

A QUALITATIVE STUDY OF PARENTS' EXPERIENCES  
OF HAVING HAD AN ADOLESCENT SON  
IN A RESIDENTIAL SUBSTANCE ABUSE TREATMENT PROGRAM

by

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Abstract

Despite the fact that much information is available in the literature regarding adolescents with a substance abuse problem, little exists that focuses on the parents' personal experience dealing with this problem. Not many researchers actually interviewed parents--when they did, it was usually for parents' observations of their adolescent or their views of treatment success--and seemingly none did so for the purpose of allowing parents to tell their own story in their own words. Furthermore, most of the existing literature has tended to see such parents in terms of their deficits, even when advocating the importance of their being included in the treatment process. Through the lens of a Family Systems perspective and by allowing parents to speak for themselves, this preliminary study explores what it was like for three parents to have had their sons go through a residential substance abuse treatment program. Six categories emerged from the semi-structured interviews: initial departure, settling in, homecoming, resources, costs and losses, and advice to other parents and professionals. The findings expand the primarily negative view of such parents to include a richer and more complex understanding.

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## Chapter I: Introduction

### *The Problem and Its Setting*

Adolescent substance abuse has been a problem to families and society for generations, and recent studies have shown that substance-abusing adolescents tend to come from homes: (1) where there is a greater likelihood of one of the parents also using or abusing substances (Cox & Ray, 1994; Heath & Stanton, 1998; Kaminer & Bukstein, 1998), (2) where families are more likely to be "enmeshed," and (3) where there is often more chaos and less warmth than in families of non-abusers (Liddle, Rowe, Dakof, & Lyke, 1998). What must it be like for probably already burdened parents to cope with a child going through a drug or alcohol rehabilitation program, having come to the point that they felt they had to turn to outsiders for help--or, worse, they were court-ordered to do so? Do they feel guilty? Empowered? Angry? Relieved? Discouraged? All of that and more? Something totally different? How do they find the resources to make it through to the other side, relapses and all? Hopefully, by giving the parents a chance to speak for themselves about themselves, a broader picture can be gained and the information acquired can be used to assist families in their struggle to help their teenagers overcome substance abuse.

Adolescent substance abuse is not an inconsequential matter. Statistics show that the number of substance-using adolescents is sizeable, and, translated into a matter of concern for their parents and families, the magnitude of the problem looms even larger. In 2007, the Substance Abuse and Mental Health Services Administration published the *2006 National Survey on Drug Use and Health*. In this survey of 67,802 Americans age 12 or older, with those 12-17 being "overrepresented," responses indicated illicit drug use

in 2006 among youths age 12-17 at 9.8 percent of the population. According to the *Monitoring the Future: Overview of Key Findings, 2004* (National Institutes on Drug Abuse, 2005), annual prevalence of use of any illicit drug was 15.2 percent for eighth graders, 30.1 percent for tenth graders, and 38.8 percent for seniors. Past 30-day prevalence was 8.4, 18.3, and 23.4 respectively.

As for alcohol use, the *2006 National Survey on Drug Use and Health* (Substance Abuse and Mental Health Services Administration, 2007) found that the rate of current use (at least one drink in the past 30 days) among youth 12-17 was 16.6 percent. Of those, 10.3 percent were binge drinkers<sup>1</sup> and 2.4 percent were heavy drinkers.<sup>2</sup> According to the *Monitoring the Future: Overview of Key Findings, 2004* (National Institutes on Drug Abuse, 2005), 77 percent in a sample size of 49,500 students have consumed alcohol (more than just a few sips) by the end of high school, and nearly half have done so by 8<sup>th</sup> grade. Sixty percent of 12<sup>th</sup> graders and 20 percent of eighth graders reported having been drunk at least once in their life. Two-thirds of high school seniors experience alcohol-related problems,<sup>3</sup> according to D'Amico, McCarthy, Metrik, and Brown (2004, citing O'Malley, Johnston, & Bachman, 1998).

The numbers represented by these statistics are huge, and there have been any number of studies, articles, and books whose ultimate purpose has been to find ways to deal with adolescent substance abuse. Some deal with etiology, risk factors, and

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<sup>1</sup> Generally defined as having 5 or more drinks (5 for men, 4 for women) on one occasion, that is, in a row or within a short period of time (Substance Abuse and Mental Health Services Administration, 2007).

<sup>2</sup> Consuming alcohol in excess of 1 drink per day on average for women and greater than 2 drinks per day on average for men (SAMHSA).

<sup>3</sup> So defined if alcohol causes difficulties in relationships, in school, in social activities, or in thoughts or feelings (SAMHSA).

co-morbidity; some the effects on users, schools, families, or society in general; and some look at potential protective factors. Others address various treatments and programs and their respective effectiveness. However, there seems to be a gap regarding the parents' experiences of having a child in treatment. Researchers' statements about parents, when they occur, are usually based upon the writers' cumulative clinical experience with such families (Liddle, 1999; Wallace & Estroff, 2001) and tend to center around "typical" parental characteristics, behaviors, and attitudes associated with adolescent drug abuse (Cox & Ray, 1994; Heath & Stanton, 1998; Kaminer & Bukstein, 1998; Liddle, Rowe, Dakof, & Lyke, 1998; Weinberg, Rahdert, Colliver, & Glantz, 1998). Researchers who actually interviewed parents typically examined topics like perceived child susceptibility (Redmond, Spoth, Shin, & Hill, 2004), observed adolescent behaviors associated with drug abuse (Ralph & McMenamy, 1996), or parents' opinions of the least and most helpful aspects of whatever treatment the parents had been a part of (Risberg & Funk, 2000; White, Godley & Passetti, 2004).

The dearth of firsthand information on what it is like to have a child in a treatment program seems surprising in light of researchers' observations that many families in treatment have deficiencies in parental functioning (Patterson and Chamberlain, 1994, cited by Liddle, Rowe, Dakof, & Lyke, 1998; Risberg & Funk, 2000). Howard A. Liddle, who directed the first NIH funded center for adolescent drug abuse treatment research, has published numerous articles relating to adolescents and substance abuse, and he, Rowe, Dakof, and Lyke commented that "by the time adolescents manifest serious emotional or behavioral problems, there is often a history of coercive family functioning and parents feel that they have lost control over their child" (p.426). Risberg

and Funk (2000, citing Risberg, 1995) note that "family members experience anger, fear, sadness, frustration, loneliness, helplessness, and hopelessness . . . and blame often follows" (p. 52). Such parents not only need specific assistance to help their adolescent; they need support themselves.

However, in order for mental health professionals to be able to provide meaningful support to parents of a substance-abusing adolescent in a residential treatment program, it would be helpful to know what the experience is actually like from the parents' perspective. Having some of these parents share their story about having an adolescent--in the case of this study, all sons--in such a treatment program is a starting point to better understand the perceptions and experiences of those who have "been there."

### *Significance*

It was hypothesized that interviewing a sampling of parents of substance-abusing adolescents who are recently out of a treatment program would be a beginning towards the illumination of the nature of these parents' experiences; could possibly lead to the discovery of patterns or stages in parental emotions, expectations, and attitudes; and, hopefully, might serve to identify parental strengths and resources. Knowing about such matters can be of great importance to the mental health professionals working with these families as it appears that parents may play important roles in cause, maintenance, and treatment of the substance abuse problems of their adolescents (Liddle, 1999).

As for cause and maintenance, a veritable chorus of researchers have linked various forms of family dysfunction to adolescent substance abuse. Cox and Ray (1994) grouped non-genetic causative factors into three categories: parental substance abuse,

parental attitudes, and parent-child relationships. This tripartite classification is echoed by Kaminer and Bukstein in their 2005 discussion of the topic, which additionally included peer and individual factors. Similarly, Segal and Stewart (1996) linked parental drug abuse and discord, as well as other individual and ecological factors, to adolescent substance abuse. Discussing etiology in their synthesis of the literature on adolescent substance abuse, Weinberg, Rahdert, Colliver, and Glantz (1998) included drug abusing parents and parental psychopathology and suggested that parenting styles, family stress, and child victimization were possible mechanisms. Gabel et al (1998) focused on maternal substance abuse and criminality as the biggest co-occurring factor in their research on the severity of male adolescent substance abuse. Included among Patricia Harrison's discussion (2001) was a wide range of predisposing factors: disparaging and blaming parental communication patterns, poor parent-child relationships, turbulent marital relationships, psychological unavailability, lack of warmth and affection, and neglect and rejection. Wallace and Estroff in their *Manual of Adolescent Substance Abuse Treatment* (2001) stated that "the impact of family pathology on adolescent behavior cannot be overestimated" (p. 236), and they noted, for parents and adolescents alike, poor communication, substance abuse, and a lack of social skills, among other factors. Reviewing over 20 studies linking various forms of child maltreatment to substance abuse, Harrier, Lambert, and Ramos (2001) concluded from an analysis of their own data that a combination of physical abuse, sexual abuse, violence in the family, and a parental history of alcohol/drug use were correlated with adolescent substance abuse.

If parents have a role in causing and/or maintaining adolescent substance abuse, as often seems to be the case, then involving them in treatment should improve the

outcome for substance abusing adolescents, and research supports this thesis. Barrett, Simpson, and Lehman (1988), studying 326 Mexican-American youths concluded that reduction of problems behaviors, including substance abuse, was positively correlated to the degree of family support available during the course of the treatment program. Stowell and Estroff (2001), citing Piercy and Frankel (1989), argued that strong family support of the treatment made a successful outcome more likely, and Schmidt, Liddle, and Dakof (1996) found in an exploratory study a statistically significant association between an improvement in parenting and a decrease in adolescent substance abuse. Writing in 2000, Ozechowski and Liddle noted that "considerable empirical support exists for the efficacy of family-based therapy in curtailing adolescent drug use" (p. 269) and concluded from a review of 16 controlled trials and 4 therapy process studies that there was solid evidence for a positive effect due to involving parents in drug abuse treatment programs. In testing the Multidimensional Family Therapy model against adolescent group therapy and a multifamily educational treatment, Liddle et al. (2001) found that the family therapy model led to the most improvement overall. Citing Brown, Myers, Mott, and Vik (1994), Liddle et al. noted that family support, parenting practices, and the parent-adolescent relationship were empirically established predictors of both adolescent drug problems and treatment success. In Koh's (2003) dissertation study of 440 middle class adolescents, results indicated that the success rate for adolescents was up to 2.2 times higher for those with parent support than for those without. Basing conclusions on what they called the "second wave of family-based intervention studies" (p. 99) and citing numerous other studies, Rowe and Liddle (2003) stated that vis-a-vis standard drug treatments, family-based approaches significantly increased engagement,

strengthened retention, and improved outcome. Adding to this, Shelef, Diamond, Diamond, and Liddle (2005) concluded that the strength of the parent-therapist alliance seemed to positively influence treatment completion and, in conjunction with the strength of the alliance with the adolescent, appeared to improve treatment outcome.

Of all the studies, only one reference was found that concluded that parental participation did not predict treatment completion or outcome, that of Harrison and Ashe (2001). However, this study of 387 adolescents and 363 parents encompassed a wide array of programs, and the existence, nature, and quality of parent involvement components were unspecified.

Given the weight of evidence pointing to the importance of parental participation in adolescent substance abuse treatment programs, the more that is known about the experiences of parents going through this process, the more empathetic and effective therapists and other mental health workers can be. Equipped with this additional knowledge, they can better help parents to access resources and to anticipate and deal with parental ups and downs during their adolescent's recovery process.

#### *Rationale*

It was hypothesized that actual interviews with the parent or parents of adolescents in or recently "graduated" from a substance abuse treatment program would provide detailed, wide-ranging descriptions of the various aspects of living life with a young person making and/or resisting major changes in his or her lifestyle. No quantitative survey, with its pre-set questions, could possibly capture the variety of different parent experiences, nor could it do so with the richness of detail elicited through the interview process. In addition, open-ended questions would facilitate parents'

bringing forward, in their own words, feelings and experiences not anticipated at the onset of the study. The lack of in-depth research or, indeed, seemingly any systematic research at all, indicates a need for exploration of this aspect of adolescent substance abuse, a need hard to meet with a standardized survey. Focus group coverage, another option, would have compromised anonymity, would not have lent itself to adequate exploration of the vast experience parents would bring to such a discussion, and any individual shifts made by parents over the course of an adolescent's treatment could easily have been- blurred together and lost in a group discussion.

### *Theoretical Framework*

#### *Family Systems Theory*

Studying parents when it is the children who "have the problem" is a Family Systems perspective. In such a perspective, causality is viewed as circular rather than linear (Brooks & Rice, 1997; Nichols & Schwartz, 2004); that is, family interactions are not about "who started it and why" but about reactions to reactions to reactions in endless rounds of mutual back and forth. So while an adolescent with a substance abuse problem can certainly be influenced by peers, school, community, and other factors, the primary reality may be that he or she is caught up in a pattern of unhealthy family interactions. For good or for ill, patterns are by definition fairly stable, which brings up the Family Systems concept of homeostasis, in which, in a dysfunctional family system, an individual's symptoms can serve to maintain a certain equilibrium (Hecker, Mims, & Boughner, 2003; Mirsalimi, Perleberg, Stovall, & Kaslow, 2003). This can occur, for example, when marital tension increases, and, to maintain family stability, an offspring may start to use or escalate the use of illegal substances, creating a crisis that takes

attention away from the parental conflict with its potential threat to the family equilibrium. "Triangles" can also form (Nichols & Schwartz) where one spouse, resentful of the other for a particular attitude or behavior, distances him- or herself from the partner and aligns with one of the children, a move which alters healthy boundaries, roles, and hierarchies (Winters, 1999), can be confusing to the child, and can undermine discipline.

In these and other ways, Family Systems Theory provides a context to understand parental attitudes and actions as a major factor in adolescent behaviors, including substance abuse. In Vakalahi's 2001 review of risk and protective factors, the author stated that family relationships and interactions "are among the most powerful components influencing an adolescent's life . . ." (p. 31). Parents are vital, and using them as the unit of analysis for this study is in keeping with the Family Systems principle of circularity, i.e., interrupting at any point in the loop affects all points on the loop because the action of one part affects all, and, likewise, observing one part gives insight into the interactions of all.

### *Phenomenology*

In addition to Family Systems Theory to aid in better comprehending the relationships between parents and their substance abusing adolescents, there is the matter of collecting and managing the data. Phenomenology, as explained by Boss, Dahl, and Kaplan (1996), provides helpful guidelines for the kind of data to be collected and for its analysis.

From a Phenomenological point of view, the participants--in this case, the parents, not the researcher--are the experts on their own experience, and in deference to this

understanding, the researcher must approach her subjects with curiosity, openness, and a "please teach me" attitude. Rather than describing pathology of a family, the researcher is interested in the "story" and in the meaning given to the story by its tellers. Avoiding predetermined categories, the Phenomenologist strives to have the participants define that which is being studied. As she does so, she recognizes that not only does she have her own biases, but that she acquires others as well in the unavoidable act of becoming part of that which is observed. Because that is so, the researcher works to increase the validity of the observations by afterwards having the participants themselves review those observations for accuracy, amending them as they deem necessary.

The Phenomenological process is a recursive one. The researcher values and examines the interconnections of previous research, data collection, data analysis, and the emerging conclusions and theory. Each additional interview, each additional article, enriches and deepens her approach to subsequent participants and authors.

#### *Researcher's Own Self*

As a parent of two grown children and as a former high school teacher, this researcher comes into the proposed study with a certain advantage in connecting with other parents and their struggles to raise their children with the values and behaviors seen as essential to success. However, one's life experience can be a liability as well as an asset--an asset in the form of a sensitivity primed to issues of parenting and success in the world of school and beyond, and a potential liability if one makes assumptions that turn out not to be true, cloud analysis, or preclude investigation of totally overlooked phenomena.

### *Purpose of the Study*

The purpose of the study was to obtain an in-depth understanding of the parental experience of having an adolescent in a residential substance abuse treatment program. The research question for this study was: What were the parents' own beliefs, expectations, and experiences as their adolescent entered, went through, and completed a residential substance abuse treatment program?

Because parent cooperation and investment in their child's recovery has been shown to be an important factor in a successful outcome (Risberg & Funk, 2000; Rowe and Liddle, 2003), the more that is known about parent reactions, the more effectively family therapists and other mental health professionals can encourage and work with them.

## Chapter II: Literature Review

### *The Research Question*

Given the magnitude of the substance abuse problem in the high school population and the importance of the family involvement in treatment success, this paper is a small step towards understanding what the parents experience when their child is deemed so out of control he or she must be placed in a residential facility for a month or more. What has it been like for parents to have an adolescent son in a residential substance abuse treatment program? Adolescents typically live at such facilities for one to six months, depending on their progress, while their parents and siblings continue their usual activities at home, although visits by family members and limited excursions away from the agency are permitted based on good behavior, and weekly family therapy sessions in one form or another are part of program expectations. What is it like to place one's adolescent in such a program, to deal with one's feelings about the teenager's reactions, to see progress and/or relapse, and to anticipate their child's return home--what do the parents themselves think and feel? What does the literature have to say on this point?

The published literature on this particular aspect of adolescent substance abuse treatment seems to be minimal or nonexistent--despite the fact that key segments of many recovery programs involve the parents. Available research seems to be limited primarily to studies about the deficits of the adolescents' parents, about the importance of including parents in treatment, about the parents' evaluations of their offsprings' progress or the like, and about the parents' ratings of program satisfaction. No one seems to have inquired of the parents about what having an adolescent in substance abuse treatment is like for the parents themselves. Furthermore, most programs last a matter of months,

while the adolescents normally return to their home to finish however many years they have left of high school. The difference in time spent in treatment programs versus living at home, plus a Family Systems perspective emphasizing the mutually influencing interactions of family members, would seem to indicate that long-term adolescent drug treatment success would be enhanced by a better understanding of parental attitudes and experiences while the adolescent is away. Knowing parents' ups and downs and also their strengths could enable health care providers to tailor support of such parents to very specific needs, concerns, and skills. This could have the effect of increasing parental participation, which has been linked to increased adolescent success in treatment, as described below.

*The Importance of Parents in Adolescent Substance Abuse Treatment*

Little seems available of what life is like for parents with the adolescent away at a residential substance abuse treatment program, and the information that does exist comes from observations gleaned from observing and working with parents. Few researchers have interviewed them specifically for this purpose, although there are numerous references to the importance of parent involvement in outcome success in a variety of substance abuse programs, some residential and many non-residential. The term "parent involvement" itself can range in meaning from attendance at group psychoeducation presentations for just parents while the teenagers are in the agency program to structured activities incorporating both parents and their children to intensive family therapy.

According to the Center for Substance Abuse Treatment (1993), "Positive family involvement is the best single indicator for adolescent success in residential treatment" (p. 30). Based on a 16-item questionnaire filled out by 199 parents/guardians evaluating

satisfaction and attendance at Family Night programs [a combination of didactic presentations and family counseling], Risberg and Funk (2000) found that "as participation level increased in 'Family Night', personal satisfaction with the program tended to increase" ( p. 60).

Just getting someone with a substance abuse problem into treatment of any kind is also more successful when it incorporates family members. In an overview of treatment engagement success with both adolescents and adults with substance abuse problems, Stanton (2004) found in 30 of 32 studies that the majority of all those who abused substances are closely connected to their parents/guardians, who can be "prime prospects" for getting the abuser into treatment. Writing on family-based treatment of substance abuse, Stanton and Heath (2005) acknowledged other etiologies, but state that "addiction generally develops within a family context, frequently reflects other family difficulties, and is usually maintained and exacerbated by family interactive processes" (p. 528). In their discussion of various stages of family therapy, the authors stated emphatically that "when a substance abuser is an adolescent or a young adult, family therapists believe that parents must be involved in all decisions about the treatment of their children" (p.550). Recognizing parental participation as one of the most influential factors in the substance abuse treatment process, Hsieh, Hoffman, and Hollister (1998) stated that in their pre-, during-, and post-treatment study of 2,317 adolescents, family participation was more significant in predicting an adolescent's favorable drug use outcome than was length of stay in treatment. More general confirmation came from Rowe and Liddle (2003) when they stated, "Family-based treatments are currently

recognized as among the most effective approaches for adolescent drug abuse" (p. 97).

Risberg and Funk (2000) concluded their own study with the following appraisal:

Quality substance abuse treatment demands family involvement. People are more compliant when they feel a part of the process. In fact, many parents have experienced a loss of control as a result of substance abuse. Empowering parents and cultivating hope in their lives are very worthy Family Night goals. Helping the client by helping the family is often not easy, but the rewards for the client are potentially great in terms of a successful recovery process. (p. 63)

Much of the literature on parent involvement in adolescent substance abuse treatments centered on family therapy, which was usually delivered on an outpatient basis. Summing up the ways in which Piercy and Frankel (1989) obtained their research information for a 138-family, multi-site, multi-year study of the effectiveness of family therapy for adolescent substance abuse, the authors spoke of two years of therapy case and videotape supervision, client feedback, and various forms of input from therapists. As part of the conclusion the researchers stated, "Indeed, the adolescent's family can play an important part in bringing about change" (p. 20). Investigating the nature and extent of parent behaviors in Multidimensional Family Therapy, Schmidt, Liddle, and Dakof (1996) coded transcripts of videotapes of family therapy sessions with 29 different families. The focus was on parents' comments and expressed attitudes, and outcome findings were that parents showed a decrease of negative parenting behaviors and an increase in positive ones, and that these changes were associated with reductions in adolescent drug use and problem behaviors. Using adolescent self-reports and a similar

session videotaping/coding procedure with 100 adolescents and their parents, Shelef, Diamond, Diamond, and Liddle (2005) demonstrated the importance of parent-therapist alliances in treatment retention. Stanton and Heath (2005) commented, "Family members are the most effective motivators known . . . by forming alliances and encouraging sober family members to step up the pressure, family therapists help to motivate substance abusers to pursue and maintain sobriety" (p. 535). Clearly, involving parents is seen as a vital part of treatment success.

Parent involvement is at the heart of Wallace and Estroff's (2001) model of intensive family treatment for adolescent substance abuse problems. While they cited no sources for their statements about parents and adolescents, the authors appeared to speak with an authority coming from extensive work with this population and referred to their approach as a "sensible proven treatment model" (p. 235). Describing their program as a continuum of inpatient and outpatient treatment, they require that parents participate in extensive psychoeducational orientation, gender-specific parent groups, individual and family therapy, and weekly two-hour psychoeducational groups.

In Stanton and Shadish's 1997 meta-analysis of 1,571 cases of family-couples treatment for substance abuse, cases that included both adolescents and adults with substance abuse problems, the authors found family therapy the most effective versus individual counseling, peer group therapy and family psychoeducation. Recognizing the value of family involvement but the also expense of family therapy in adolescent substance abuse recovery, the Center for Substance Abuse Treatment and the Substance Abuse and Mental Health Services Administration of the U. S. Department of Health and Human Services funded the development of the Family Support Network (Hamilton,

Brantley, Tims, Angelovich, and McDougall, 2001), a program designed to be a supplement to any standard adolescent treatment approach. The Family Support Network for marijuana users, as laid out by Hamilton et al., provides a limited number of more costly in-home therapy sessions in conjunction with several less costly group sessions that offer psychoeducation and a support for the parents.

Despite the above studies, there is little in the literature that focused specifically on parental involvement in *residential* programs for adolescent substance abuse treatment, although one exception was Winters' (1999) excellent summary of a variety of adolescent treatment programs and issues. He described therapeutic communities for adolescents as being for youth with the severest problems and needing long-term care, which he defined as several months. Compared to programs in therapeutic communities for adults, Winters said that family involvement was emphasized and expanded for the adolescents. In discussing core principles upon which adolescent therapeutic communities are based, he cited what he saw as the first principle, that adolescent drug involvement is "shaped largely by observable family relationships and interactions" (p. 213) and that therefore it was critical to include all family members in the family therapy sessions.

Family involvement also seemed to be the case at one Northeastern adolescent residential treatment center (Fishman, Clemmey, and Adger, 2003), described in a volume on ten outstanding adolescent substance abuse treatment models in the United States (Stevens and Morral, eds., 2003). Included in the many modalities of this particular residential program were a multiplicity of services, including an extensive family evaluation, psychoeducation, and ongoing family therapy and multifamily groups. However, the authors did not have data on treatment outcomes, either in general form or

broken down by component, though they spoke very positively of the program. Four other residential programs were described in Stevens and Morral's compilation of exemplary models of adolescent substance abuse treatment, and all four had strong statements about the importance of involving the family and similar requirements for parent involvement, although, unfortunately, no outcome data seemed to be available for these four programs.

That parent involvement is a vital part of adolescent substance abuse treatment programs seems uncontested. However, much of the published research supporting parent involvement looks only at parents' negative influences on their children and has been gathered from surveys and clinical observation rather than from asking the parents themselves. Hopefully, understanding what parents go through from an "insider's" perspective could provide a more complex view to bear on the strong negative images so prolific in the literature.

#### *Parent Characteristics Viewed As Causative Factors*

As discussed in Chapter One of this study, numerous articles mentioned or elaborated upon family problems associated with adolescent drug abuse. Stanton and Heath (2005) saw substance addiction as "usually maintained and exacerbated by family interaction" (p. 528), and the authors presented a detailed, six-stage family treatment process to address these difficulties. Stanton and Heath also listed additional problem parent characteristics: multigenerational chemical dependency, propensity for other addictive behaviors, more primitive and direct expressions of conflict, and more overt alliances between addict and overinvolved parent, and sometimes denial of a substance abuse problem in the family. In a review of a number of studies, Piercy and Frankel

(1989) affirmed that family correlates for adolescent substance abuse were well documented. Piercy and Frankel refer to "many studies examining families of delinquents and adolescent drug abusers report ineffective parental authority and control, as well as overinvolved or distancing parenting styles" (p. 7), citing studies by Kaufman (1985), Stanton, (1979), and Tolan, Cromwell, and Brasswell (1986). Liddle and Rowe (2006) similarly list poor parenting practices, high conflict, and parent-adolescent disengagement to be consistently associated with adolescent substance abuse and related problems. Wallace and Estroff (2001) profile parents as frequently former or current substance abusers, as exhibiting "imperfect maturity," and lacking critical social skills. Mothers they characterize as often having left a bad home situation and having borne children in their teen years, with mental health problems compounded by past abuse, prescription drug use and abuse, disappointing relationships with men, and the seeking of acceptance from a negative peer group. Fathers they describe as similarly disappointed in relationships with the opposite sex and as having dysfunctional men as role models, in addition to other problems. Wallace and Estroff noted that both mothers and fathers "have often missed affectionate platonic relationships with members of the same gender" and that that "makes it difficult for them to build and teach relationship skills to their own same-gender children" (p.239). The authors detailed a number of these parents' own poor developmental experiences (and hence subsequent deficits in parenting their offspring) and went on to develop a sympathetic portrayal of these parents' frustration, guilt, and lack of understanding about their own behavior and about how to respond effectively to their child's drug use.

In a study of 89 male adolescents, Malkus (1994) found that those with substance abuse problems tended to come from families perceived by the adolescents to be inflexible, disengaged, lacking in pride and harmony, exhibiting marital problems or parental alcohol or drug abuse, and spending little time together. Discussing multiple factors involved in adolescent drug abuse, Dishion, Capaldi, Spracklen, and Li (1995) stated that drug problems commenced and worsened "in a context of low adult involvement and monitoring" (p. 525). This was corroborated in a quantitative analysis of the response of 4,987 adolescents (Dorius, Bahr, Hoffmann, & Hoffmann, 2004) showing that parent-adolescent closeness and parental watchfulness mitigated peer drug use and adolescent marijuana use.

In an article reviewing numerous studies on the topic of parental engagement in child and adolescent treatment for a variety of psychological disorders (vs. specifically adolescent substance abuse treatment), Morrissey-Kane and Prinz (1999) explored the role of parental cognitions and attributions about their problem children. They found that parents who regarded problem behaviors as being inherent in the child rather than being influenced by their own parenting practices held negative cognitions and attributions about the child that adversely affected parental competence, communication, and willingness to engage in treatment.

If parents' involvement and functioning are as important to the success of their adolescent's recovery from substance abuse, as so much research appears to indicate, and if indeed parents have so many deficits that need correcting because they are contributing to the problem of substance abuse, direct investigation of the parents' experience when their child is in treatment, especially an intensive one like a residential stay, might lead to

a more complex and more complete picture. Such an understanding could be a significant resource in the planning and execution of the parent-involvement component.

#### *Actual Parent Interviews and Surveys*

Researchers and program personnel do talk to parents, of course. Staffs of treatment programs frequently had the parents come with their adolescent for assessment interviews to provide information about their child's problems and the family situation and history, and in family sessions therapists may have explored parents' attitudes and stress levels in order to create a good alliance and boost motivation for involvement and change. But these conversations do not seem to have appeared in the literature, other than in generalizations about parents. When researchers interviewed parents for other purposes, such as Ralph and McMenamy's (1996) study of over 100 adolescents and their families in a 45-day inpatient chemical dependency unit, the focus was on what the parents said about their adolescent -- past behavioral characteristics of the adolescent, recovery-oriented behaviors, drug use status, etc. -- not about themselves or their experiences of having their child there. Analyzing the recollections and subsequent observations of the parents, Ralph and McMenamy found that parents described their adolescents as having decreased their drug use and other problematic behaviors and that better treatment outcome was associated with older adolescents, greater participation in aftercare, and less time passage since discharge. In Hoffman, Cerbone, and Su's (2000) study of 861 adolescents, the parents and children completed a self-administered questionnaire on an annual basis for four years, with assistance from trained interviewers as necessary. Questions pertained to stressful life events, support systems, health status, drug and alcohol use, delinquency, and depressive symptoms. The questionnaire was

part the authors' exploration of effects of a number of factors such as sex, income, self-esteem, mastery, and family attachment on the escalation of adolescent drug use during early and mid-adolescence. Their results showed that, while experiencing a high number of stressful events over time was related to a significant increase in drug use among the adolescents, the impact of that increase was reduced significantly by high levels of attachment within the family.

More than one study interviewed parents regarding their opinions of the treatment outcome. For example Richter, Brown, and Mott (1991) examined 160 families during treatment and twice afterwards. The adolescents and their parents completed self-report questionnaires and were interviewed at six- and 12-month post-treatment on the topics of substance use, family functioning, school/work/ peers, emotional health, and interactions with the law. The findings were that those who successfully abstained from drugs after treatment had better social support than adolescents who relapsed and that fewer psychosocial problems post-treatment were associated with higher self-esteem and greater satisfaction with one's social resources. Ciesla, Spear, and Skala (1999) interviewed 119 adolescents and parents separately at 3, 6, 9, and 12 months after completion, using the same questionnaire for both youth and parents in order to assess adolescent self-reports vs. parental reports of treatment outcome. Ciesla, Spear, and Skala found high rates of correspondence between the two groups on questions on substance use for the first three of the three-month periods and high concordance on outcome-related behaviors, suggesting that parents can provide reliable information on their adolescent's post-treatment substance use and related behaviors if they are asked to report on observable behaviors.

Godley, Fiedler, and Funk (1998) assessed 22 community mental health agencies scattered across the state of Illinois, using preset questionnaires for parents (469) and youth (387) to respond in writing regarding their satisfaction with the specific mental health services they had received. Analysis of the data showed that adolescents' satisfaction with the services was significantly less than that of their parents, that the best predictor of parents' satisfaction was their rating of the severity of their child's problem, and that the best single predictor of the adolescents' satisfaction was the type of school attended. In a qualitative study of 12 adolescents and four parents, White, Godley, and Passetti (2004) went into depth on the two groups' respective views of treatment success in their outpatient program and on the most and least helpful aspects of treatment. Devoting three pages to the adolescents in the Results section and a half page to the parents, the authors found relatively little common agreement within or between groups on the two main topics. According to the authors, the adolescents had no clear idea of what to expect in treatment although they had useful suggestions about how to improve program formats. The authors found that parents' views about the definition of treatment success tended to focus more on subjective measures of their adolescents' behavior, like being respectful or being responsible about schoolwork, vs. the teens' emphasis on clean drug screens and reduction in drug use. White, Godley, and Passetti concluded their article by stating that they believed that "these findings illustrate the importance of seeking input from adolescents and their parents to help shape interventions that are more acceptable and thus enhance engagement and retention" (p. 73).

Deskovits, Key, Hill, and Franklin (2004) mailed questionnaires and conducted telephone interviews with 100 adolescents and their parents to survey treatment outcome

in three different types of programs, including one residential, at a Michigan adolescent substance abuse treatment center. Surveying clients and parents from the first five years of the program, the researchers noted high client-parent agreement in the 51 and 61 percent response rate respectively. The authors found that 98 percent of clients reported drug use reduction, 51 percent reported no use since discharge, and 23 percent reported one or two relapses. On other measures, 88.2 percent of the adolescents reported improved family relations, and 90.2 percent reported improved quality of life. The researchers also compared abstainers with relapsers and found that the former were twice as likely to have a diagnosis of uni-polar depression at admission.

One other type of parent interview surfaced. Redmond, Spoth, Shin, and Hill's (2004) telephone interviews with 1,156 parents of sixth graders examined rural parents' perceptions of their child's susceptibility to drug use, their perceptions of their ability to prevent such problems, and the perceived benefits of family-skills programs to prevent drug involvement. The authors found that the higher the risk the parents felt their child faced of becoming involved in substance abuse problems, the more likely the parents were to see the benefits of engaging in a family-skills drug-prevention program. The researchers found that factors such as being married, being a father, having a daughter (vs. having a son), and/or being a resident of a small, less economically stressed rural community all decreased the perception of one's child's being at risk. They found that, unfortunately, that in turn decreased the likelihood of participating in family-focused, drug-use prevention programs, despite published findings that substance use by rural adolescents equals or exceeds use by non-rural teens for some substances (citing the National Center on Addiction and Substance Abuse at Columbia University, 2000).

Mallick, Evans, and Stein (1998) employed questionnaires sampling 947 parents of 14-16-year-old teenagers and followed up with 60 telephone interviews to explore parents' concerns, needs, and knowledge of drug issues in relation to their adolescents and to inquire about these parents' perspectives on drug education. The authors also analyzed data from six focus groups of primary and secondary school parents. The findings showed that parents were concerned about drugs' availability, that the parents were largely misinformed about drugs and school drug policies and programs, and that they requested up-to-date information and better access to relevant services.

Neither of these last two studies, which sampled parent opinion by phone, questionnaire, and focus group, directly addressed treatment issues, and both also dipped down into younger student age levels in the data gathering process.

However, two other studies, although small, stand out in examining parents' experiences, even though not pertaining to having an adolescent in a residential substance abuse recovery program. Butler and Bauld (2005) conducted 21 in-depth interviews with mental health professionals and parents regarding the availability of services for their heroin-using offspring in "a relatively deprived part of England" (p. 37) . Both quoting and summarizing comments of the nine parents interviewed, the authors made vivid the shame and self-blame these parents felt at discovering their youth was addicted to heroin, the difficulties they had in finding appropriate services, and, without services or family support, their feelings of aloneness in facing such a problem. The authors discussed with the participants the devastating impact their offspring's heroin use had on the family, and parents spoke of the escalation of conflict, loss of trust, their isolation from family and friends, and financial, emotional and health problems. In talking with parents, Butler and

Bauld found that parents' having access to supportive services made a significant difference for them: reduced their sense of isolation, provided knowledge about drugs, resulted in more compassion for their son or daughter, and improved the way they related to and helped their offspring.

The other study that examined the parents' experience by talking about it to the parents themselves was Walsh's (1997) unpublished master's thesis, a qualitative study of parents who, for a wide variety of reasons--not just substance abuse--had adolescents in family therapy. Walsh conducted 60-90 minute initial interviews and 20-minute follow-ups with 15 parents in family therapy with private practitioners. She found that these parents were willing to share their pre-therapy experiences with her , that the pre-therapy presentation affected the way the parents initially approached therapy, that a strong therapeutic alliance was necessary to accomplish the therapeutic work, and that parents were able to identify changes that family members had made and elaborate upon what they liked about the family therapy process.

### *Summary*

Relatively little information appears to exist in the literature about parents' own experiences of having an adolescent in substance abuse treatment programs, even less about having a child in a residential treatment facility. Furthermore, in a recent and comprehensive book on current research in the field (Liddle and Rowe, 2006), no mention is made of a need to examine parents' own experiences. Thus this study is an attempt to fill the existing gap so that, by interviewing the parents themselves about their own experiences, more is known directly about what it means to have one's adolescent in a residential substance abuse treatment program.

## Chapter III: Methods

### *Participants*

The participants were to be taken from a convenience sampling of parents who had an adolescent who had completed a residential substance abuse treatment program within the past two years or who currently had an adolescent considered by his or her program manager to be most of the way through such a program. As set up, the term "parents" included two parents, or one parent and/or step-parent, or another family member or guardian who had been involved like a parent in the child's treatment.

The original goal was to interview a minimum of six sets of parents, who, because of confidentiality, were to be contacted first by the agency through counselor encouragement and letters of inquiry. However, of 80 letters sent out, only three recipients volunteered--all single parents at the time of their adolescent's participation in the agency's residential program, and all with sons rather than daughters in the program. These three parents followed through when subsequently contacted by the researcher and were the ones interviewed for this study. Although a larger number would have undoubtedly provided greater diversity among families, these three had differing financial circumstances and were of two different ethnic groups. In addition, one of the boys was recovering from addiction to heroin, which created a magnitude of parent problems different from the two sons that were dealing with addiction to marijuana.

### *Procedures*

1. Recruitment. The researcher was fortunate to have one of the area's most well-known agencies to work with for the recruitment of parents. The agency gave generously of its time and resources. The agency agreed to contact parents of adolescents in the

program and in follow-up groups, with agency staff drawing attention to the study and inviting parent participation (see Appendix A, recruitment flyer). However, there were several director departures during the recruitment period, and recruitment may not have been emphasized as much as originally intended. Nevertheless, 80 letters of inquiry (Appendix B) to current and former program families were mailed out, and for those parents who were interested and willing, an agency staff member had the parents sign a release form (Appendix C) giving their permission for the agency to supply Virginia Tech with the parents' contact information. The researcher then called responding parents to explain the purpose of the study, encouraging them to share their experience. The researcher confirmed that the parents were willing to participate, and she set up an appointment time for a telephone interview. (The original intention was to have face-to-face interviews at an office at the agency, but those who responded lived three or more hours away, and so the researcher obtained clearance from the Institutional Review Board to conduct the interviews by telephone.) Those agreeing to participate received a follow-up letter (Appendix D) to verify the initial phone agreement. It restated the purpose of the study, thanked them again for being willing to be interviewed, reassured them of confidentiality, and reminded them of their opportunity to review the transcript after the interview.

2. Consent and confidentiality. Enclosed in the initial follow-up letter was the three-page consent form (Appendix E), with a prepaid envelope for its signed return to Virginia Tech. The researcher called participants to verify that they had received the letter and consent form and to confirm their interview appointment time. At that time, she made sure that all their questions about the study and matters of confidentiality were

fully answered, including procedures, risks and benefits, compensation, freedom to withdraw without penalty, and the extent of the parents' anonymity and confidentiality. With respect to confidentiality, the audiotapes of the interview and the typed interview transcriptions were kept in a locked file and only the researcher and her advisors had access to them. All identifying information was removed from the copies of the interview, and the tapes will be destroyed when the study is completed. Prior to the parents' signing the consent form, it was also explained that the study was approved by the Virginia Tech Institutional Review Board (Appendix F) and that an NIH Certificate of Confidentiality (Appendix G) protected their identifying information permanently. Pseudonyms were assigned to participants for purposes of written or oral presentation.

3. Collection of demographic information (Appendix H) At the time of the telephone interview, after receiving the signed consent form, the researcher had the parents provide demographic information: contact information for the family; the parent or parent's names, ages, and ethnicity; the name and age of the adolescent in the residential program; the adolescent's length of time in the program; the ages of other children in the family; and the names of any previous treatment programs.

5. Interview (Appendix I). The first part of the 60-90 minute meeting with parents, the gathering demographic information, served to ease into the research topic. The actual interview questions were designed to elicit responses about the parents' emotions and expectations as they originally placed their adolescent into the residential substance abuse program, as they dealt with the reactions of their child going through the program, and as they looked back upon the whole experience. The interview also included open-ended questions about their highs, lows, and possible parental "stages"

during the treatment period and about the advice they had for other parents and for mental health professionals.

6. Transcription. Having completed an interview, the researcher transcribed the tape of the conversation with the parents, locked up the original tape, and used the hardcopy transcription with pseudonyms for all further work.

7. Analysis. After transcription of an interview and relying upon Phenomenology to guide the analysis, the researcher went over the transcripts from beginning to end, using open coding to discover the varieties of categories for subsequent analysis (Strauss & Corbin, 1990). From there, along with memos and field notes, (Boss, Dahl, & Kaplan, 1996), the researcher shifted to axial coding, discussing her observations with her faculty advisor Dr. Eric McCollum. Dr. McCollum cross-coded several parts of the interviews for reliability. Using axial coding, the researcher organized data into temporary themes or motifs, which were subject to change as information from the interviews accumulated (Strauss & Corbin). In the final stage of analysis, the researcher employed selective coding to finalize her interpretation of the differences, similarities, and other insights gained through this recursive process. Conversations with faculty advisors were an invaluable component of the analysis and indeed of the all of the parts of this study as these more seasoned researchers offered their reflections and suggestions.

8. Interview transcripts. After the interview, along with a cover letter thanking each participant (Appendix J), the researcher mailed a copy of the interview transcript to the parent, requesting that the parent look it over in anticipation of a telephone discussion regarding accuracy.

9. Verification. The researcher called the parents shortly after mailing the above to give them an opportunity to discuss the contents and accuracy of the findings and to ask if they have anything they wanted to add, change, or delete (Appendix K). Parents changed very little of what they said, primarily adding a few additional details to some of their account, as well as making a few changes in the accuracy of a time or a name, or fixing a grammatical wording.

10. Literature review and faculty input. As an ongoing process, the researcher searched the available literature and consulted with faculty advisors.

## Chapter IV: Results

This research project was undertaken to develop an in-depth understanding of the experiences of parents who had or recently have had an adolescent in a residential substance abuse treatment program within the past two years. Working with an agency in a large, Northeastern metropolitan area, the researcher interviewed all who volunteered to participate in the study, which turned out to be the parents of three sons who had completed a residential recovery program at the agency. These three were all single parents--two Caucasian mothers in their 40's and a 60-year-old African-American male--and all lived a considerable distance away from the program site.

Each parent struggled with different levels of difficulty, particularly the parent whose son was addicted to heroin, yet they struck a number of similar notes in sharing the hardships and hopes of having a child far away in an addiction treatment program. Amid different family structures and varying financial resources, all three parents evidenced a deep love and concern for their troubled offspring, and categories of both similarities and differences began to emerge in the interview process. The final categories, reflecting various aspects of the parents' perceptions, beliefs, and behaviors, are presented in this chapter.

The story is a summary of the common themes expressed by the parents as they shared their experiences. The background for each of the three families provides a framework for the description of the findings--six core categories and various subcategories that emerged during the data analysis. The names of all those involved have been changed to protect their identity and maintain confidentiality, but their words are their own and serve to make vivid their respective views and individual situations.

### *The Story*

The parents in this study faced ongoing problems with their adolescent sons, who were involved in drug abuse and other difficulties and for whom a residential treatment program seemed appropriate. The story is about what their experiences were as they placed their sons in such a program, as they dealt with his being a significant distance away from home for an extended period of time and for such a purpose, and as they handled his anticipated and actual return to the family. The stories were full of emotion and concern: fear, hope, sense of loss, cautious eagerness, disappointing events, encouraging events, but with worry or longing as a constant shadow, looming large or shrinking down, but present always. The parents were actively supportive of their sons as well as resourceful in finding assistance and encouragement for themselves, particularly essential in moments of self-doubt or heightened concern.

The role of the researcher was to elicit from each his or her own particular story, giving the person a chance to be heard and understood, not just as somebody's parent assessing his or her adolescent's progress or a program's effectiveness, but as an individual with emotions, interpretations, and behaviors of his or her own.

### *Case Studies*

*Case study #1: Willa Browning and Tad.* Willa Browning was a 41-year-old, single mother whose 18-year-old son Tad was a recovering heroin addict. She seemed eager to participate in this study for a number of reasons: to share what she went through personally, to warn parents of the ready availability of heroin and the leniency of the law, to raise serious questions about treatment procedures, and to protest what she felt was a general lack of help for families struggling with drug-addicted young people. Originally,

her 20-year dream for her son had been to give him a small house of his own not too far from hers when he turned 25:

That way he wouldn't have to struggle as hard. If he wanted to live in it, he could live in it. If he wanted to sell it, he could sell it. It's nice out there. If there's something he wanted to build or whatever. He's my only child. I was five years from having it paid off. As a single parent I didn't think that was too bad.

But her dream was not to be. According to Willa, when Tad was a senior headed for college and "on his way to a full ride, ball scholarship," he became addicted to heroin because his father, who was a heroin addict, "got him started on it. . . . [That way] he wouldn't have to be by himself." Once hooked, Willa declared, "he went from having it all to having nothing within a matter of days." She spoke of having to sleep on her pocketbook at night to prevent her money's being stolen, of fearing for Tad's safety every time he left the house, of rushing him to the hospital semi-conscious and hallucinating, and of paying thousands of dollars to repair her son's neglected, acid-eaten teeth. She recounted various measures she had taken to try to get her son help, including getting one-on-one counseling for herself and for Tad, urging the police to pull her son over if they saw him disobeying any rules while driving, requesting a petition to the court for official help, and paying for expensive surgical implants to keep the drug from producing a high. The residential stay, a 30-day stay, was the third recovery program Tad had participated in, and Willa described her experience of that 30 days as both a relief and also a very difficult time. Her son called home often to berate her for putting him there, and "he was on the phone with his dad time after time. His father'd get him all upset--'Your mom is going to court and suing me for non-support,' and stuff like that." Tad also

ran away for a little over an hour while at the residential program, and Willa described not knowing where he was or what he was doing as "terrifying."

The ongoing financial and emotional crisis took its toll on Willa physically, and she had difficulty with migraines, depression, and elevated blood pressure. She said her tears and prayers were constant--"it's any parent's worst nightmare!"--and she felt very grateful that her family, her fiancé, the school, and the people at work were all so supportive. Tad graduated from high school and stayed clean for four months after his discharge from the residential program, and "then he fell back into it." Realizing she was worn out from the ordeal with Tad (and also with having earlier dealt for years with her own alcoholic parents), "the day he turned 18," Willa said, "I told him he had to leave my home because I couldn't continue living with him, because I was going to end up dead or in the hospital," and she made him leave the house. At the time of the follow-up interview with this researcher, Tad was on a methadone program and, although Willa objected strongly to that approach, her love for him was every bit as evident as before. Speaking of what she had been through, she commented:

All I want to do is save my child. It didn't mean--selling my house, or driving a 30-year-old car, whatever I had to do--none of that meant nothing. The only thing that meant anything to me was my son and knowing that he was going to be all right . . . I will always love Tad. I may have to love him from a distance. But still, nobody could be any prouder or any happier.

*Case study #2: Viola Jenkins and Darrell.* Like Willa Browning, Viola Jenkins seemed to be glad to have the opportunity to tell her story. She was 46 and had two other

children, ages 9 and 13, in addition to Darrell, who was 17. Unlike Willa, however, who talked primarily of her son's concern for his father and of the danger and deleterious effects of the drug itself, Viola spoke more of Darrell's problem behavior at home and with other boys in and out of school, which ultimately led to Darrell's 90-day stay at the residential recovery program at the agency.

Viola said that the trouble began five years earlier when she and Darrell's father were divorced and her son would spend custodial time with his father, going from a more rural, isolated situation to a city environment where there were more ways to get in trouble and less in the way of supervision. A fight, problems at school, a court appearance, probation, testing positive for marijuana, and other difficulties led to a short stay at the juvenile detention home. Darrell continued to have problems: "He talked to me any way he wanted to, and he didn't want to go to school. And there was always the fear about drugs and alcohol doing things to people. He would be violent; he would punch doors."

Viola said she felt more and more at a loss, yet "I didn't want to admit I couldn't control him . . . and his dad couldn't control him either." However, Viola said she still was not ready to take the parole officer's advice to put Darrell in a drug program, even though "intellectually I knew it was a bad choice." They tried individual counseling and anger management for Darrell as well as group counseling for the family. A social worker was assigned to the case; the first was helpful, the second was not. It was after a D.U.I. charge in conjunction with five other violations and Darrell was faced with another, longer stay at the juvenile detention home that Viola, not wanting her son to

return to "jail for kids," as she termed it, proposed the agency residential program as an alternative and the judge agreed.

Viola's experience of her son's stay at the residential substance abuse treatment program was much smoother than Willa's. "Darrell called me a few times in the beginning wanting to come home, but he knew he had to stay three months because of the D. U. I and all," but "for the most part he behaved," and she felt encouraged by the progress he made. She was pleased that he began speaking more respectfully to her and that he said he was talking a lot at the AA meetings he was required to attend. She liked that he seemed able to manage his temper better and his behavior was much improved when he was at home on weekend passes. Like Willa, Viola felt bad about having to put her son in a residential drug treatment program, but for Viola, the hardest part was contrasting her son's very regulated life with the family's freedom--"our life went on as usual and his was controlled"--which for her hit most intensely at dinner time: "he's a gourmet cook . . . and up there there's just a bunch of guys cooking for him."

Viola expressed gratitude for the support she received from her family, friends, and co-workers, and, like Willa, spoke of all the things her boyfriend did to help her with Darrell. Viola was relieved when, at program's end, he returned to school and graduated with his class, although knowing the honors she felt Darrell surely would have won without the drug and behavior problems made her very sad--"no awards." At the time of the follow-up interview, Viola was still worried about peer pressure, noting, "I can see some of the behaviors and the anger coming back," and she wondered how he managed to lose his cell phone, "his life line," the previous night at the graduation trip with classmates to the beach.

*Case study #3: The Reverend Manfred Williams and Barry.* The third participant, Reverend Manfred Williams, was a talkative, 60-year-old African-American minister, motivational speaker, and father to 17-year-old Barry and an older sister. Reverend Williams<sup>1</sup> seemed glad to share his story for this study and also had plenty to say about young people, drug abuse, parenting, and dealing with a recovering adolescent. Barry's mother was a drug addict, and the couple had split when Barry was six, but Reverend Williams "wanted to give her the opportunity to clean herself up--get a job, take care of the kids, and stuff like that--but that fell through the wall." The Reverend obtained full custody of his two when Barry was 14, but trying to keep his children connected with their mother and two half siblings resulted in Barry's smoking marijuana with his mother, "and it was laced with crack cocaine and that's worse. I didn't know. Even though he was doing good in school, he was running here and there and everywhere at night. Diana--that's his older sister--she was taking care of them." While the daughter graduated from high school with honors, Barry's situation deteriorated as he started skipping classes, popping over-the-counter pills, and huffing household products, eventually ending up in several detention homes before spending six months in the residential substance abuse recovery program at the agency. Reverend Williams had spent a lot of time on outings with his children and the fact that Barry was far away was "hard, a hard feeling," especially since the Reverend had health problems, used a walker for back pain, and was unable to travel to visit his son.

I mostly did a lot of praying and I had support from my church. People at my church let me know I wasn't the only one [with a teen with a drug problem]. I got

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<sup>1</sup>A note regarding the usage of names: The two mothers seemed to prefer a less formal conversational tone than the father, who went by his ministerial title, "Reverend," and so the use of first names for them seemed appropriate while preserving the more formal form of address for the father.

involved in the youth movement in church and in the anti-drug movement in church. Then I started talking about the drug problem on my motivational speeches, telling parents to be aware of their kids and all that.

Although hard on Reverend Williams, having Barry at the agency did provide relief. Like Willa and Viola, he found the frequent crises at home stressful: "That stress on your body took quite a toll, and I started feeling better and also, you know, I could accomplish more than I had been able to before." It was near the end of Barry's stay at the residential program that Reverend Williams said things turned around for him when he realized that he did not have any control over his son's situation. "I had to accept. I found out that that began to loosen things up because I knew I couldn't control what happened. I had to *work* with it." Upon Barry's return home, Reverend Williams said he became more actively involved in his son's rehabilitation, and while there were still problems to deal with, at the time of the study's follow-up interview he was hopeful about his son's having a career in computers. He was very concerned about how young the children were that were getting involved in drugs, and he had strong words urging parents and professionals to get involved with their children and their schools. As for the cost to himself of dealing with Barry's addiction, Reverend Williams stated:

It's money also, but that's not the most important part. I didn't look at the dollars part. I looked at it as my son's life, and his life is worth more than money. I'll get that back some other way. The only thing I wanted to do was save his life.

#### *Core Categories*

While each of these parents' stories was unique, there were common themes and experiences among them. Analysis of the data led to the formulation of six core

categories, the first three of which are chronological. These six categories provide a conceptual framework for the description of these three parents' experiences of having an adolescent son in a residential substance abuse treatment program. The categories with their subcategories are as follows:

Initial Departure

Settling In--Unique Situations, Unique Responses

I. General Reactions

II. Turning Point

III. Involvement in Alcoholics/Narcotics Anonymous

IV. Running Away

V. Worst and Best While at the Agency

Homecoming Anticipation and Concerns

Resources

I. Personal Contacts and Official Agencies

II. Alcoholics Anonymous and Narcotics Anonymous

Costs and Losses

I. Money

II. Health

III. Dreams and Expectations

IV. Emotional Costs

Advice for Other Parents and for Mental Health Professionals

*Initial Departure.* Having made the difficult decision to send his or her adolescent to a residential substance abuse treatment program and with the teenager left in the hands of the program staff, the parents reported feeling a set of conflicting emotions. All three parents in this study had an emphatic and identical response about this point in the process: "It was *hard!*" They knew they would not be seeing their sons for a month or more and realized too that any visiting time would be very limited.

For Willa, guilt and worry were intense. Despite her son's clear need for a higher level of treatment than outpatient, Willa--and Tad as well, she said--were "worried that the people wouldn't understand what it was like for him, being on heroin." According to Willa, no one else in the program at that time was there for problems with that particular drug.

They were all in there because they had got caught smoking a joint here or they had been caught with possession of marijuana. They couldn't relate to anything Tad was going through because, heck, [compared to the difficulty of quitting heroin] that was like chewing bubble gum! . . . . They don't know what a hard time, what this s--- does to you!

She then elaborated on the horrendous physical reactions to withdrawal, concluding with, "It's a terrible ordeal, something you never ever want to see, especially in a child of your own."

In addition to the ongoing doubts about whether others at the agency would understand her son's situation, Willa also faced the guilt of having forced her son to be in the program, even though she did it with the hope of its helping him:

It was heartbreaking. I cried and I cried because, you know, he didn't want to stay. He hated me due to the fact that I was leaving him there. He would call me on a regular [basis] and go off on me and tell me he was going to run away and he was going to do this and he was going to escape from the building. Just [*pause*], I was in a constant panic because I didn't know . . . . He has no--he does things before he thinks, and, you know, I was very concerned about what was going to happen. It was just--it was devastating.

In addition to the guilt, Willa was worried, scared that if something happened or Tad ran away, that "by the time I got up there it would be three hours, and God only knows what can happen to you, you know, in that length of time!"

Reverend Williams did not speak of feeling guilty, and his view of the distance was more that it prevented him from seeing his son, rather than its being a barrier to physically rescuing him. However, a sentiment the Reverend expressed at least three times in the course of the interview was the fact that a lot of Barry's problems, like at school and with the drugs and pills and poor friendship choices, were things that he found out only when the situations had gotten serious. Giving advice to parents to be watchful over their children, he stated, "The father is always the last to find out things." If he could be described as feeling guilty, it would be over this issue, rather than over placing Barry in an out-of-town residential treatment program. What he did speak of was embarrassment, but tempered with the knowledge that he felt he was doing the right thing:

It was, it was--I put it like this, it was kind of embarrassing, but so long as I was helping him it didn't bother me. In my mind I wondered how did he get involved

in this taking drugs and skipping class and hanging out with guys like that and I just didn't know!?

Like Reverend Williams, Viola also talked about embarrassment, although she seemed to feel it more keenly than he did:

It was very stressful. I worried a lot, and in a way it was embarrassing. Darrell had been a private school his whole life. He had every opportunity to do well. It was embarrassing. We didn't raise him to do this. I was divorced five years ago and that's when it started. The whole family was embarrassed. When he was away, his sister would tell people he was at camp.

Viola felt bad, too, even though she knew the other alternative, the juvenile detention home, would have been worse:

I had a lot of guilt. It wasn't my fault, but I felt responsible because I had pursued this. I had initiated this because I thought it was better than the detention home. I was very upset. It was upsetting to see your child handcuffed and taken away.

Nevertheless, both of the mothers also expressed a sense of relief and hope. Willa spoke of not having to worry about her son risking his life or getting killed:

In another way, it was 30 days that I knew he wasn't going to be going downtown or the police wasn't going to be knocking on my door and telling me, you know, "Your son's been shot downtown trying to buy drugs," or I would come home and have my stuff in my house be gone because he's took it to the pawn shop, you know, to get his next hit. I mean it's one of the worst things you can ever imagine!

She said the first night she left Tad there, she was "really, really depressed' at the thought of being able to see him only once a week, but that she was "hopeful that this was what it was going to take to make him see the light and that he still had his whole life ahead of him." Viola echoed this theme when she commented, "It was a relief to know he was safe and that hopefully this would make the difference and he would snap out of it." For both of them there was a respite from the tensions at home--from the threat of items being stolen to buy drugs, from the backtalk and the arguments, and from acting-out behaviors:

As a parent, if you've been through what I'd been through, well, frankly, it was nice not to worry about him or have to deal with him. It was a relief. Every day was a struggle. He was very demanding. He wants to do this and do that. I have two other kids, and he causes a lot of controversy [arguments]. It can be stressful and difficult, and it gets to be impossible. He was always doing stuff and he talked to me any way he wanted to, and he didn't want to go to school. Knowing he was in a controlled atmosphere, it was peaceful. And there was always the fear about drugs and alcohol doing things to people . . . . Having him in the program, it was a relief, like a vacation not to have him home with me. We actually went on a vacation while he was away! I felt guilty, but it was a relief.

As for Reverend Williams, despite his comment earlier about his health suffering because he missed seeing his son, he later stated that with the stress gone of having his son at home, his health began to improve. He also talked about the whole family 's being affected by his son's behavior: "Other members of the family suffered, too. For example, Barry would take things from his sister, [and Reverend Williams would think] 'Lord, help me with this!' " The Reverend did not speak directly of hope, but when he discussed how

hard it was having Barry away, he talked about getting involved in the anti-drug movement, about which he said, "It helped me a lot. I learned about support programs and all kinds of things."

*Settling In--Unique Situations, Unique Responses*

Once past their sons' initial entrance into the residential program, the parents had varying reactions to what they saw as the boys settled into their respective residential treatment programs. The three parents also had differing reactions to the Alcoholics Anonymous (AA) component of the program, and only Willa had to deal with her son's running away while at the agency. Significantly, the parents each identified a unique turning point for themselves vis-à-vis their sons-in-recovery. Last, they all had their own opinion of what was the best and worst part of having an adolescent in a residential substance abuse recovery program.

*General reactions.* It seemed to take Willa's son Tad longer than the other two to adjust to his new circumstances, and Willa recounted her first visit as a most painful experience:

When I got there he was so angry at me because I wouldn't take him home and him blaming me. I was hurt and I walked out of there and I had drove three hours up there to see him, you know, and he reams me out. I didn't stay ten minutes to see him because he cussed me out the whole time I was there. I was so hurt that I didn't know what to do. I just sat out in the parking lot two hours bawling and, you know, regrouped to be able to get myself home.

Even though the intensity of blame eased off after that, which was an improvement, Willa reported still feeling wary about the situation because she did not trust that Tad was

actually using the program to turn his life around:

It was in the third week I felt more like he was trying to pull the wool over everybody's eyes, like he was telling them what they wanted to hear. You know, "Well, I'll go ahead and play the game. I'll tell them what they want to hear and I'll get out of here." You know.

For Willa, the shift from initial departure to settling in could be described as more of a transition from a lot of pain, mingled with some relief and hope, to a reaction of skeptical caution--a definite improvement, but not a major change.

For Viola, on the other hand, the movement was steadily positive and she was pleased with the progress Darrell was making. After some initial protest calls home, Viola noticed that he was being more respectful in his conversations.

He changed after talking to them. It didn't take long. He changed up there and he started to talk nicer to me . . . . I was glad when he started talking to me with more respect. He got to have day trips because he had earned them through good behavior, and then when he came home for a weekend he was a totally different person than what he used to be while doing drugs . . . . He got to move up from his first room to a bigger room, and then, he was behaving, he got a room with a shower. Just little things like that, knowing he was improving.

For Reverend Williams, it was a matter of recognizing the level of difficulty in the situation and resolving to do whatever he could; taking classes himself; and spreading the word to other parents:

I want to be the best father I can be to him. I don't want to see him fail. I have to continue to fight the fight. I guess I was just determined--you

*have* to be! Plenty of times I wanted to give up. I've been through this and I've been through that and it's so much, but, then, well, I can't do that. I have an obligation and I have to take care of my child and do the best I can, and then, if I can't do any more, then I can say I've done my best. I had determination at first, but my understanding at first was that it wasn't going to be that hard. After all, I was the father, he was the son. But the deeper he went and the more understanding I got, the more determined I became.

*Turning point.* Each of the three parents had his or her own inner "turning point," that experience inside themselves that signaled a major change in the way they viewed the situation. For Viola, that moment came relatively early in the course of Darrell's residential stay. She had been talking to him on the phone and liked the more respectful tone he was using--this from the boy whose previous interactions she had described as "always an argument." Viola had been pleased about the good reports she was getting from the program staff, including his earning a switch to a better room, but it was not until she was actually present with Darrell to witness the change for herself did she let herself truly believe that real change was taking place:

We went up to spend the day. He had to earn visits and you could get an overnight and a whole day. He'd earned 12 hours, and we were going to [a nearby city] and do things and he was excited. [But right before the kids and I got there,] he'd gotten caught with some cigarettes, and we were only able to eat and come back. He only had an hour and a half and then had to go back. Used to be that he

would have thrown a fit if something like that happened, but he didn't . . . It was *seeing* the change in his behavior. Talking to him over the phone he seemed better, but actually *being* with him was proof to me that it was the right decision.

For Reverend Williams, the turning point was less about Barry's behavior than about a shift in how the Reverend viewed his son's situation. At first Reverend Williams talked about the turning point's being the improvement in his health--"I was getting better health-wise, and I really needed that!" but when asked if it was something inside him that changed then, he described his feeling of lack of control in terms of a metaphor of constriction and release. He exclaimed:

I *know* it was something inside of me! On the inside I was kind of bottled up on the inside and felt something binding me and I couldn't break loose from it. It was just something, something I didn't have any control over--whether he was going to get better, you know--you can't change it . . . It happened near the end of [the residential program] and a little while afterwards I would say because I knew my son was coming home and I would be able to see him. I would say I meditated and went over things that seemed to have me bound and knew I didn't have any control over that. I had to accept. I found out that began to loosen things up because I knew I couldn't control what happened. I had to *work* with it.

"Letting go" proved to be the key for Reverend Williams' coming to peace with the ongoing situation and also for feeling more motivated to increase his involvement with his son upon his return home:

The more understanding I got, the more determined I became. I got involved in his rehab. I decided I could show him, I could see and do different things to get

his mind clicking. To get him to see things in another way, some kind of way, I took him to three areas [of town] to see how people were living. "Is this kind of life you want? What is your plan to get there? You have to have a plan."

Willa's turning point came later, seven months after Tad had completed the residential program. Back home again, he had stayed clean for four months after his discharge, but then, once more, heroin renewed its hold on him. Two months later Willa created her own "release" from the long strain of care and worry:

This is going to sound terrible. The day he turned 18, I told him he had to leave my home because I couldn't continue living with him--because I was going to end up dead or in the hospital from my blood pressure and worrying myself to death! I had tried everything in God's power. The only thing left *to* try was tough love. If he got out there and hit rock bottom, maybe he would realize what I was trying to get through to him.

I had lost control of Tad, the Tad that I knew and raised and loved. For two and a half years I had kept him alive, kept him out of trouble. I'd managed to get him through high school--he graduated and walked across the stage with his graduating class. And the harder I tried to tell him and show him and help him, the more he deliberately went out and did things to hurt me because he knew at that point anything that he did *I* felt responsible for, and by law I was. He went out and robbed somebody or hurt somebody, you know, he ends up in the hospital--*I'm* the one who's got to pay the bills, *I'm* the one that's got to pay the restitution.

At 18 I was like, "Tad, you want to be adult, be an adult but you got to--I can't live like this anymore! I can't cry myself to sleep every night. I can't sit up to 2-3-4 in the morning because you haven't come home and I got to get up at 4:30 in the morning to go to work. You know, I can't. I had done everything that everybody told me to do--the doctors, the counselors, the school, the judges, the police. It came to a point to where if I didn't let go, I was going to die and then I *really* wasn't gonna be around anymore!

*Running away.* In the course of a substance abuse treatment program, outpatient or residential, it is not uncommon for those in recovery to relapse, that is, have a "dirty urine," or to become involved in some form of treatment noncompliance, like running away. When asked about whether either of these things had happened to their sons and if it did, what was it like, two out of the three participants simply said no, these sorts of things were not a problem. In fact, Reverend Williams stated:

No, there were no relapses while Barry was in the residential program because he was away from things--people, places, and things--and not being with the same [drug using] group. They use anything as an excuse to walk out to get high. This program was the only place he *didn't* get in trouble!

For Willa, however, it was an entirely different story. The agency called to let her know he had run away and had not returned. For Willa, all the old fears came rushing back--his not knowing his way around, the possibility and dangers of his trying to get a hit, memories from the past where she had had to rush him to the hospital and of the failure of the expensive implants--plus thoughts of what might happen to Tad in the

future. As she described what the experience was like for her, the fear and sense of helplessness came across vividly, not at all diminished for her by Tad's having been absent for only about an hour:

I'll never forget the day they called me and told me that Tad had ran from the program and they didn't know where he was at. They had taken him out on an outing and he didn't come back. Then I went into panic. I was at work, [so] I wasn't going to call the police right then. I was going to give it a few more minutes to be sure he was back up, and like I said, I've been fighting rock bottom since the very first time I found out Tad was actually doing it, because I have done and done and done trying to [deal with it]. I have gone as far as--he even went to [a doctor who was an addiction specialist]. He actually had surgical implants put into him.

I was scared to death. There he was in a strange town, didn't know nobody, nothing. I didn't know whether he's going to end up in a bad part of town, whether he was going to be trying to make a score, I didn't know *what* he was going to do. I didn't know how desperate he was to get back home to where he knew people. I didn't know whether he was going to just go the opposite direction to where we *had* no control over what kind of program he was in or what we wanted him to do to try to help him. I didn't know if he was just going to disappear off the face of the earth. It was terrifying, it truly was. I've taken him to the hospital where he was talking out of his head. He didn't know day from night, I mean just hallucinating from the drugs, where he was overdosed, and it's just a feeling that you just can't even really describe. It's the worst hopeless

feeling in your life to have your child, the one that you love so much, the one you'd do anything in the world for, you don't want them in pain or suffering or sick, and it's *completely* out of your hands! There's not anything you can do.

Trust me, I've done my share of praying and crying.

*Worst thing while in the program.* When asked what the worst part for her was during the residential program, Willa's response was immediate, "It was like bottom ever since it began!" However, she then described the ordeal of her son's running away.

Reverend Williams also felt the low point was something that lasted the whole time, but for him it was missing his son constantly:

When Barry went to the residential program, I was down because he was far away in the middle of nowhere and he didn't know nobody and I had to make the best of it. I couldn't make no long trip to see him because of my health, and he was there for six months.

For Viola the low point was a recurring mealtime experience at as she compared what the family was enjoying with the "junk food" that she imagined Darrell was having to eat; it seemed to be a constant reminder that they were free to move about and eat what they liked, while Darrell, because of his drug and behavior problems, was having to do what others told him and eat what others served him.

*Best thing while in the program.* The best thing about the residential program for Viola was seeing the changes that Darrell was making, evident in telephone conversations, then in person when she saw how calmly he handled the last minute loss

of hard-earned visiting time and subsequently when he came home for visits and then completed the program. It was also comforting to her that despite glitches over homework, Darrell returned to school without suffering academically for having been away:

The best thing was seeing the change in his behavior when he came home. I missed him, I missed him a lot. We went through so much, and I didn't know how hard it was going to be. There were a lot of things that had to be done with regard to his schoolwork. We were supposed to have a teacher handling the assignments and stuff, but *I* would have to go there and do it. There was supposed to be someone sending the homework, but it didn't work that way. The wrong homework got sent back and other things didn't work the way they were supposed to. I was worried about where he'd be when he came back to school. He did fine.

For Willa, there were two best things--the relief of having Tad safe, away from everyone connected to drugs, and the hope of having the residential program change his life:

Well, a) I knew he was away from the people he had been doing drugs with and that was all to the good. I knew he was safe. He was in a place where there were *no drugs* and *no one associated with drugs*. You just can't imagine the danger every time he goes in to get a stash. I knew he was where he should be at night and that he wouldn't be going downtown trying to buy drugs . . . I could actually lay down at night and know I wouldn't get a knock at my door in the middle of the night telling me my son got shot or something. I mean, you take your life in your

hands when you go downtown to get heroin. It's not like marijuana or cocaine, which you can get on any street corner. You could get robbed, you could get shot, you could get killed.

And the other thing is, Lord knows I prayed that [the residential program] would be the answer that would turn his life around. I felt like he needed the time away from all that to think about things without being interrupted. I thought if he was with the counselors and doctors and people who specialize in that kind of thing that they would be able to get through to him where no one else had been able to. I felt it had a chance of working because it was a 24-hour-a-day thing, day in and day out, and that something would register with him. There was more consistency and all and people were watching him all the time. I have to say, [his being away] was a good thing; it was a relief.

The best thing from Reverend Williams' perspective was his view that if Barry had to get involved with drugs, that he have the experience of the long treatment program while he was young and before he got more seriously drawn in to drugs:

The best thing was him getting that experience earlier in life. I rather for him to find out now than to find out later because later on might be too late. It might be at a time no telling what on the street might take his life, no chance to accomplish his dreams. I'm glad he didn't get any worse and he saw what happened.

Like most parents, Reverend Williams wanted the best life possible for his son and hoped that his son's making a mistake now and recovering would teach him what he needed to know in order to avoid such mistakes in the future.

### *Homecoming: Anticipation and Concerns*

As the time of program completion nears for the adolescent, it is typical for parents to start thinking about what it will be like for the teenager to be back at home around old haunts and old friends and peer pressure. All three boys had made significant progress in their program, and the parents were concerned about whether they would be able to maintain the gains that they had achieved. Willa's view on the impending discharge was:

How long would it last? How long was he going to stay clean? It was an every minute fear. Every time, every minute of the day that I wasn't with him I was worried and I was concerned that something was going to trigger him to go back. . . . You wonder what pressure, or somebody's going to say something or do something, or is he going to end up with the wrong person that's going to turn him on again?

Viola echoed this sentiment, with a special focus on the school situation:

Of course coming home meant he'd be back with the same group of people. It was hard because he's 17 and he'd, you know, he'd want to get back together with his old friends. Things are different in high school [versus the program setting]. There are lots of kids there in school, and I knew he'd have to make a lot of changes. . . . Thinking about him being back home again, I was afraid that negative influences would pull him down. Peer pressure can be really hard, especially at his age, and I was worried.

Reverend Williams worried, too, and in reflecting on his feelings then, he expressed gratitude for what he felt kept his son from going downhill again when he returned home:

Well, the thing was, was the relapse [which he feared might happen when his son came home from the program]. I would say, I don't think, I don't know, and it's not a thing that you can know. I prayed that these things didn't come back to his mind [when he came back home again] and the awful, *dreadful* things that came with it. It's not a beautiful life [being addicted to drugs]. If he hadn't had the support system that he had, what would have become of him? He's gotten interested in all this computer stuff, and I'm hoping now that he'd become a computer technician, that he'll really get involved in it and don't look back.

### *Resources*

Having an adolescent in the house who is abusing substances can be very difficult, and when a parent has no one to turn to, it is even more so. The parents in this study made varying use of community and personal resources, and all felt that the support they received made a big difference in their ability to cope with the situation. When asked about resources helpful during their child's residential stay, they tended to enumerate personal and agency sources that assisted them before, during, and/or after their child's participation in the specific agency program.

*Alcoholics Anonymous and Narcotics Anonymous.* In many substance abuse treatment programs, both outpatient and residential, participation in Alcoholics Anonymous and/or Narcotics Anonymous meetings is required of the adolescents, and often parents are strongly encouraged to go with them. Tad and Darrell both went to a number of AA meetings, although Viola did not accompany her son and Willa did. Both women felt that it was beneficial. In speaking of the impact on AA on Darrell, Viola

stated that, "It was good. He told me he talked a lot at those meetings," [5] and she elaborated on the different sorts of meetings Darrell went to while in the residential program and repeated how he had talked at the meetings. But she then went on to comment on her own ambivalence:

Even so, it's hard knowing your child is going to AA. Years ago I was in nursing school and as a student I remember thinking about that, about having a kid in this type activity. It's not exactly what you want for your child, if you know what I mean. It's not what you think will ever happen. I'm disappointed now, though, that he doesn't want to go to the AA meetings here in town [because there are no adolescents in the groups in town].

Willa's ambivalence was of a different sort. On the one hand, she attended frequently and felt she got a lot out of going:

I'd come home in tears almost every night, just listening because they would have a speaker, an addict who'd been clean so many years who worked the program and doing that and the stories they would tell of what they had lost, what they had given up--their families, their life--what they had to do to regroup. It was touching.

But on the other hand, Willa had had some serious reservations about the requirement for attending meetings in light of the injunction to "avoid people, places, and things" associated with drugs. She put it this way:

How you can say you need stay away from people, places, and things, but yet they tell you this is where you need to go when you're doing nothing *but* talking about

the drug, you're *with* people who have done the drugs. To me that's a contradiction."

As for Reverend Williams regarding Barry's attending AA meetings during the residential program, he said, "There was counseling, but I don't remember him saying nothing about going to no AA meetings." The Reverend's view on AA came from his experience as a speaker at several different meetings almost 20 years ago, and he felt such groups had a definite value, "Folks are learning and knowing the effects and the influences and what it'll do to your family and to your body. It's a good thing." But the Reverend wanted something more, and he continued on to say, "But if you do it as a family, it takes more of a spiritual background, if you know what I mean, as well as working physically and intellectually." He spoke enthusiastically of a comparable program at his church, which he said had been in existence for many years and was recognized by the state government, and said he had been a part of it for 14 years, "before my son ever had a drug problem."

*Personal contacts and official agencies.* Of the three parents in the current study, Reverend Williams drew the most heavily on agency-type resources. He found support from the people at his church, got involved with its youth and anti-drug movements, and took advantage of classes given through the Urban League, the Red Cross, and the local health department. Speaking of the help he got, he said:

It was not only the church and a lot of churches, but not only other churches.

There were other organizations like the Urban League and different ones like the

Health Department, the Red Cross teen classes--all these things combined helped

overcome the situation. The HIV and AIDS classes, breaking up in to groups, role plays also, helped relieve my worry. It took my mind off things, and I could keep informed with what's going on with youth. I felt less alone, and it kept me busy with things to help me with him.

Reverend Williams also referred from time to time to prayer--"Lord, help me with this!" [13]--as did Willa, who said she'd done her "share of praying." In addition, the Reverend also spoke of a video he found helpful:

The video would show how people were overcoming drugs and how this was doing good and going forward. Somehow it helped me in difficult times. I wanted to understand it. If I don't understand it, it's going to be harder to deal with . . . I wanted to understand the drug part.

Of the three parents, Willa found help from the broadest array of resources: family, individuals, one-on-one counseling, school, and Narcotics Anonymous. Like the Reverend, her use of these resources was not limited to her son's residential stay, and the list here gives a broader idea of the kind of resources that may be available to parents. Willa felt very grateful for the help she received:

My family was a trooper. My fiancé at the time--had it not been for him, I know I would have failed, because he would ride the roads with me at nighttime looking for my son. He would comfort me on the nights that I was crying and tore all to pieces. My mom was my best friend, thank God for her. I did one-on-one counseling. I had Tad involved in counseling, just trying to work through it all. . . A lot of friends at work have been very understanding. I mean customers that would come in daily and I'd be on the phone in tears talking to a counselor or

talking to the school or something going on all the time. It was very helpful. Like I said, I went to NA. I think *I* got more out of NA than he did! . . . I [also] had a good English teacher, a 12<sup>th</sup> grade English teacher, the school counselor, and one of the principals. I could not have *asked* for anybody to be any better to anybody than they were. I mean, they were absolutely amazing!

Viola, on the other hand, relied primarily on her family and on other individuals she knew. Reflecting on her resources, she identified them as:

My family. My family and friends and co-workers. Just by constantly sending cards, you know, and being with him and talking to him. They were sending my son packages and cards to show they cared and to let him know that they hadn't given up on him. It meant a lot to us that they did that, it was very encouraging.

And of course my boyfriend. He actually has driven up to get him when I had to be at work at 9 a.m. That and other big favors.

### *Costs and Losses*

Having an adolescent with a substance abuse problem took its toll on all three of the parents in this study. They spoke of problems with money and health and of expectations and dreams not realized.

*Money.* Viola was very fortunate in regard to payment for the residential program. She talked about an organization in the community that paid for most of the cost:

I don't actually know what [the initials] stand for; it's a group of leaders in the county and city, social workers, teachers from the community college, people like

that. They have money for this type of thing and they make a lot of decisions for other things, too. Anyway, they had money and the probation officer met with them and set it up at the meeting. They paid all the expenses for Darrell to go except for \$600 that I had to pay and my husband, he paid \$600. I think it cost 8,000 per month to go there. It's *very* expensive!

Willa's financial burden was considerably greater than Viola's. Willa stated, "I have paid every dime for what he's been through!" In addition to selling her house, she reported that she had paid "\$15,000 worth of dental work on his teeth" and "8,000 up front for the implants alone."

Reverend Williams was reluctant to state what his financial costs were, even to offer an approximate figure. He said that he felt his son's life was at stake and that "his life is worth more than money." When pressed, however, he spoke about difficulties:

It's hard to say about the money--whatever it took. I'll tell you, though, it made a significant dent at the time because I was having nurses come--I had just had a back operation and rehab. It was hard. It put the pinch on, it really did.

*Health.* Viola mentioned worry and stress, but did not indicate that she had any health consequences. Reverend Williams had back problems going in to the situation, and, on the one hand, while he said that having Barry so far away for so long was hard on his health, which he characterized as "unstable," he also said:

It seemed as though my health was turning around while Barry was at [the agency] and when he was coming home and I was getting better health-wise, and I really *needed* that! That stress on your body took quite a toll, and I started

feeling better and also, you know, I could accomplish more than I had been able to before.

Of the three parents, it was Willa who seemed most affected in terms of health.

She explained:

I mean, I was on 4 blood pressure pills a day, my blood pressure was out of control. In this process I had missed many days of work, I had uncontrollable migraines; they couldn't get my migraines to go away . I was on depression medicine. I mean, I was--every day that went by a little bit more of me was dying.

*Dreams and expectations.* Of the three parents, Reverend Williams was the most consistently positive parent and made no mention of specific disappointments about what his son might have accomplished "if only . . ." . Instead he gave a lot of advice about how to deal with an adolescent with a substance abuse problem and talked about his son's hopefully making a career out of computer work. Nevertheless, he was not without concern for how his son would handle future challenges:

I have a sense of satisfaction about the whole thing, but in my mind I still had concerns about my son and him staying on the right path. You want a person to succeed, but sometimes there's a little doubt . . . They have to make their own choices. You can't make them for them. You do the best you can and you just got to keep on praying.

For Viola, however, the contrast between what her son could have done in school and how things turned out was sharp, and the disappointment was palpable in her voice:

He graduated but he failed math. He got 1535 on his SAT's! And he was originally picked for Governor's School. No awards [at graduation]. There were 400 kids graduating and there was a valedictorian and a salutatorian for [the son's high school]. The counselor told me one of them could have been him. I'm glad he graduated, but sad because I knew what he could have done. I don't know. I don't know what it's going to take.

At the time of the follow-up interview, Viola recounted how she had just heard from Darrell and that he had lost his cell phone at the beach--"It's his lifeline! He *depends* on his phone! I know he wouldn't have lost that if he hadn't have been doing something. I'm sure he was doing something, drinking or something." She was originally pleased with the change she saw in Darrell when he came home from the residential program, but seemed no long certain that the changes would hold:

When he came home, for a month he was a different person. He understood what he had up there, but I'm not real sure. I talked to the parole officer and hoped he would be done, but she said, "I don't know" . . . . I can see the behavior and anger some of the time coming back. So--[her voice trailed off].

Willa also regretted the lost academic opportunity--the "full ride ball scholarship"--and she felt even more keenly the loss of her 20-year dream to present up her son with a house of his own at age 25. Yet far worse for her than either of these was what the addiction did to the totality of his life:

You have to sit back and watch the child destroy themselves. You have no control. Day by day a little bit of you dies each day. You know your child is just killing himself. The drugs that they're on, what he was on. There's three things:

it's going to be institution, jail, or die. He's been hospitalized, he's been in rehab, he's been real lucky not to go to jail because I *begged* them to put him in jail thinking maybe that would straighten him out. A child not doing drugs--you go out here and have an accident and their life can be taken just like that. I understand that. But [the difference] is just like a child walking on the *side* of the railroad tracks and a child walking *on* the railroad tracks. And that's what my child does, walking *on* the railroad tracks. Every day could be the day that it's happening and it's the end of him. But he doesn't understand that.

*Emotional cost.* Over and over again these parents spoke of the worries and strains of trying to deal with their son's situation. It was hard when the boys went to the residential program and the parents missed them greatly, even though they were simultaneously relieved. Both of the mothers also felt guilty about sending them off, despite their hope that the program would produce change for the better. Willa felt particularly misunderstood. The pain of her son's not only not appreciating what she had done, but turning on her for putting him in the residential program was devastating:

To have your child have you tell you how much they hate you--you know, it--it breaks your heart. [Willa speaks from Tad's point of view:] 'I didn't love him. If I loved him, I wouldn't be taking him up there leaving him somewhere where he didn't want to be and it won't do no good. I'd never done anything for him.' I remind you that I'd sold my house, taken the equity out of it to pay for the medical bills and all the rehab and the surgical implants and everything I had done so I wouldn't have to file bankruptcy. [But still he says:] 'I haven't done anything for

him.' You know, it's things like that hurts you to the point where eventually you finally get numb.

Viola worried about her son's getting his McDonald's job back and about his successful return to the classroom, especially given her frustration with the school's mishandling of homework, and Willa felt constantly upset by Tad's telephone conversations with his father. All three parents worried a great deal about possible relapse when their adolescent came back home and had to face peer pressure again. Willa had the frightening experience of having her son run away for a brief period, and she felt sheer panic then, as well as near panic the time Tad told her he was being abused by the staff, which, when she called the program manager, turned out not to be true. Willa also seemed to have a lot of frustrations with certain things not happening at the agency the way she felt they were supposed to, including Tad's easy phone access, infrequent feedback to her as the parent, and the lack of family counseling.

For these three parents the journey was long and hard on a number of counts, and it is still not guaranteed over. Out of the midst of it all, they had plenty of recommendations for other parents and for health care professionals.

### *Advice*

*Advice for other parents.* When asked what they might give to parents of an adolescent newly entered in a residential substance abuse treatment program, each of the three parents had something different to say by way of encouragement and practical principles. Willa's counsel was to utterly resist the temptation to pull them out of the program. Her words to parents were:

To be tough, to be strong. Don't give in! Do *not* give in! Do *not* bring them home no matter how much they beg, scream, cry, cuss--do *not*! Because it's hard to take a child knowing they're not coming home when they're begging you.

Viola talked a lot about her reluctance to put her son in a residential program despite the signs and recommendations that he needed it--"I wasn't ready"--and she too had to deal with phone calls from her son wanting to leave. However, when she finally did put him in a residential program and saw the positive changes he ultimately made, her advice to other parents was:

It'll be hard, but in the long run it'll be worth it. Darrell called me a few times in the beginning wanting to come home but he knew he had to stay three months because of the D. U. I. and all.

Reverend Williams spoke about how best to handle the stay itself once the parents are committed to having their son in a residential program. He recommended getting to know the staff, staying informed, and maintaining the lines of communication with one's adolescent:

My advice would be stay involved with them [the adolescents]. Go see them. Become involved with the counselors. Don't let them get away with no answer or just saying "I don't know." See that they give them an answer and see that the counselors get an answer. Also if you learn to have communication--if you don't come or talk with the child, then they don't think you care. I don't care what happened in the past, you going to have to deal with them and talk to them. Do different things, find out the things they like to do. In a group home, everyone in the group home has issues and different issues, and they don't all have a counselor

dealing with them one-on-one on issues. Dealing with all of them won't work. So you have to talk to your child. That's my suggestion. If you do that, I guarantee, not 100%, but it will knock it down so far they will see it's working.

Willa would have agreed with Reverend Williams about the importance of being with one's adolescent while he or she is in the residential program:

The counselor at the program told Tad--it was one of those times when he was complaining about what I'd done and what I hadn't done--and he said [to Tad], "Do you realize you're the only child here that the parent came to see?"! I could hardly believe that when he told me, I mean, where are all those other parents?! It's so unfair.

The Reverend also talked about how to handle the teenager once he or she was discharged from the program, suggesting a balance between trust and firmness:

As a parent when you get your child home, don't be too overprotective. You got to show some trust, not a lot of trust, but you got to show a little. If you don't show a little, they get angry, they rebel: "You don't trust me!" You know what I mean? Do a little bit at a time. Don't let them put you on that guilt trip.

He further advised:

The part that, the last past [when they're doing better], you kind of don't want to give them too much credit. You got to let them wonder what you're thinking. It's like saying you're doing too good too fast. If you do that, they're very manipulative, and they'll take advantage of you, and you have to stay laid back and stay hard and firm and into being fair. You are being fair in a way you can have a relationship. In other words, you can have a relationship and you can talk

it over. As for rewarding them every time they do something, that's not so good. You can reward them down the road. You can tell when it's time. You will have the discernment.

Willa added a different dimension to the "aftercare" aspect, coming as she was from a situation where, over Willa's objections, her mother, Tad's grandmother, was paying for Tad's methadone treatment following the post-discharge relapse. However, when her son got a job and began having money of his own, Willa noticed a shift in Tad's view about going off methadone:

When Tad got his job, *he* started having to pay for his methadone. "God and behold, it's time to come off of this!" [Willa imitated Tad's speaking] because *he's* having to pay for it . . . it's coming out of *his* pocket.

Willa's recommendation was not to give the person abusing substances any money or other things that will permit him or her to continue using drugs or alcohol:

The longer you enable them and take care of them and give them what they want, pray that they'll turn around, the worse off they'll be because they're going to continue to take, and all you're going to get is heartache.

*Advice for mental health professionals.* The parents in this study had the greatest amount of advice for those who work with adolescents with substance abuse problems. Viola did not have any particular advice for the staff at the residential program, but prior to entering that program, Darrell had two case workers, who were each very different in the way they interacted with Darrell and the family. When asked about advice for mental health professionals working with a teenager and his or her family, Viola had strong

opinions about which way was most effective. She characterized the first as willing to listen and to understand Darrell--"Darrell liked him"--and the second as demanding and not making any effort to get to know him--"Darrell just threatened to do the opposite of whatever she said." Viola's advice for such professionals was, "I think it's really important to get to know the family and the child and to work *with* them because you have to work together if you're going to help the child get over this."

Like Viola, Willa had definite opinions of what was helpful in the mental health professional/adolescent interaction. She was frustrated that when the expensive implants were doing their job of keeping Tad from getting high, the one-on-one counselor let Tad know that he had the right to refuse them, and so he did, only to end up in residential treatment later because he went back to heroin:

First of all, do not at any point let the child know how many rights they really do have. 'Cause that wasn't down [wasn't clear] with my one-on-one counselor. When Tad was doing so well with his implants, and he was doing so well and he went to his one-on-one and he was talking to him, "Yeah, I got to tomorrow to get my next implant in and I really don't want to do that." And she was like, "Well, it's your body, Tad. You don't have to. All you got to do is say no." And up to that point, Tad thought if I said, "You're going to get it," he thought he had to go get it, [and] he didn't have a choice. So he didn't go back anymore to get his implants and that when he ended up--you know [in the residential program].

Willa felt that parents should have more rights than they do vis-à-vis their adolescents:

I think the kids have too much rights. The parents are the ones going through all this. The *kid's* not going through it. The parents are going through it. They should have more say so in the well being of their child.

In line with that sentiment, Willa advised that parents with teenagers in a residential program should be given more feedback and that the parents should not have to be the ones to initiate that all the time:

They should update the parent every day. There wasn't enough communication with the parent. I wasn't getting enough feedback. I'd call them and ask how Tad was and how things were going, and, yeah, they'd usually call back, but not once did they call me on their own, and I wanted to know.

Out of her experience with Tad, Willa strongly advised that program staff limit the adolescents' phone calls and monitor the ones they do have:

They're calling you 10-15 times a day, and that's another thing . I was told Tad wouldn't have access to the phone. He was calling his dad. He was the person Tad was not supposed to be in contact with. He was calling his dad. He was calling me. He was reaming me out, and all that did was tear me up. Here I am at home, he's up there, he's cussing, screaming, saying that they're abusing him and that they're doing this and they're doing that. I do not feel that should be allowed.

I feel if a child must be given a telephone privilege, I believe a counselor should be with them. They should be able to hear what is being said. I do not think they should be allowed to call two and three and four times a day. I understand that they've got to disassociate [which is hard], but [by calling so frequently] all they're doing is keeping the parents at home tore up more than

what they were before they put them in there because-- I didn't know what was going on when he called me and told me they were abusing him and all this stuff. Yes, I got on the phone. I called the man at home. I said, "Look, my child's here at your program. I want to know what's going on. I want to know who's with my child. I want to know who's doing what," 'cause it scares you to death.

Oh, he told me, "I'm on my way. I will call you when I get there." And when he got there, he made Tad get back on the phone and at that point, Tad told me everything was fine . . . .

Fine, okay. The man's saying everything's fine here, don't worry about anything. Well, *are* they being sexually abused, *are* they being beat? I'm not there, I don't know anybody personally there, so how'm I supposed to know that they're not covering up something?

Like Willa, Reverend Williams, felt monitoring the adolescents to be essential. In regard to that, he had very specific advice about agencies with a "closed door" policy, which is residents being allowed to go in their rooms and shut the door and other people having to knock before they go in:

A closed door policy, a closed door policy is kind of, well, they [the teens] create things you wouldn't believe what! You and your roommate go in and close the door. You may study, or one goes in and closes the door, and they do this and they do that and you wouldn't believe what they do. It keeps the counselor from knowing what's going on, and you won't get to that level of trust. They going to be creating things you wouldn't believe. "What is that smell in here?!" Huffing things. You can't trust them with nothing. They can take anything fluid--

cleaning fluids, you name it. They're smart and they get very creative. A closed door policy, it just doesn't work.

The Reverend also advocated monitoring at other times during program activities:

Keep an eye on them. Keep up the communication and watch their behavior, what they do, how they move. Once you get involved in them, I mean, watching ballgames is fine, but always have a facilitator with them so they won't be ganging up on somebody and you won't be worrying about them trying to form a gang. You have your chance to work with them.

Reverend Williams' advice about working with the teenagers sounds very similar to Viola's--get to know them so one can bring in the rest of the family:

You have to kind of be a mediator. You are with the teens every day--pay attention to them: What do they like or not like? See what they are doing. They are sneaky and you have to pick up on it. Once you do, you go with what you know, and you know who's a troublemaker and who's not. They all got problems, but as for anger problems, you deal with the person and you kind of bond with them and find out. "What's wrong with you, not get enough love in your life?" Especially guys, you know, and the more they talk to you, then you can pull the family to you and work with the whole family.

### *Summary*

Coping with an adolescent who has a recurring problem with illegal substances is a long and difficult journey for the parents. The three who volunteered for this study were single parents who had their sons in a program miles away from home, and distance

itself was a stressor. From the decision to put them in such a program to dealing with them after completion thereof, these parents continued to love, support, and worry about their offspring. They had similar reactions about their sons initially being in the program and about them returning--a mixture of hopefulness, guilt, and concern. However, as their respective sons settled into the program, the reactions of the three parents were unique to each individual situation: their view in general; what they regarded as their own "turning point"; one's experience of her son's running away; and what they regarded as the best and worst. The three parents had a variety of resources to which they turned for support in the journey, and they also all suffered losses in one way or another--emotionally, financially, and/or physically. All three were relieved that their sons subsequently graduated from high school (or, in the case of Barry, got his G.E.D.), and they were cautiously hopeful that their adolescents would put the drug problem behind them and go on to be successful in life.

Out of all this experience, these parents offered a wealth of advice for future parents and for professionals and others, the essence of which was to be aware, to be strong, to get involved, to keep the lines of communication open, to monitor the adolescents closely, and, without being lenient, to balance firmness with fairness. That these three parents spent as much time as they did with this project is testament to their own willingness to be part of the solution.

## Chapter V: Discussion

### *Introduction*

The purpose of this study was to examine parents' experience of having an adolescent in a residential substance abuse treatment program. The researcher worked with a treatment agency in a metropolitan area of Northeastern United States, and, through the recruitment efforts of the agency, three parents volunteered to participate. All three were single parents and happened to have had sons in the agency residential program. In hour-and-a-half taped telephone interviews, these volunteers gave detailed views of their personal experiences of what it was like to send their son off to treatment--all three families lived several hours or more away from the facility--have him there, and then have him return home again.

The theoretical underpinning that provided the framework for this study was a combination of Family Systems and Phenomenology, the former focusing on the back-and-forth interconnections between parent and child and the latter on the parents' experience as they themselves viewed it and understood it. The three case studies laid out at the beginning of the previous chapter gave an overview of the parent-son situations that were the focus of this study. In obtaining the "story" and the meaning given to it by its respective tellers, certain categories and themes began to emerge, which were brought together in the previous chapter, following a natural chronology and also including other topics of concern and interest to the parents. Statements by the participants illustrated the findings in their own words, which the researcher verified in a 30-minute discussion of the typed transcript sent to each parent a week prior to the follow-up conversation,

wherein parents added small additional details; adjusted minor errors regarding names, sequence, and locations; and corrected several grammatical mistakes.

This chapter begins with a summary of the procedure and the findings and, wherever applicable, an exploration of how the findings fit with previous research, although, as the Chapter Two review of literature indicated, there is a relative dearth of research regarding the parents' own perspective. Based on the findings, this writer offers an expanded model of understanding for parents going through the experience of having a son in a residential substance abuse recovery program. Subsequent discussion includes clinical relevance, limitations of the study, implications for future research, and personal reflections.

#### *Summary of the Procedure*

The volunteers in this study were asked to describe various aspects of the experience of having an adolescent son in a residential treatment program. During the semi-structured interviews, the parents answered open-ended questions about what went on with them before, during, and shortly after their son's return home from the program, with the emphasis entirely upon what the experience was like for the parents rather than for their sons. The researcher employed open and axial coding to discover themes and important ideas brought out in the conversations with the parents, and subsequently gathered that information into six categories. Initial Departure, Settling In, and Homecoming Anticipation and Concerns were the first three, and, of these, Settling In--where the son was actually working the bulk of the program--proved to contain the most diverse responses. The last three categories were Resources, Costs and Losses, and Advice.

### *Summary of the Findings*

In talking about their son's "Initial Departure," much of the discussion was around the difficulties dealing with their sons prior to placement, then really missing their teenagers, feeling mixtures of embarrassment and guilt while at the same time being hopeful about the outcome and relieved both to have more peace at home and to know that their son was safe. Having the son in a monitored environment away from drug-using friends, a sentiment voiced by both Willa and Viola, is echoed in White, Godley, and Passetti's (2004) qualitative study of 12 adolescents and four parents regarding their perceptions of outpatient substance abuse treatment. One of the mothers in the White, Godley, and Passetti study said the most helpful aspect of the program her adolescent participated in was that it "kept her son away from bad influences" (p. 71).

The category entitled "Settling In: Unique Situations, Unique Responses" broke down into five subcategories of reactions (noted in italics below), and, within the individual subcategories, the responses were unique to each parent depending on the son's situation as he became more used to being in the residential program. For that reason, few generalizations can be made regarding this part of the study.

Willa's *general reaction* during this time was worry that her son was fooling the staff into thinking he was compliant, Viola was glad when she saw real improvement, and Reverend Williams became determined to help his son by learning all he could. The *turning point* for Viola was being present to see her son take a disciplinary measure in stride instead of getting upset. For Reverend Williams, it was an inward personal revelation that he would have to accept not having control of his son's situation, which, he said, enabled him to "work with it." Willa's turning point did not happen until some

months after program completion when her son turned 18, and she could --and did--ask him to leave her home. (It can be noted here that Willa consistently seemed to have a harder time all the way through, and this can perhaps best be explained by the fact that her son was addicted heroin, where the immediate physical consequences of withdrawal from dependence are more serious than those of marijuana, the principal drug used by Viola's and Reverend Williams' sons. Willa herself discussed this [see p. 51], and it is corroborated by information in the *Diagnostic and Statistical Manual of Mental Disorders-IV-TR* [American Psychiatric Association, 2000].)

*Running Away*, the third of the subcategories in the Settling In section, was a point where only Willa had such an experience, and she was "terrified." With only the one response, this leaves open the question of how parents react to a child's leaving the premises, a subject for inquiry in future research.

In terms of the *worst while at the agency*, again, each parent had a different response. For Willa, the worst was the running away as well as the whole idea of her son needing to be in residential, while for Viola, the worst was hearing her son ask about the dinner menu at home. The Reverend found it most difficult not seeing his son at all for six months straight. As far as the *best at the agency* went, Willa was relieved to know her son was safe and had hope that "experts would get through to him." For Viola, the best was seeing her son's behavior improve, and for Reverend Williams, it was the thought that by Barry's having this kind of experience now, his son would avoid problems in the future.

The uniqueness of so many of these responses in the midst of the constancy of the parents' concern for their sons heightens for this researcher the importance of a broader

perspective on parents who face and live through the necessity of placing their adolescents in a residential substance abuse recovery program.

When it came to "Homecoming," all three parents expressed concerns about whether their sons would relapse once back at their regular school with old friends, although Reverend Williams was also pleased that he would be getting to see his son again, and when it came to "Resources," they all made good use of community resources, with the mothers talking a lot about family, friends, and co-workers as well. Reverend Williams preferred his church's program to Alcoholics Anonymous, but Viola was glad her son talked a lot at AA meetings while at the agency and regretted that none near home were age-appropriate for him. Willa felt she got more out of AA and NA than Tad, though she questioned the near-daily exposure to drug talk and drug addicts.

The "Loss" that troubled Viola the most was her son's disappointing academic performance vis-à-vis what he had accomplished previously in school, and Willa, too, rued the sure scholarship that her son's heroin habit had cost him. But she and the Reverend, who spent by far the most money trying to deal with their sons' addictions, seemed able to minimize the seriousness of their financial losses by seeing it as simply doing what they felt necessary to save their children. She and Reverend Williams also suffered in terms of their health, which was more worrisome to them than the money, though the Reverend said his health got better with the lower stress level while his son was away and while thinking with happiness about his son's coming home soon.

The mothers' "Advice" for other parents was to be strong and keep the adolescent in the program. Reverend Williams had a great deal to say about being involved and communicating and, upon the teen's return home, balancing strictness with trust and

slowly, watchfully, granting them more freedom. Advice to mental health professionals varied: suggestions to shore up parents' rights and improve communication with parents, getting to know and work with the family, and bonding with and closely monitoring the adolescents. Furthermore, while not actually coming out and saying it specifically, these three successful parents (their sons were program completers) in their interview responses talked about the emotional ups and downs-- relief /guilt, hope/embarrassment, pride in progress/fear of relapse, gratitude/disappointment, etc.--that come with having a teenager in residential substance abuse treatment. Knowing that being on an emotional roller coaster is a normal part of the process, even for "successful" parents, could be helpful in the future for therapists and other staff working with struggling families dealing with similar problems.

#### *An Expanded Model of Understanding*

The general lack of research on the parents' experience of having an adolescent in residential substance abuse treatment is the gap that this project has sought to fill. Most of the currently available literature addressed one of two topics: the importance of positive parental involvement in the adolescent's treatment, or, more common, the ways in which parental deficits contributed to or were associated with the problem of adolescent substance abuse. A half dozen different studies, two of which were meta-analyses (Stanton, 2004; Stanton and Shadish, 1997) and a third one of which involved over 2,000 adolescents (Hsieh, Hoffman, and Hollister, 1998), either reaffirmed the value of bringing the parents into the recovery process, noting improved engagement and increased satisfaction with the program, or discussed the effectiveness of family therapy vis-a-vis other modalities of treatment. Parents do matter.

Most often, however, parents are seen negatively, both in and of themselves and/or in their interactions with their children. Available studies focus on a variety of possible deficits: multigenerational chemical dependency, propensity for other addictive behaviors, more primitive and direct expressions of conflict, and more overt alliances between addict and overinvolved parent, and sometimes denial of a substance abuse problem in the family (Stanton & Heath, 2005); ineffective parental authority and control, as well as overinvolved or distancing parenting (Piercy & Frankel, 1989); "imperfect maturity" and lacking critical social skills, disappointing relationships with the opposite sex, and a history of seeking acceptance from a negative peer group (Wallace & Estroff, 2001); inflexible, disengaged, lacking in pride and harmony, exhibiting marital problems, and spending little time together as a family (Malkus, 1994); low adult involvement and monitoring (Dishion, Capaldi, Spracklen, & Li, 1995); and seeing the child as the problem rather than considering their own parenting practices as influencing their adolescent's behavior (Morrissey-Kane & Prinz 1999).

It is certainly true that parents of adolescents involved with a substance abuse tend to have problems of one sort or another, yet, in all of these studies, the information about the parents came from clinical experience with parents of adolescents, from surveys of adolescents and/or parents, and/or from observer ratings. Most of the researchers who actually interviewed the parents themselves focused primarily on what the parents said regarding their adolescent: past behavior of the adolescent, elements of treatment success (Ralph and McMenamy, 1996); treatment outcome (Deskovits, Key, Hill, and Franklin, 2004); satisfaction with services (Godley, Fiedler, and Funk, 1998); effect of post-treatment social support (Richter, Brown, and Mott, 1991); health status,

substance use, delinquency, depressive symptoms, income, family attachment (Hoffman, Cerbone, and Su, 2000); reliability of post-treatment parental reports (Ciesla, Spear, and Skala, 1999); views on getting involved in prevention programs (Redmond, Spoth, Shin, and Hill, 2004; Mallick, Evans, and Stein, 1998); etc. The research did not discuss parents' own personal experience of having had a child in a treatment program.

However, two studies looked at a parent's own experience for its own value rather than what parents said about their offspring--Butler and Bauld (2005) and Walsh (1997)--and what these researchers said regarding parents dealing with offspring in difficulty and connecting--or not--to services points toward a more complex understanding of such parents. In Butler and Bauld's 2005 exploration of what it was like to have a heroin abuser in the family, the researchers tapped into the mixture of heartache and love that was characteristic of parents with a heroin-addicted young person. According to the study, these parents' lives were turned upside down by their children's drug abuse, and, while there were moments for some when they wanted to turn their back on the addict, with agency support they stayed the course and found new understandings for themselves and new ways to help their child. In Walsh's study, where parents were faced with a variety of adolescent issues and sought family therapy with private practitioners, these parents, too, were committed to helping their children and used the therapy to gain new understanding and make appropriate changes.

Like the parents in Butler and Bauld's (2005) and Walsh's (1997) studies, the three parents in this study were unequivocally committed to helping their sons, and the story of their strengths needs to be told. For all three, the initial damage came from a situation largely beyond their control--it was either the other parent introducing the son to

drugs or having the son visiting the other parent in an environment with few boundaries and many temptations--yet none of them expressed any bitterness, not even Willa. For her, there was disbelief, anger, and disapproval, but not one word wishing the father ill, not even when talking about the continually upsetting phone calls between father and son during her son's stay in treatment. In addition, the path to residential placement varied, but these parents cooperated with the agencies and governmental entities working with them. Willa's comment was, "I had done everything that everybody had told me to do--the doctors, the counselors, the school, the judges, the police." Viola admittedly took longer to heed the advice of others that her son needed a special program--"I wasn't ready"; however, when he was faced with the possibility of returning to juvenile detention, she took action to research the options and came up with the idea to the judge of sending her son to the residential program instead.

Of interest also is what these parents did *not* say in the course of the two interviews that each had with the researcher. There was not much recognition about their own actions' having an impact on the son's behavior. In fact, Viola remarked that her son would not do what she told him and that he was "out of control," a phrase Willa also used at one point. Discussing her decision to make him leave her house, Willa said, "The harder I tried to tell him and show him and help him, the more he deliberately went out and did things to hurt me because he knew at that point anything that he did *I* felt responsible for, and by law I was." Her emphasis was on his being rebellious just to get back at her, but she did not discuss the possibility of his feeling unduly confined by her well-intentioned, continual attempts to guide his actions. In somewhat similar fashion, Reverend Williams did not reflect back on his own earlier statements about "always

being the last to know," despite his many admonitions to parents and counselors to monitor their adolescents closely

The parents also did not offer any reactions to this researcher about what it was like to actually sit down and read the transcript containing their own words about what it was like to go through all that they did with their sons. Hopefully it was useful to them--put things in perspective, provided some sort of catharsis, helped them feel heard, led to new insights, gave them some sense of achievement or at least endurance, or whatever--but there was no indication from them that this was so or that they had given any particular thought to the process of telling their story and what it meant for them to do so. At the same time, however, one cannot draw any conclusions or make any judgments about their not having done so. It simply remains interesting that that was the case.

These three parents truly seemed to love their sons. All talked about missing them a great deal when they were at the residential agency, and the two mothers visited their sons as often as the agency permitted. (Reverend Williams could not travel because of his health, but he was particularly excited at thought of his son's return home and became more active with him when he did come back from the program.) Meanwhile, compensating for the school's poor handling of the homework assignments, Viola went to extra lengths to make sure her son received and turned in the work he was supposed to. When it came to paying for the residential program, Viola was fortunate to have a local community group pay almost the entire cost, but Willa and Reverend Williams never complained about the money they put out. The Reverend said, "God will supply my need," and Willa stated, "It's a house. It's wood. It can be replaced. A child can't be ...." In terms of their concerns about the homecoming and of their advice to parents and

professionals, these parents were realistic and they homed in on core essentials of what would be most useful for other parents and for mental health workers.

In a study by Velleman, Bennett, Miller, Orford, Rigby, and Tod (1993), family members dealing with drug users in the family, including teenagers, described themselves as lonely, isolated, and unsupported, among a number of other things as well. In contrast, Butler and Bauld (2005) in their study of families of heroin users, including adolescents, found that when parents of drug users had agency support, the benefits included feeling less isolated because of having somebody to talk to, comfort from realizing others were going through similar situations, and feeling more competent because of knowledge gained about drugs and more compassionate because of having gained an understanding of broader issues. The three parents in this study avoided the isolation trap and made good use of resources, drawing strength and assistance from family, friends, co-workers, church, various agencies, and Narcotics Anonymous. Reverend Williams went one step further, in that not only did he learn as much as he could about drugs from the classes he attended, but he became a resource himself, reaching out to other youth and their parents in his church and through his motivational speeches to the broader community.

All three parents were persistent in their concern and care for their sons, and Willa and the Reverend, who had struggled the longest with their respective situations, also evidenced a real capacity for personal growth. Through their experiences, they came to new insights about themselves in the parent-child relationship. For Willa, it involved a recognition of her own limits--"my whole entire life has been spent taking care of somebody with problems . . . I can't do it anymore"--and a refusal to do what she saw as enabling her son's habit by paying for his methadone: "I will help him live, but I won't

help him die." As for Reverend Williams, he was 60 years old and struggled with chronic pain, and in the many months of dealing with his son's problems and not seeing his son for six months, he could have easily lapsed into self-pity and resignation. Instead, he made a concerted effort to remain positive, and growth came in increased involvement with his son and in a better understanding of the need to balance watchfulness with fairness, firmness with praise.

All these families must certainly have had their difficulties leading up to the necessity of placing their son in a residential substance abuse treatment program--two drug-addicted parents, two divorces, and a long-term separation bear witness to that probability. With a Family Systems framework in mind, one could potentially identify some of the problems alluded to in the literature regarding parents as causative--enmeshment, lack of boundaries and of monitoring, and possible neglect. However, in the face of these three parents' genuine love for their children, their ongoing efforts to do whatever would help, and their evident strengths, a richer and more complex understanding is a well warranted adjustment to the model of parents of substance-abusing adolescents as simply deficit-ridden.

#### *Clinical Relevance*

In assessing and dealing with families whose adolescents are substance-involved, clinicians need to take into account more than "what's wrong with this family?". It is hard enough to parent an adolescent through the teenage years without substance abuse problems; respect and empathy for how difficult it is to do that *and* deal with an adolescent with addictive behaviors validates the effort and frustration of these parents and gives them a feeling of being appreciated and supported. Willa made that point and

one more as well when she stated, "The *kid's* not going through it--the *parents* are going through it! They should have more say so in the well being of their child." Working collaboratively with parents, using existing strengths while also building new ones, honors parents as the ones ultimately in charge. All three of the parents in this study demonstrated a willingness to "be there" for their sons, and, as a clinician, discovering and capitalizing on parental strengths with a collaborative approach should provide a better foundation for enhancing the family's ability to deal more effectively with their children, not only during formal treatment but also well after they have been discharged. Furthermore, parental abilities, like parental deficits, vary from family to family, and, rather than relying on a one-size-fits-all program, clinicians will need to be flexible and creative in identifying and utilizing what each family comes in with.

#### *Limitations of the Study*

This study's most serious limitation was the fact that only three parents volunteered to be interviewed. Three is a very small number and a major reason that generalization to the population at large would not be valid. With only three people, there was minimal diversity in age and ethnicity--two middle-aged Caucasian women and one older African-American man. Socioeconomic status was not listed on the demographic forms, and as the researcher did not ask the participants to self-identify in this regard, no conclusions can be drawn with respect to the size of personal financial resources' affecting the parents' response to the situation.

All three were single at the time their sons were in the residential program (though that may have been a technicality, since both women had supportive, long-term boyfriends). There were no daughters of study volunteers, and thus no exploration of any

mother-daughter dynamics, and so, without corroboration from other studies that included teenaged girls, the findings of this study are restricted to parents of male adolescents and can only tentatively be applied more broadly. In addition, the three participants in this study were a convenience sample recruited through a connection with just one agency, and, had there been several facilities involved, a more varied picture may have emerged.

Another limitation of this study was that the research design specified that the volunteers be parents of program completers or near-completers so as to explore more of what makes for a successful experience for the parents. Hence, the parents' considerable strengths and persistence may well be a reflection of having worked with a pre-selected sample set, whereas had a broader group of parents been solicited for the study, more diverse findings might well have resulted. A further limitation of having only the parents of program completers in the study is that it precluded investigation into the matter of relapse, when the former user goes back to his or her addictive substance. Because most residential treatment programs discharge youths who relapse, they do not complete the program, and so their parents would automatically be excluded from a study set up for parents of program completers. And yet, relapse is a common phenomenon in the overall recovery process and it would be helpful to know what this is like for the parents of those adolescents.

In addition, each of the three sons had a different length program--one month, three months, and six respectively--and the one with the most serious problem, Willa's son, addicted to heroin, had the shortest stay. If he had had additional months in the program, would his--and presumably her--experience have smoothed out over time?

Ideally, for more rigorous comparison among parents, the participants' adolescents would have all attended the same length program, and the adolescents would all have had similar drug difficulties at entry. At the same time, however, limiting the study to parents from only one agency rules out the possibility that drawing from parents at different treatment agencies (agencies that provide more or different services from this one) would have produced different results from the experiences of the three parents in this study.

#### *Implications for Future Research*

Mentioned earlier, only one parent in this study had to deal with her son's running away while he was at the residential program. Exploring this more extensively with other parents would make for a sharply focused separate study, or it could be part of a broader look at the residential experience for parents.

Many other suggestions for future research are, not surprisingly, a correction to this study's limitations: more parents with greater diversity among them in terms of ethnicity, socioeconomic status, and gender of the adolescents in the program; an increased number of facilities in the study; and more uniformity in the length of the residential programs. Expanding thus, one could continue this study with more volunteers but still limited to program completers, or, also include program dropouts, whether they had relapsed or had departed for other reasons (though recruitment might be difficult). Given that, short of hospitalization, a residential program is the most intensive and expensive form of substance abuse treatment, it would seem that prevention of the need for it would be a desirable goal. With that in mind, a longitudinal study of parents' experiences coping with their adolescents' treatment programs earlier in the process and then following those whose children needed additional programs, up to and including the

residential ones, would begin to reveal commonalities in the negative traits and in the positive attributes of those parents who avoided the necessity of a residential stay and in those parents whose adolescents ended up needing such a program. Hopefully, the results of such a study would provide helpful information for fine-tuning programs all along the line so that families could be better supported at each point.

#### *Personal Reflections*

This researcher was struck by the graciousness and generosity of the parent participants. All of them had regular jobs to attend to, but they gave willingly of their time to share personal and often painful family information with a stranger on the other end of the telephone, and did so not once but twice. They were thoughtful. They were articulate. They were patient. When the follow-up call was made to Viola, she was just recovering from a 24-hour virus and she needed to go do things for her other children, but she still answered every question fully. Reverend Williams, who had an impressive sense of community service, had pored over his transcript in detail prior to the second conversation, offering corrections and answering all questions at length, despite physical pain and despite concerns about an upcoming operation. Willa had an especially incisive mind, a strong sense of self, and an eloquence of speech that was a pleasure to hear and read. Perhaps, because of the self-selection process, these three individuals were notable exceptions to the rule--they certainly seemed glad for the opportunity to share their experiences--but they were definitely not stereotypically "deficient parents." The opportunity to interact with them and to hear their story has been educational, inspirational, and an amazing gift in the final leg of the graduate degree journey.

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Appendix A

Recruitment Flyer

GOT A TEEN NEAR COMPLETION IN VANGUARD'S  
RESIDENTIAL RECOVERY PROGRAM?

(OR WHO COMPLETED IN THE PAST 2 YEARS?)

JOIN THE  
VA TECH STUDY OF

**THE PARENT'S VIEW :**

SHARING YOUR OWN UPS AND DOWNS  
OF HAVING YOUR TEENAGER  
GO THROUGH A  
RESIDENTIAL SUBSTANCE ABUSE  
RECOVERY PROGRAM

ASK YOUR COUNSELOR FOR DETAILS

OR

CALL 703-867-8410, x 206

Appendix B  
Agency Recruitment Letter to Parents

(Agency Letterhead)

Dear Parent(s):

I am sure you have experienced many challenges as you sought to work effectively with your son or daughter who has a substance abuse problem. It can be very difficult for you.

As treatment professionals in an adolescent residential substance abuse program, we would like to know more about what your teen's time here has been for you. We believe if we learn this information, we can provide better help to families.

Virginia Tech, Northern Virginia Center, is conducting a study called "The Parent's View" through its Marriage and Family Therapy Master's Program. This study is designed to hear your concerns, feelings, reactions, insights and suggestions, as parents of a teen in treatment. The findings from this study will help all treatment professionals do a better job working with families and their teens.

Please consider participating in this study. You will be invited to share your story about being a parent of a teen in a residential substance abuse treatment program. The study leaders want to hear your worries, reactions, and find out from you what helped you cope.

I encourage you to join the official Virginia Tech study of parents who have had a teen complete a residential program in the past two years or who will complete within the next few months.

Of course, your participation is voluntary, and anything you share will be kept confidential.

If you would like to participate or learn more about the study, please complete the enclosed form and give it to your [agency] counselor. Someone from Virginia Tech will be in touch with you.

Thank you for considering this request.

Very truly yours,

[Name]  
Director of Clinical Operations

## Appendix C

### Contact Information Release Form

Please print

Name of parent(s)/step-parent(s)/guardian(s): \_\_\_\_\_  
\_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Best time to call: \_\_\_\_\_

Name of son/daughter in the agency's residential substance abuse recovery program:  
\_\_\_\_\_

Child's age: \_\_\_\_\_

Length of time in current program: \_\_\_\_\_

Or:  Completed residential program at this agency within the past two years

I give my permission to the agency staff to release my address and phone number to Myra Gillum, primary researcher and 4<sup>th</sup>-year graduate student, and to Dr. Eric McCollum, faculty advisor, so that they may contact me about volunteering to be interviewed for a Virginia Tech research study. This study is about what it is like for parents/guardians to have an adolescent in the agency's residential substance abuse recovery program.

I understand that this information will not be given to anyone else and that any information I/we give in the course of an interview will be kept strictly confidential.

---

Name \_\_\_\_\_

---

Date \_\_\_\_\_

Agency Staff Member:

---

Name \_\_\_\_\_

---

Date \_\_\_\_\_

---

Title \_\_\_\_\_

Appendix D  
Follow-up Letter from Researcher

Dear \_\_\_\_\_,

I enjoyed talking with you a few days ago. Thank you for you offering to participate in our study here at Virginia Tech. I have your appointment scheduled for:

Time and Date: \_\_\_\_\_

The purpose for conducting this research is to find out what it is like for parents to have a teenager in a residential substance abuse recovery program. You said your son/daughter is currently involved in the agency program/ completed the agency program within the past two years. Because of that, we feel that you have much experience and wisdom to share with us.

The information that you share will be confidential. Neither you nor anyone else interviewed will be personally identified. Any details identifying you will be removed, and your interview information will be combined with that of other sets of parents. You will have the opportunity to go over a summary of the findings to check for accuracy. Your information will not be used for any other purpose beyond this study. Insights from the study will be used to help therapists, counselors, and others better understand the parents and teenagers they work with. None of these professionals will be told how you yourself responded.

Feel free to call about any questions you may have. If you need to make a change in your appointment time, please call me at any time. If I am not there when you call, I will return your call as soon as possible. (Should you decide not to participate, you are free to withdraw. No one in the treatment program will be told of your decision not to be a part of this study.)

Thank you very much for your interest in our study. I look forward to meeting with you.

Sincerely,

Myra Gillum  
Principal Investigator  
703-538-8470

## Appendix E

### Informed Consent Form

#### **Informed Consent for Parent Participation in Virginia Tech's Qualitative Study of Parents' Experiences of Having Their Adolescents in a Residential Substance Abuse Recovery Program**

##### **What kind of study is this?**

- This study is to look at parents' descriptions of what it is like to have an adolescent in a residential substance abuse recovery program. Much research has been done about the adolescents in such programs, but there is little information about what it is like for parents themselves. We are interested in learning about what you yourselves have felt as your son or daughter has gone through this type of recovery. The emphasis will be on your experiences, not your child's.

##### **What will I have to do?**

- Today, after you fill out a short form, participate in a 60-90 minute interview, which will be tape recorded.

- Later you will receive in the mail a transcript of the interview so that you may look it over to be sure the information is correct.

- A few days afterwards, talk to the researcher, who will telephone you, to let her know if there is anything you wish to change, add, or take out.

##### **What are the benefits?**

- Your help will assist the researcher and those who work with parents and teenagers. It will tell them what it is like for parents to have a teen in a residential recovery program. From what you and others share, therapists and staff personnel can learn how to be more helpful to families like yours.

- You and the other parents will get a summary of the findings when the study is complete.

##### **What are the risks?**

- You may at one point or another find it uncomfortable to talk about certain things. You have the right to control what is talked about. If the interview is too uncomfortable, you can end it at any time. If you would like, counseling will be made

available to you. You, the participant, will be responsible for all costs associated with this counseling.

- After the in-person interview, you may wish you had said something different or not mentioned certain things. You will have the opportunity in the phone interview to add, change, or take out information to better reflect your views or to further protect your privacy.

### **Is it private?**

- The researcher will ask about your experience of having an adolescent in a recovery program. She will not be sharing your specific responses with anyone connected with the agency program(s). Your information will be completely confidential. False names will replace yours on the short information form and in the typed copy of the interview. Only the researcher and her advisors will have access to the data.

- We have a Confidentiality Certificate from the US government that adds special protection for the research information that identifies you. It says we do not have to identify you, even under a court order or subpoena. Still, we may report medical information (if you need medical help), probable harm to yourself or others, or probable child abuse, and the government may see your information if it audits us. This Certificate does not mean the government approves or disapproves of our project.

- Once the completed study is accepted, any material containing identifying information will be destroyed, including the audiotapes, notes, and transcripts with identifying information in them. None of your personal information will ever be available to the staff of any adolescent recovery programs.

### **Can I quit if I want to?**

- Participation in this study is voluntary. You may withdraw from it at any time. There is no penalty now or in the future for you or your child if you decide to withdraw. If your teenager is currently in the program, your withdrawal will not affect his or her participation in the program.

### **Is there any compensation?**

- When this project is complete, participants will be provided with a summary of the study's findings.

- You will have the satisfaction of sharing your story.

- You will know your contribution may help others.

- Beyond the above, you will receive no additional compensation.

## **Approval of Research**

- This project has been approved, as required, for research involving humans. Virginia Tech's Department of Human Development has approved it. Virginia Tech's Institutional Review Board has approved it.

## **Participant's Permission and Responsibilities**

- I agree to be part of this study. I have read this consent form. I have had all of my questions answered. By signing below, I freely give my consent to participate in this project. I agree to follow the guidelines of this study. I am aware that I have the right to withdraw at any time.

- If I have any questions about this research I will contact:

Myra Gillum      Dr. Eric McCollum  
Researcher      Faculty Advisor  
703-538-8470      703-538-8470  
mgillum@vt.edu      emccollu@vt.edu

Marriage and Family Therapy Program  
Virginia Tech  
7054 Haycock Road,  
Falls Church, VA 22043

Dr. David M. Moore  
Chair, Virginia Tech Institutional Review  
Board for the Protection of Human Subjects  
Office of Research Compliance  
1880 Pratt Drive, Suite 2006 (0497)  
Blacksburg, VA 24061  
540-231-4991 moored@vt.edu

---

Participant's Name (Please print.)

---

Participant's Signature

---

Date

---

Participant's Name (Please print.)

---

Participant's Signature

---

Date

Appendix F  
IRB Letters of Approval



Office of Research Compliance  
Institutional Review Board  
1880 Pratt Drive (0497)  
Blacksburg, Virginia 24061  
540/231-4991 Fax: 540/231-0959  
E-mail: moored@vt.edu  
[www.irb.vt.edu](http://www.irb.vt.edu)

DATE: January 11, 2007

PWA00000572 (expires 7/20/07)  
IRB # is IRB0000667.

MEMORANDUM

TO: Eric E. McCollum  
Myra Gillum

Approval date: 1/11/2007  
Continuing Review Due Date: 12/27/2007  
Expiration Date: 1/10/2008

FROM: David M. Moore 

SUBJECT: **IRB Expedited Approval:** "A Qualitative Study of Parents' Experiences of Having Their Adolescents in Residential Substance Abuse Recovery Program", IRB # 06-726

This memo is regarding the above-mentioned protocol. The proposed research is eligible for expedited review according to the specifications authorized by 45 CFR 46.110 and 21 CFR 56.110. As Chair of the Virginia Tech Institutional Review Board, I have granted approval to the study for a period of 12 months, effective January 11, 2007.

As an investigator of human subjects, your responsibilities include the following:

1. Report promptly proposed changes in previously approved human subject research activities to the IRB, including changes to your study forms, procedures and investigators, regardless of how minor. The proposed changes must not be initiated without IRB review and approval, except where necessary to eliminate apparent immediate hazards to the subjects.
2. Report promptly to the IRB any injuries or other unanticipated or adverse events involving risks or harms to human research subjects or others.
3. Report promptly to the IRB of the study's closing (i.e., data collecting and data analysis complete at Virginia Tech). If the study is to continue past the expiration date (listed above), investigators must submit a request for continuing review prior to the continuing review due date (listed above). It is the researcher's responsibility to obtain re-approval from the IRB before the study's expiration date.
4. If re-approval is not obtained (unless the study has been reported to the IRB as closed) prior to the expiration date, all activities involving human subjects and data analysis must cease immediately, except where necessary to eliminate apparent immediate hazards to the subjects.

**Important:**

If you are conducting **federally funded non-exempt research**, this approval letter must state that the IRB has compared the OSP grant application and IRB application and found the documents to be consistent. Otherwise, this approval letter is invalid for OSP to release funds. Visit our website at <http://www.irb.vt.edu/pages/newstudy.htm#OSP> for further information.

cc: File

Department Reviewer: Angela J. Huebner

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*An equal opportunity, affirmative action institution*

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Office of Research Compliance  
Institutional Review Board  
1880 Pratt Drive (0497)  
Blacksburg, Virginia 24061  
540/231-4991 Fax: 540/231-0959  
E-mail: moored@vt.edu  
[www.irb.vt.edu](http://www.irb.vt.edu)

FWA0000572 (expires 1/20/2010)  
IRB # is IRB0000667

DATE: April 4, 2007

MEMORANDUM

TO: Eric E. McCollum  
Myra Gillum

Approval date: 1/11/2007  
Continuing Review Due Date: 12/27/2007  
Expiration Date: 1/10/2008

FROM: David M. Moore 

SUBJECT: **IRB Amendment 1 Approval:** "A Qualitative Study of Parents' Experiences of Having Their Adolescents in Residential Substance Abuse Recovery Program", IRB # 06-726

This memo is regarding the above referenced protocol which was previously granted approval by the IRB on January 11, 2007. You subsequently requested permission to amend your IRB application. Since the requested amendment is nonsubstantive in nature, I, as Chair of the Virginia Tech Institutional Review Board, have granted approval for requested protocol amendment, effective as of April 4, 2007. The anniversary date will remain the same as the original approval date.

As an investigator of human subjects, your responsibilities include the following:

1. Report promptly proposed changes in previously approved human subject research activities to the IRB, including changes to your study forms, procedures and investigators, regardless of how minor. The proposed changes must not be initiated without IRB review and approval, except where necessary to eliminate apparent immediate hazards to the subjects.
2. Report promptly to the IRB any injuries or other unanticipated or adverse events involving risks or harms to human research subjects or others.
3. Report promptly to the IRB of the study's closing (i.e., data collecting and data analysis complete at Virginia Tech). If the study is to continue past the expiration date (listed above), investigators must submit a request for continuing review prior to the continuing review due date (listed above). It is the researcher's responsibility to obtain re-approval from the IRB before the study's expiration date.
4. If re-approval is not obtained (unless the study has been reported to the IRB as closed) prior to the expiration date, all activities involving human subjects and data analysis must cease immediately, except where necessary to eliminate apparent immediate hazards to the subjects.

cc: File

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*An equal opportunity, affirmative action institution*

Appendix G  
NIH Certificate of Confidentiality



National Institutes of Health  
National Institute on Drug Abuse  
Bethesda, Maryland 20892

## CONFIDENTIALITY CERTIFICATE NO. DA-07-016

Dear Investigator:

The original Confidentiality Certificate issued to your organization is enclosed. Please keep the original certificate in a safe place. Any correspondence sent to NIDA regarding the certificate must reference the certificate number. Please note the Certificate expires at the end of January 2009. We have provided one more year of Certificate coverage than you requested because it has been our experience that many studies take longer to complete than initially projected. Providing an extra year ensures coverage for subjects and may spare you the need to formally submit a request for an extension.

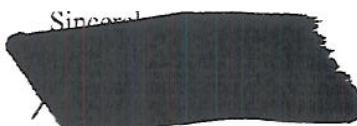
Please be sure that the consent form given to research participants accurately states the intended uses of personally identifiable information (including matters subject to reporting) and the confidentiality protections, including the protection provided by the Certificate of Confidentiality with its limits and exceptions.

If you determine that the research project will not be completed by the expiration date, you must submit a written request for an extension of the Certificate three months prior to the expiration date. If you make any changes to the protocol for this study, you should contact me regarding modification of this Certificate. Any requests for modifications of this Certificate must include the reason for the request, documentation of the most recent IRB approval, and the expected date for completion of the research project.

Please advise me of any situation in which the certificate is employed to resist disclosure of information in legal proceedings. Should attorneys for the project wish to discuss the use of the certificate, they may contact the Office of the NIH Legal Advisor, National Institutes of Health, at (301) 496-6043.

Correspondence should be sent to: Anne Jarrett, 6101 Executive Boulevard, Room 220, MSC 8401, Bethesda, MD 20892-8401, Phone (301) 402-6020 and fax number (301) 443-0538.

Please visit the NIH website for Confidentiality Certificates at  
<http://grants.nih.gov/grants/policy/coc/index.htm>.

Sincerely,  


Mark R. Green, Ph.D.  
Confidentiality Certificate Coordinator

Enclosure

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**CONFIDENTIALITY CERTIFICATE NO. DA-07-016**

issued to

**VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY**

conducting research known as

**"A QUALITATIVE STUDY OF PARENTS' EXPERIENCES OF HAVING  
THEIR ADOLESCENTS IN A RESIDENTIAL SUBSTANCE ABUSE  
RECOVERY PROGRAM"**

In accordance with the provisions of section 301(d) of the Public Health Service Act (42 U.S.C. § 241(d)), this Certificate is issued in response to the request of the Principal Investigator, Eric E. McCollum, Ph.D., Department of Human Development, Virginia Tech, Northern Virginia Center, 7054 Haycock Road, Falls Church, VA 22043, to protect the privacy of research subjects by withholding their identities from all persons not connected with this research. Dr. McCollum is primarily responsible for the conduct of this research.

Under the authority vested in the Secretary of Health and Human Services by section 301(d), all persons who:

1. are enrolled in, employed by, or associated with Virginia Polytechnic Institute and State University and its research sites, contractors or cooperating agencies and
2. have in the course of their employment or association access to information that would identify individuals who are the subjects of the research pertaining to the project known as, "A Qualitative Study of Parents' Experiences of Having Their Adolescents in a Residential Substance Abuse Recovery Program."

are hereby authorized to protect the privacy of the individuals who are the subjects of that research by withholding their names and other identifying characteristics from all persons not connected with the conduct of that research.

This research began on January 22, 2007 and is expected to end on January 31, 2009.

The purpose of this study is to explore what it is like for parents to have an adolescent in a residential substance abuse recovery program.

Study subjects' identities are protected by replacing their names with pseudonyms on all information forms and transcriptions of interviews. Both the code name identification key and the audiotapes are secured in a locked file. The code name identification sheet and the audiotapes will be destroyed when the study is completed.

A Certificate of Confidentiality is needed because sensitive information concerning the participation of the adolescent children of the study subjects in a substance abuse treatment program is collected during the course of the study. The Certificate will help researchers avoid involuntary disclosure that could expose subjects or their families to adverse economic, legal, psychological and social consequences.

As provided in section 301(d) of the Public Health Service Act 42 U.S.C. 241(d):

"Persons so authorized to protect the privacy of such individuals may not be compelled in any Federal, State, or local civil, criminal, administrative, legislative, or other proceedings to identify such individuals."

This Certificate does not protect you from being compelled to make disclosures that: (1) have been consented to in writing by the research subject or the subject's legally authorized representative; (2) are required by the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.) or regulations issued under that Act; or (3) have been requested from a research project funded by NIH or DHHS by authorized representatives of those agencies for the purpose of audit or program review.

This Certificate does not represent an endorsement of the research project by the Department of Health and Human Services. This Certificate is now in effect and will expire at the end of January 2009. The protection afforded by this Confidentiality Certificate is permanent with respect to any individual who participates as a research subject (i.e., about whom the investigator maintains identifying information) during any time the Certificate is in effect.

Date:

*January 13, 2007*

Nora D. Volkow, M.D.

D:

**Appendix H**  
**Demographic Information Form**

Name(s): \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone Number(s): \_\_\_\_\_

May the researcher identify herself and the study when calling?       Yes       No

Your age(s): \_\_\_\_\_

How do you define yourself ethnically? (white, black or African American, Hispanic or Latino, American Indian, Alaska native, Asian, Native Hawaiian or other Pacific Islander, some other race, two or more races,)

\_\_\_\_\_

Name and age of the adolescent in the treatment program: \_\_\_\_\_

Ages of other children in the home: \_\_\_\_\_

Your relationship to the adolescent in the program: \_\_\_\_\_

Name of current treatment program: \_\_\_\_\_  
\_\_\_\_\_

How long has your adolescent been in the current program? \_\_\_\_\_

Names of any previous treatment programs

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

## Appendix I

### Guiding Interview Questions for the Parents' 60-90 Minute Interview

This interview schedule served as a guide during the actual interview. The researcher asked these questions after a brief introduction reiterating the purpose of the study and reminding them of their right to decline to answer any question or to stop the interview without penalty.

1. I am interested in knowing about your experience of having a son in a the residential substance abuse treatment program at the agency. Can you tell me briefly what led up to his being in such a program?

*Probe:*

- When was the first time your son/daughter attended a recovery program?
- How many times have they been in a recovery program?
- When did your child enter the residential program he/she is currently attending?

2. What was it like for you as a parent when you and your son/daughter went through the intake process--talking to the staff, having to answer all those questions, etc.

3. When your child first went to treatment, in the initial month or two when your child was living at the facility, what was that like for you?

4. What thoughts and/or concerns ran through your mind later as your child neared completion of his/her program?

5. Therapists sometimes talk about "stages" in the recovery process where there are noticeable shifts in attitude and behavior. Do you think that as a parent in the program you went through stages of your own? If so, tell me about that.

6. Was there a most difficult or low point for you when your child was in the agency recovery program? (*If not, go to the next question.*) If so, what was it and how did you handle that? (*Probe for personal resources like extended family, friends, church, hobbies, etc.*)

7. Agencies often require the resident adolescents to attend AA meetings while they're in the program. Was this true for your son? (*If not, move on to the next question.*) If so, how do you feel about that requirement and about its impact on you as parents?

8. Many kids relapse while in treatment (use again, have a dirty urine, run away). Did this happen to your son/daughter? If so, what was that experience like for you?

9. What were the best things about having your child in the program? What was it like for you during those times?

10. Was there a specific turning point when things really started to get significantly better for you as a parent? (*If no, go on to the next question.*) *If yes:* tell me about that.

*Probe:*

- I'd also like to know what you think it was inside you or about you that changed then.
- Why do you think that happened at that particular time?

11. *Omit if short on time or if already covered in responses to earlier questions:* Sometimes, outside resources like family, friends, church, etc., can be an additional source of help. Was this true for you?

12. Some people find that as they look back they see things differently or more clearly. Are there ways in which your thoughts and feelings about the experience of having a teenager in a residential alcohol and drug treatment program have changed since you have been in/have completed the program?

13. What advice, if any, might you have for parents of an adolescent newly entering the residential treatment experience?

14. What advice might you have for various professionals--counselors, family therapists, program personnel -- who would be working with a new teenager and his or her family?

15. Are there any other things you'd like to talk about that we haven't touched upon?

## Appendix J

### Cover Letter for Follow-up Interview

(to be sent to participants shortly after their first interview)

Dear \_\_\_\_\_,

Thank you again for your participation in the study on the experiences of parents having an adolescent in a substance abuse recovery program. It was very helpful.

Enclosed you will find a copy of your comments in response to my questions on (date) from the Virginia Tech study of Parents' Experiences of Having an Adolescent in a Residential Substance Abuse Recovery Program. It is very important to me to be true to what was said in our conversation. I will be calling you in about a week to get your response. This will be your opportunity to have me remove anything that you do not want included or for you to tell me about anything important that I have left out or new that I should add.

If you wish, you may call to let me know when would be a good choice of times for us to have this conversation. Otherwise I will go ahead and call in about a week. If it is not convenient to talk then, we will find a better time.

I look forward to talking with you again.

Sincerely,

Myra Gillum  
703-538-8470

## Appendix K

### Questions for Parents' Follow-up Interview

First go over the transcript of the first interview and ask for corrections and additions.

Then ask:

1. What else have you thought of since our first interview that you would like to share about the experience of having a teenager in a substance abuse treatment program?
2. What questions haven't I asked that you think are important?

Thank the parents for their time and their thoughtful responses and wish them well.

## Curriculum Vita

Myra H. Gillum is a graduate of Virginia Tech's Marriage and Family Therapy Master's Certificate Program, where she was a therapist intern at the Virginia Tech Center for Family Services from 2004-2007. She also served an internship at Alternative House, a residential teen crisis center in Fairfax County, from January to May, 2007. She is a former high school English teacher and holds an M.A. in English literature from the University of Pennsylvania and a B.A. from Chatham College in Pittsburgh, PA.