assist,

that is politically correct, if you can put it that way (412)

...I knew that what I had been through would have had to be of some value to someone. (404)

Through gaining employment the participant felt reassured in regard to her ability. It also provided a means for her to use her skills to assist people. This is evident through her current line of work in the human services industry. Comments include:

Before I knew it worked because I went from that spot to that spot, and I knew that it worked. It gives you other ways of using that knowledge and you have to transfer over to skills, so that's where it fits in to help people, like all the shit you went through and all the shit you were in, you know, what can you do from that experience because during that time there are a lot of things that have limited me, my ability now you know (412-415)

During the time when the participant's partner went to jail for armed robbery, she relocated her family interstate back to Western Australia. This move signified the start of the distancing process with an internal drive to separate that aided the coping process. She responded:

I couldn't afford to stay there and plus I saw it as my opportunity to get away from him...(297)

Furthermore, once her partner had left her she described that overcoming dependency was a factor contributing to her improved method of coping. Evident in the comments:

I remember waking up and fuck like my heart was pounding and I just thought what the fuck am I doing, you know, you have times in your life when you can make the right decision, ah like, looking back this was one of them. (498-500)

I'm a lot clearer now, with him out of the picture I see the real effects of when I was using, its always easier looking back (506-508)

The feelings of chest pains represented a cathartic experience for the participant and provided additional motivation for continuing the path that she had already commenced.

Furthermore, emotional support from her current husband was described as influencing all aspects relating to the participant's personal growth. Evident in the comment:

...what's helped in the process, my husband, support from friends and me, a combination of all of them (370)

Family and friends also provided an avenue for emotional support. Her social networks were accessed for childcare, friendship and drug using purposes. Meanwhile, her parents provided emotional assistance during the period of time the participant was between 0-25 and between 31-36 years of age. The participant reported additional factors that might have aided the coping process. They included, minimising her drug use at an early point in time, having a better relationship with her partner, establishing a routine in life, being involved in a mothers group and accessing a constant supply of drugs. Furthermore, having an insight into what life would be like beyond the current abusive situation was seen as another potential aid. Comments included:

...essentially I knew what was happening but didn't know where that awareness would take me...(397)

... where now, looking back on it, there wouldn't be that fear because even though you were aware of what was happening, you were still afraid of what was going to happen. (410)

Back then, you didn't know where you would be, where as now I know next week we'll still be in this house(385)

Therefore, the period of time following her partner's departure from the family can be seen to represent a change in the participant's coping behaviour. The partner represented the main complicating factor in the participant's life. With the partner out of the way, the participant was able to take care of the business of reducing her drug use, seeing it as not performing the same role as it did with her partner. In addition, a renewed social and family network, obtaining employment and furthering her education provided personal stability. Subsequently, this had the effect of minimising harm to her children through the reduction of all drug-related issues relating to health, safety and the law, which in turn created a more secure family environment for the children.

Improvements in service delivery

The participant came into contact with a number of youth focused services. Following her attempted suicide she had visits from the child protection agency. Her experiences with the agency produced a feeling of distrust and fear, as she believed they would take her children away from her. The participant had difficulty in describing potential improvements to existing services. She felt that the option was never available to her taking into consideration her relationship with her partner and their drug using lifestyle. However, she responded with the following criteria for improving service delivery for mothers who use amphetamines. They included, a non-judgmental, confidential approach that provided peer support on an out reach basis. An example is provided below:

You know, I didn't trust them, they weren't there for me or the kids, fuck that,

I didn't trust them, no way. (516)

You gotta have someone that's going to come out, give the time and not judge, you know, and not want to call the cops and that, someone who knows the story...(519)

Barriers to seeking support from external based drug treatment agencies

A number of barriers to seeking external based drug treatment agencies were identified by the participant. At the time of heavy amphetamine use the participant did not identify that she had a problem. Evident in the following comments:

Ah I think I didn't need it (475)

...but I still don't see it as problematic. It performed a function for me to cope... (477)

Another barrier was the problem of drug use being identified as an another problem. A general practitioner referred the participant to see a psychiatrist for issues suspected of relating to anorexia rather than drug use. Subsequently, this referral produced another barrier. Counselling directed solely at solving the problem of her abusive partner. Meanwhile, the participant sought answers into how she could live a more functional life at home, maintaining both her relationship and her drug use. The psychiatrist offered the answers in the form of solution focused and pharmacotherapy, prescribing her antidepressants and advising the participant to leave her husband. An option, that at the time was not available to her. As a result she withdrew from further counselling.

One of the main factors to explain why the participant did not access mainstream drug treatment services was the fear of losing her children. Illustrated in the following comment:

yeah I was scared that they would rip the kids off me, after I got my stomach pumped in hospital they sent someone around to check things out, fuck that, there just gonna make you out to be a bad parent, plus to many questions are asked, you got all these secrets, the last thing you gonna do is leave your self open to all these questions... (522)

Furthermore, her partner's abusive behaviour and their drug using lifestyle created an air of secrecy around the household and isolated the participant and her children from outside resources. The participant responded:

He wouldn't let me do fuck all, he didn't want his dirty laundry on the line, he didn't want anyone to know...(535)

Factors that influenced a change in drug using behaviour

A number of key determining factors influenced a change in the participant's drug using behaviour. These included; the initial relocation away from her partner, her partner's departure from the family, a reduction in fear and fears related to stress, her internal resilience to satisfy a goal of gaining an education and for the future of her children.

Examples include:

Limited access to drug supply.

I did it when I moved because I didn't have access to it. (372)

Limited feelings of fear.

...and I wasn't dealing with what I had to before you know...(373)

Reduced stress.

*and plus their was other uses for it back then, there aren 't anymore now
its purely recreational. (379-380)*

Resilience.

*I needed to be alert and I needed to be ok and it came to a point where you
can fuck yourself up, or you and pick yourself up from here and go the other way, it
was a conscious choice. (374-375)*

Children focused.

...a lot of it was for the kids...(428) ,

Education.

I wanted an education and you cant learn anything if you 're off your head...(539)

Section 5-Main Implications for Harm Reduction

A review of the factors that could cause potential harm to children revealed a complex interaction between 4 risk areas. These include:

- 1) Parent's intoxication
- 2) Parent's drug using lifestyle
- 3) Modeling of counter productive coping behaviors
- 4) Domestic violence / abusive relationship

Parent intoxication posed a risk of verbal and physical abuse to the children from the mother and partner respectively. Intoxication affected the children's pattern of behaviour by disrupting their sleeping, eating, socialising and school routines. In addition, it produced the health risks associated with IV drug use.

An air of secrecy filled the home environment caused directly by a drug using lifestyle. This had the long-term effect of creating social isolation for the children whilst constraining their behaviours by not providing definable boundaries to work within. In relation to the children's safety, there were a number of risks associated with a drug using lifestyle. There was the potential danger related to exposing the children to a social network of drug users and the health risks associated with their route of administering the drug. Furthermore, the children were at emotional risk through being exposed to drug related criminal activity.

A drug using lifestyle interrupted more functional methods of coping. As a result the children were exposed to potentially harmful models of behaviour. Counter productive methods of coping included avoidance, compliance, aggression, lying to children, family and friends, robbery, other drug related crime, and an increased use of drugs.

The children were also at risk of psychological, emotional and physical harm due to witnessing and being subjected to domestic violence.

The main implications for harm reduction stem from the risk areas identified. An abusive relationship hampered the participant in all areas of functioning, whilst a drug using lifestyle interrupted more functional methods of coping. The data illustrates the complexity of interactions among various parenting challenges, coping strategies and complicating life factors. Attention needs to be focused on placing drug use and the various methods of coping within a social context. Thus providing a more holistic approach to service delivery, including peer based, women and child outreach models of intervention.

Discussion

Focusing on the experiences and perceptions of the challenges of parenting, an open-response format interview facilitated exploration of the experiences of a woman who uses amphetamines. Her experiences were predominantly centred on the challenges of parenting, their relationship to drug use and the type of coping strategies employed. There was a complexity of interactions between the various parenting challenges, coping resources, and life circumstances. The participant's preferred methods of coping were impeded by the participant's intoxication, drug using lifestyle and a number of complicating life factors centring on her abusive relationship. Subsequently, this created additional parenting challenges whilst posing a potential risk to her children. Nevertheless, her children's current level of functioning was considered to be within the normal range. Furthermore, the participant who considered herself to be a resilient and capable parent sought no assistance from professional drug treatment services in reducing her own drug use.

The participant's story provides an insight into this relatively under researched group of community members and the findings challenge the suggestion from mainstream residential treatment settings that drug-using mothers predominantly require parenting skills programs. In addition, the themes and sub themes in the qualitative data suggest trends similar to those reported in studies involving parental alcohol, heroin and cocaine use specifically as regards the negative implications of parental drug use, children's resilience, the centrality of motherhood, natural recovery and barriers to treatment. (Baker & Carson, 1999; Bauman & Dougherty, 1983; Chabay, 1996; Colten, 1980; Drasin & Thomas, 1996; Hawley, Halle, Rosenbaum, 1979; Kandel, 1990; Kearney, Murphy &

Rosenbaum, 1994; Richter & Bammer, 2000; Wellisch & Tseinberg, 1980). Furthermore, the qualitative data reinforces current methods of service delivery that focus on placing drug use within a social context (Merrick, 1985; Kumpfer & Turner, 1990-1991; Metsch, Rivers, Miller & Bohs, 1995; Magura & Laudet, 1996; Brindis, Berkowitz, Clayson & Lamb, 1997; Byrne, Bedford, Richter & Bammer, 2000; Keen & Alison, 2001; Sanders, 2001). However, it extends this holistic philosophy by suggesting an alternative approach to service delivery. One which focuses on providing a more genuine concern towards individuals and family members by taking into consideration their own perspective in regard to reducing harm.

The participant acknowledged the potential negative impact of both her drug use and her drug using lifestyle on her children. It posed a number of safety issues including difficulty in providing a safe environment when going outside to score drugs, drug related social networks, criminal activity and health risks associated with intravenous drug use. Furthermore, the children were exposed to a disruption in their routine and a modeling of counter productive coping mechanisms. These findings support an extensive body of research including studies involving the drugs of alcohol, heroin and cocaine. Alcohol using parents had difficulty providing a safe environment for their children (Bijur et al., 1992) whilst the children of cocaine and heroin using parents were exposed to criminal activity (Hogan, 1998; Inciardi, Lockwood and Pottieger, 1993). The negative impact of parental drug use on their children is also supported by studies involving crack-cocaine and meth-amphetamine (Baker and Carlson, 1999). Baker and Carlson interpreted such findings as supporting the notion that in general, drug using mothers perceived that their children are potentially at risk of a wide range of negative outcomes.

However, in this study, the participant's children, though potentially at risk of exposure to an illegal drug using lifestyle, displayed a normal range of functioning. These results are compatible with findings from Anthony (1974). Anthony interpreted such findings as supporting the belief that similar experiences affect children differently where children of substance users can not be considered as a single entity but rather a heterogeneous group of individuals. The underlying reason for the children's normal range of functioning is difficult to gauge but may comprise factors including internal resilience, the subsiding of situational stress or that their parent improved her own level of functioning.

The participant considered herself to be a capable parent in providing her children with food, clothing, shelter, education, love and attention. She placed motherhood as of primary importance in her life. On the departure of her partner, her focus of attention turned to her own drug use. Subsequent reductions in drug use lead to improvements in the areas of personal health, children's safety and emotional stability. At all times, the participant felt guilt associated with the ambivalence created from performing the role of mother and drug user. These findings are consistent with the results of Baker and Carlson (1999). Baker and Carlson supported the view that mothers felt capable as parents and exhibited behaviours associated with socially acceptable, intensive parenting, a process that is child centred, expert guided, emotionally absorbing, labour intensive and financially expensive. Motherhood emerged as a fundamental part of their lives. Additional support comes from the findings of Colten (1980), Kearney, Murphy and Rosenbaum (1994) and Rosenbaum (1979). The results indicated that heroin using mothers felt extreme remorse and guilt over neglect issues involving their children and wanted to leave the heroin lifestyle when their children and their role of mother were in jeopardy. Mothers had a high capacity to cope

with parenting and accepted the dominant cultural role prescription of motherhood as being central to a woman's purpose and being one of women's central work and social roles.

The findings of the current study present a mother who was highly resourceful at shielding her children from her amphetamine use. The participant employed a number of coping strategies including: reducing the time and amount of drug use, shielding her children from drug using, accessing a trusted care giver, segregating her children from her drug using social group, reducing and limiting the children's exposure to violence and scoring at the times when the children are at school or out of the house. These results were in accordance with the findings of Kearney, Murphy and Rosenbaum (1994). Kearney et al. (1994) supported the view that cocaine-using mothers adopted the coping strategy of defensive compensation to protect both their children and their maternal identities from the negative influence of illegal drug use.

One strategy within the concept of defensive compensation, was the reduction of the participant's drug use. Over a period of six years the participant managed to reduce her alcohol use (5-6 cans of beer a day to 2-5 standard drinks, 1-2 times per year) and dramatically reduce her amphetamine use (6-7 grams per week to 1 gram, 3-4 times per year). At the same time she maintained her drug of choice, cannabis, at five to ten cones every one to two days. Through this period of time the participant sought no professional assistance relating to her drug use. These results are compatible with the literature pertaining to the concepts of natural recovery and harm reduction strategies. Her reduction in amphetamine use to low risk consumption is consistent with the findings of Dawson (1996), where 25 percent of problem drinkers resumed low risk drinking. The participant's reduction in amphetamine and alcohol consumption whilst maintaining and/or increasing her cannabis use, is consistent with the findings of Sobell et al (1994). Sobell et al.

supported the view that some participants stop using one drug but increase the use of another. Additional support comes from Toncatto et al., (1999), whose results indicated that respondents, who had naturally recovered from a cocaine problem, reported that they continued to use alcohol at levels deemed as high risk. The participant's subsequent change in drug using behaviour also involved changes in other areas of her life including education, employment, family support and personal health. These findings are similar to those reported by Saunders and Kershaw (1979) who found that maintenance of change in ex-problem drinkers was associated with changes in relationships, employment and residence.

In adopting a self-change process, the question must be asked: What barriers prevented the participant from seeking professional assistance for her drug use? Results of the current study revealed that the participant did not see her drug use as problematic but believed it to be a symptom of dealing with the abuse inflicted on her from her partner. The stigma attached with being a drug user and a mother, in conjunction with her partner's demands for secrecy in the household prevented her from seeking treatment. Furthermore, a general practitioner sought a psychiatric referral for the participant, seeing the symptoms of her drug use as related to another disorder. These findings are consistent with the results from the "Women Healing Restoring Connection" conferences in Philadelphia and Palm Springs, California Springs in 2001. These conferences revealed that shame, the inability to admit that a problem was severe enough, the thinking that addiction was a symptom of an emotional problem and seeking psychiatric or mental health were all barriers to seeking drug treatment (Barriers to Treatment, 2001).

The challenges that the participant faced in being a mother and amphetamine user illustrated a number of common themes found in studies focusing on heroin using populations. She reflected that a constant supply of drugs could lead to a successful combination of drug use and parenting. Consistent with these findings are the results from a study by Rosenbaum (1974) where participants described that a constant supply of heroin in conjunction with not having to go out of the home to work, can lead to being healthy (not withdrawing) and being available for their children. In exceptional cases, combining heroin use and parenting meant a mother could control her habit and competently care for her children. Further parenting challenges relating to safety issues and finance, were consistent with the findings of Baker and Carlson (1999). These results indicated that crack-cocaine and meth-amphetamine using mothers in a residential treatment setting reported the challenges of exposing their children to danger, violence and drug use; being emotionally unavailable for their children; and having difficulties with finance. Mothers had difficulty managing their children along with their habit. The present study extends onto these findings to include a number of complicating factors that brings into consideration the participant's social context. These factors predominantly involved the impact of an abusive relationship on the family dynamics, which created additional parenting challenges.

The participant's story highlights the complexity of interactions involved in the parenting process whilst living an illegal drug using lifestyle and being involved in an abusive relationship. It suggests that services need to cater for this complexity. The findings of the current study are consistent with research that promotes an extension from parenting skills programs to encompass drug use within a wider social context including; gender specific and family centred programs (Brindis, Berkowitz, Clayson & Lamb, 1997;

Magura & Laudet, 1996; Metsch, Rivers, Miller & Bohs, 1995) and peer based support and advocacy groups (Byrne, Bedford, Richter & Bammer, 2000). An ecological approach to parenting support targeting a variety of social contexts was proposed by Sanders (2001). However, using the Triple P Positive Parenting Program as a guide, the primary focus of attention is on assisting parents, who have a concern about the behaviour of their children, with information and brief and intensive therapy. It is evident that this model of service delivery is more comprehensive than providing basic skills to parents through the incorporation of counselling into the program. However, it is limited in dealing with issues pertaining to broader life problems that might involve the parent wanting to maintain her drug use. It is evident that the current study supports a movement for the provision of services to be broader than a parenting skills focus, however, it questions the underlying philosophy of services in regard to how they approach community mothers who use illegal drugs.

Strengths and Limitations

The participant represents a section within the community that is difficult to reach and therefore difficult to research. The secrecy attached to illegal drug use provides a challenge for researchers with regard to developing methods of accessing this target group that are both non-judgmental and flexible. Through a number of informal meetings with mothers' who use amphetamines, it was revealed that the current formal and centralised meeting venues for the purpose of conducting interviews were considered inconvenient, difficult to access and lacking incentive. It is the belief of the author that an outreach approach to the recruitment and interviewing of participants is the most feasible method of ensuring a relationship of trust and providing for many families that have financial problems and transport difficulties. The strength of the present study lies in the fact that it

provides a voice for this under researched group of community members. Furthermore, it illustrates the complex interactions involved between parenting challenges, drug use, coping strategies and domestic violence.

The use of qualitative methods questions the authenticity of the participant's account. Although the participant's three children were interviewed, they only provided a measure of their current level of functioning rather than a verification of their mother's experiences. The accessing of the partner's account of the participant's story would have strengthened the current study, however, given the past history of their relationship this was not a viable option. Being a current recreational user of amphetamines, the participant had to recall her experiences of life as a mother dependent on amphetamines. This retrospective account brings into the play the confounding variable of memory. Though in a position to record the children's perceptions and subsequently strengthen the current study, the researcher refrained from eliciting recalled memories believing that they could potentially cause more harm than good. The study uncovered the depth and complexity of life interactions at a given point in time and revealed the factors that affect the decision-making of one mother who uses amphetamines. Incorporating this cross sectional approach with further longitudinal studies involving a greater number of participants across time would provide further insight into the complexity of challenges faced by this target group.

The implication of the current study is that it assists in clarifying issues related to parenting interventions by questioning the mainstream message from residential treatment settings that drug-using mothers require parenting skills programs. The findings of the present study contain particular lessons for policymakers and service providers. The participant reduced her drug use through a self-change process and achieved a normal level of family functioning. However, it involved the departure of her abusive partner from the family environment before any action was activated. Clearly, the social context needs to be taken into consideration when devising interventions. Harm reduction strategies need to focus upon the abusive relationship that hampered the participant in all areas of functioning and the participant's drug using lifestyle that interrupted more functional methods of coping. By placing drug use within the social context of the participant's life, it provides for a more holistic approach to service delivery. Drug use is then not viewed in isolation, and the various risk and protective factors involved in parenting are addressed.

In reviewing the barriers that prevented the participant from accessing treatment, the stigma attached with being a mother and a drug user, might be addressed through peer based user advocacy and support programs. Furthermore, this often hard-to-reach community group must have the option of outreach services in providing a wide variety of supports that prevent further isolation. However, there are limitations in having gender focused, child and family centred, drug treatment, peer based user support programs to minimise the harm to children, individuals and families, if they cannot earn the trust of the target group. Using the current participant as an example illustrates this point. The participant employed compliant and protective coping skills to care for her children during her abusive relationship. She managed to survive through two attempts at suicide, amphetamine dependence, domestic violence and the other risk factors associated with a

drug using lifestyle. While at the same time, raising three children who are within normal range of functioning. The participant managed to do this without seeking support from any professional drug treatment service. Furthermore, her partner represented the main complicating factor in her life. Following his departure the participant recovered naturally through various harm reduction techniques. The professional help she did seek, via a referral from a medical practitioner provided an approach that the participant viewed as being judgmental and non-supportive. The participant currently acknowledges that both her husband and her amphetamine use represented unique problems to both herself and her children. However, it was the approach and underlying motive of service providers that caused her distrust and subsequently prevented her from seeking further treatment.

The participant was ambivalent with regard to both her relationship and her drug use. She hated her partner but still loved him. She knew the negative impact of drug use, but she liked the drug's effect and felt that she protected her children. The participant wanted someone to trust and listen to her side of the story, to support her in wanting to maintain both her relationship and her drug use. She wanted someone that would be non-judgmental and supporting whilst providing an insight into what life would be like beyond an abusive relationship. The findings of this study guide the development of programs that meet the real needs of these women by questioning the current approach to intervention. It suggests an approach to service delivery, which focuses on providing a more genuine concern towards individuals and family members. An approach that allows the consumer ownership of the harm reduction process whilst providing the widest range of accessible, professional and non-judgmental supports services.

Currently in Western Australia there are a wide variety of services that are offered in conjunction with parenting programs. These include drug treatment services, peer based user support services, access to health workers, gender and family centred programs and outreach services for amphetamine users in the community. The findings of the current study not only question the approach of existing services. It questions their capacity to extend into the broader community and to provide an adequate level of expertise necessary in addressing the complexity of presenting issues.

This study echoes a need to study the processes, interactions and complexities involved in decision making over time. A combination of cross sectional research in conjunction with longitudinal studies will lead to a better understanding of the underlying complexity of issues facing this section of the community. Future research might focus on the experiences of the children of illegal drug users. Little research has been conducted on the potential psychological risks to children of drug users (Hogan, 1998). Consequently we know little about the environments that these children are being brought up in and the type of parenting and care they receive. We need information on their exposure to drugs, drug induced violence and drug related criminality (Barnard, 1999). We need to know the children's experiences concerning their parent's drug use and how this may vary depending on the extent of the drug problem. Furthermore, there is paucity in the literature regarding the prosocial development of children of drug users.

In conclusion, at the time of writing this paper the author was unaware of any there qualitative studies examining the experiences of mothers who use amphetamines within the general community. The participant's story is one of resilience and self change. It provides an insight into the amphetamine user's world that reinforces the importance of placing drug use within a social context. Both drug use and domestic violence impeded this mothers

preferred method of coping. Service providers and researchers involved in harm reduction “need to move beyond simply recognising that drug related harm is experienced by others than the user, to holding a more genuine concern for how to best reduce the level of such harm” (Dear, 1996, p. 222). It suggests an approach that specifically targets the harm experienced by family members and to delivery a service that is based on trust. Trust in receiving a professional and non-judgmental service. Trust in receiving a holistic and accessible service and trust in the knowing that the consumers voice is considered when providing harm reduction.

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Appendix A: Interview Schedule and Probe Questions

- The term “parenting challenge” refers to any situation or event relevant to your child’s needs that is challenging in that you have to think carefully about how to deal with the situation.

Parenting challenges can occur in the following areas:

Health – e.g., your child comes into your room at night and tells you that he/she feels unwell.

Finance – child needs something (e.g., new shoes) but you are short of money at the moment.

Personal – an aspect of the child’s behaviour is emotionally challenging.

Family - Family issues that might cause parenting challenges.

Social - Social contacts that might cause parenting challenges.

Relationship - Relationships that might cause parenting challenges.

Legal - Legal issues that might cause parenting challenges.

Other - all of the challenges that parents face that don’t fit into the above categories.

- 1) Tell me about a recent parenting challenge that you have faced?

Apart from general probes such as “tell me more about that”, probe questions asked about each parenting challenge will include:

Situation

- Can you tell me more about the situation you’ve just described?
- What were the kids doing at that time?
- What time of the day are we talking about?
- What’s the usual routine at this time?

Relationships

- Who else was around at this time?
- Can you tell me a bit about the person or people you’ve just mentioned?
- How do you know them? Are you related?
- When do you usually see them?

Self

- What were you thinking at this time?
- How were you feeling at this time?
- Tell me more about what you were doing at the time

Role of Drugs in the Situation

Questions that follow on from the probes and focus on the role of drug use in the parenting challenge

1) In what way does your drug use fit into this particular parenting challenge?

Probe questions asked during each parenting challenge discussed, these will include:

- To get a time frame on things, when was the last time that you used prior to this challenge (event/situation/etc. as appropriate)?
- If you were off it / on it at the time, how you think the situation might be different?
- So how do you see drug use fitting in with the current situation?

Consequence of parenting challenge and coping strategies adopted

Questions that follow on from the drug relationship probes and focus on the consequences of the parenting challenge and the type of coping strategies adopted.

2) How did you cope with this parenting challenge?

Probe questions asked during each parenting challenge discussed, these will include:

- In the situation you have just described what ended up happening?
- How typical is that outcome for that type of situation?
- Is there anything you would do differently next time?
- What could have helped you in that situation?

Can you tell me another challenge that you have recently faced? (Repeat probes as for question 1 followed by the line of questioning for drug role and coping strategies adopted).

4) What factors aided coping?

5) What are the positive implications of parental drug use?

6) What are the negative implications of parental drug use?

7) What are the factors that influenced a change in drug using behaviour?

8) What are the barriers to seeking support from external based drug treatment agencies?

Appendix B: Information Form (canvassing)

Dear Sir/Madam

My name is Derek Bilton and I am an Honours Student in Psychology at Edith Cowan University. I am exploring the experiences of women who regularly use amphetamines and the challenges that they face when parenting young children.

The project meets the standards and requirements of the Community Services, Education and Social Sciences Faculty Ethics Committee, Edith Cowan University. My supervisor is Greg Dear (9400 5052).

This study was designed to provide an insight into the social realities faced by women such as yourself. It is anticipated that the data from this study will be used to guide future programs that truly meet the needs of women like yourself and your children.

I would like to interview you about your experiences. The interview will be tape-recorded and will take about 90 minutes. The tapes will be transcribed and the recordings will be erased following transcribing. Your name will not be identified on any of the transcripts, nor will there be any way of linking your name to any of the transcripts. Participation in the study is voluntary and you are free to withdraw from the interview at any time.

I would like to hear from you if you are:

- 18 years of age and older,
- A parent of one or more children aged 2-5 years living with you (regardless of whether or not you have other children), and
- A regular user of amphetamines (e.g., at least once a week) regardless of whether or not you also use other drugs.

If you have any questions concerning the project, these can be directed to Derek Bilton on 0408 933080, my supervisor, Greg Dear on 9400 5052 or the Honours co-ordinator Dr Elizabeth Kaczmarek on 9400 5193.

Thank you for your help, it is greatly appreciated.

Derek Bilton

Appendix C: Information Form (consent)

My name is Derek Bilton and I am a Fourth year Honours Student in Psychology at Edith Cowan University. I am exploring the experiences of women who regularly use amphetamines and the challenges they face when parenting young children.

The project meets the standards and requirements of the Community Services, Education and Social Sciences Faculty Ethics Committee, Edith Cowan University. My supervisor is Greg Dear (9400 5052).

This study was designed to provide an insight into the social realities faced by women such as yourself. It is anticipated that the data from this study will be used to guide future programs that truly meet the needs of women like yourself and your children.

I would like to interview you about your experiences. The interview will be tape-recorded and take about 90 minutes but can be longer if there is a lot that you want to talk about. I will transcribe the cassette tapes. All tape recordings will be erased following the transcribing process. Your name will not be identified on any of the transcripts, nor will there be any way of linking your name to any of the transcripts. All data concerning yourself will be regarded as strictly confidential, however, in the event that at the end of our discussion I am concerned about a risk of harm to yourself or others I cannot keep that information confidential. I will need to talk with you about my concern and what we will do about it. Participation in the study is voluntary and you are free to withdraw from the interview at any time.

I would like to hear from you if you are:

- 18 years of age and older,
- A parent of one or more children aged 2-5 years living with you (regardless of whether or not you have other children), and
- A regular user of amphetamines (e.g., at least once a week) regardless of whether or not you also use other drugs.

If you have any questions concerning the project, these can be directed to Derek Bilton on 0408 933080 or my supervisor, Greg Dear on 9400 5052 or the Honours co-ordinator Dr Elizabeth Kaczmarek on 9400 5193.

If you would be prepared to take part in my research, please sign the attached consent form. Thank you for your help, it is greatly appreciated.

Derek Bilton

Appendix D: Consent Form: Parenting Challenges of Women Using Amphetamines

I have read the information above and any questions I have asked have been answered to my satisfaction. I agree to participate in this activity with the understanding that I may withdraw at any time.

I agree that the research data gathered for this study may be published provided that I am not identifiable.

Participant (signature only)

Date

Investigator (name & signature)

Date

Appendix E: Information Form: Children's Participation

Dear Parent/Guardian

I wish to invite you to the follow up phase of this research. We are seeking consent for your children to participate in the research project. This would involve a basic assessment of how your child is functioning at this time. The project meets the standards and requirements of the Community Services, Education and Social Sciences Faculty Ethics Committee, Edith Cowan University. My supervisor is Greg Dear (9400 5052).

This study was designed to provide an insight into the social realities faced by women such as yourself. It is anticipated that the data from this study will be used to guide future programs that truly meet the needs of women like yourself and your children.

The information gathered will come from a variety of sources. These will include:

- An interview with your child covering the topics of hobbies/interests, school, peer relationships and their self-concept
- Completion of a Child Behaviour Checklist (CBCL) by each mother
- Completion of a Youth Self-Report by each child aged 11-18 years
- Completion of a Teacher Report Form by your child's classroom teacher

The interview will be tape-recorded and will last approximately 15- 20 minutes. I will transcribe the cassette tapes. All tape recordings will be erased following the transcribing process. Your name will not be identified on any of the transcripts, nor will there be any way of linking your name to any of the transcripts. All data concerning yourself and your children will be regarded as strictly confidential, however, in the event that at the end of our discussion I am concerned about a risk of harm to yourself or others I cannot keep that information confidential. I will need to talk with you about my concern and what we will do about it. Participation in the study is voluntary and you are free to withdraw from the interview at any time.

Each checklist will take approximately 15 to 20 minutes to complete. Data will then be used to gauge your child's present level of functioning. Neither your child's name nor any other details that could distinguish him/her will be used in any part of the research.

If you have any questions concerning the project, these can be directed to Derek Bilton (95343824) or Greg Dear (9400 5052) at the School of Psychology, Edith Cowan University. If you wish to contact someone who is independent of the project about the study please contact Dr Elizabeth Kaczmarek, 4th Year Co-ordinator (Psychology), Edith Cowan University. (9400 5193)

If you consent to yourself and your child participating in this research and their teacher completing the relevant checklist please sign the attached consent form as soon as possible and return it to the student researcher.

Yours Sincerely

Derek Bilton

Appendix F: Consent Form: Children's Participation

I _____ (the parent/guardian of the participant) have read the information above and any questions I have asked have been answered to my satisfaction. I agree to complete a Child Behaviour Checklist (CBCL) and give my authorisation for the current researcher to make contact with my children's teachers and consent to the completion of a Teacher Report form.

I agree to allow my child _____ (name) to participate in the activities associated with this research including an interview and the completion of a Youth Self-Report Form. I understand that I can withdraw consent at any time.

I _____ (the child of the participant) have read the information above and any questions I have asked have been answered to my satisfaction. I agree to complete a Youth Self-Report Form.

I agree that the research data gathered for this study may be published provided that my child is not identified in any way.

Parent (signature only)

Date

Child (signature only)

Date

Investigator (name & signature)

Date

If you have any questions concerning the project, these can be directed to Derek Bilton (95343824) or Greg Dear (9400 5052) at the School of Psychology, Edith Cowan University. If you wish to contact someone who is independent of the project about the study please contact Dr Elizabeth Kaczmarek, 4th Year Co-ordinator (Psychology), Edith Cowan University. (9400 5193).

Appendix G: Authorisation for Completion of Teacher Report Form

Community Research Project- Edith Cowan University

I _____ (the parent/guardian) of _____
authorise the current researcher to make contact with my child's teacher and consent to the
completion of a Teacher Report form. This satisfying a requirement of the Community
Research Project, School of Psychology Edith Cowan University.

Parent (signature only)

Date

I _____ (the parent/guardian) of _____
authorise the current researcher to make contact with my child's teacher and consent to the
completion of a Teacher Report form. This satisfying a requirement of the Community
Research Project , School of Psychology Edith Cowan University.

Parent (signature only)

Date

I _____ (the parent/guardian) of _____
authorise the current researcher to make contact with my child's teacher and consent to the
completion of a Teacher Report form. This satisfying a requirement of the Community
Research Project , School of Psychology Edith Cowan University.

Parent (signature only)

Date