MENTAL HEALTH OUTCOMES, SOCIAL FUNCTIONING, AND THE PERSPECTIVES OF CHILDREN FROM METHAMPHETAMINE-INVOLVED FAMILIES IN THE RURAL MIDWEST: CHALLENGES AND STRENGTHS

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ABSTRACT

Social workers must confront a number of significant challenges as front-line workers in their efforts to provide appropriate prevention and intervention services to children from methamphetamine-involved, rural-dwelling families. Developing an understanding of children’s strengths as well as their limitations is necessary to the development of interventions that not only remediate deficits, but develop strengths. This cross-sectional, descriptive research describes the mental health, social functioning, and social context of 39 children aged 6 to 15 from methamphetamine-involved families receiving child protective services in rural Illinois. An examination of how social context may provide protection from risks to children’s mental health and social competence posed by parent substance misuse was explored. Two illustrative cases of children experiencing differing levels of risk and protection are also presented.

Mental health was assessed utilizing the Child Behavior Checklist and Trauma Symptom Checklist for Children and results indicate half of the children in this study were experiencing internalizing symptoms and over half were experiencing externalizing problem behavior based on the CBCL. Slightly less than half of the children were experiencing problems associated with dissociation, post-traumatic stress, anger, and depression and over half of children had clinically significant scores on one or more of the five TSCC subscales. As a group, children scored in the normal range on the CBCL Competence scales. This finding suggests that children had some level of protection from the risks associated with substance-affected homes. Children reported that they received social support from a variety of sources including immediate and extended family members. Importantly, family history of intergenerational substance misuse and the presence of a supportive grandparent were shown to be significantly related to children’s mental health and adaptive functioning.
# TABLE OF CONTENTS

CHAPTER 1: INTRODUCTION .................................................................................................. 1

CHAPTER 2: RESEARCH METHODOLOGY ......................................................................... 20

CHAPTER 3: A DESCRIPTION OF CHILDREN’S MENTAL HEALTH, SOCIAL COMPETENCE, FAMILY-OF-ORIGIN EXPERIENCES, SOCIAL SUPPORT, AND HOPE .......................................................................................................................... 39

CHAPTER 4: CASE STUDIES ................................................................................................... 61

CHAPTER 5: DISCUSSION AND CONCLUSION .................................................................. 88

REFERENCES .......................................................................................................................... 103

APPENDIX A: TRAUMA SYMPTOM CHECKLIST FOR CHILDREN ........................................... 114

APPENDIX B: CHILDREN’S EXPERIENCES IN THEIR FAMILY-OF-ORIGIN INTERVIEW .............................................................................................................................. 116

APPENDIX C: RECORD REVIEW FORM .................................................................................. 117
CHAPTER 1
INTRODUCTION

This cross-sectional research describes the mental health, social functioning, and social context of 39 children aged 6 to 15 from methamphetamine-involved families receiving child protective services in rural Illinois. To meet the needs of children from methamphetamine-involved families, child welfare professionals and social work practitioners need systematic, descriptive data regarding the family contexts in which children have been reared as well as their social and psychological functioning. Understanding the context of methamphetamine-involved families in predominantly white, rural communities is necessary to the elaboration of any effective preventive and intervention services within this distinct cultural context. Much of the literature regarding children from substance-affected families, and methamphetamine-involved families in particular examines psychopathology. This study is unique in that it includes examination of social functioning and positive family-of-origin experiences as well as psychopathology and associated risk factors among a sample of children whose parents misused methamphetamine. Developing an understanding of children’s strengths as well as their limitations is necessary to the development of interventions that not only remediate deficits, but develop strengths.

The aims of this study are addressed from a socio-cultural framework. The aims of this study are, 1) To describe the mental health and social functioning of children from methamphetamine-involved families; 2) To describe these children’s perspectives of their social context; 3) To identify any relationships among mental health and social functioning and social context variables; and, 4) To explore, using case cluster analysis, any patterns emerging across
children pertaining to possible risk and protective factors for mental health and social functioning.

Socio-cultural theory, specifically, cultural developmental psychology (Rogoff, 2003; Bruner, 1990), was utilized to gain perspective of the complex interaction of psychological and social factors operating within the particular cultural context of methamphetamine use in rural Illinois (Gaskins, Miller & Corsaro, 1992; Goncu, 1999; Greenfield & Suzuki, 1998; Rogoff, 2003; Shweder, Goodnow, Hatano, LeVine, Markus, & Miller, 1998; Vygotsky, 1986, Wertsch, 1985). A basic premise is that children’s development is largely embedded within, and cannot be understood apart from, their cultural context (Haight, 2002). Their proximal context includes the practices and beliefs of adults within their care-giving environments communicated through child-rearing, parenting, material conditions, moral direction, and interpersonal relationships. From a socio-cultural perspective, other aspects of the child’s ecological context potentially influence functioning such as relationships with caseworkers and social service agencies, rulings by the judicial system, and cultural beliefs regarding substitute care (Orme & Beuhler, 2001). Such aspects of ecology are outside the purview of this research.

The constructs of interest in this study include resilience, risk, protection, mental health, social functioning, and hope. For the purposes of this research, the term resilience is defined as individual variations in response to risk (Rutter, 1990). Resiliency is clearly not a static state (Cicchetti, Toth, & Maughan, 2000; Egeland, Carlson, & Sroufe, 1993). All children show fluctuations in resiliency over time and within particular developmental domains. As Rutter (1990) argues, key global risk and protective composites (individual, familial, external support) are highly robust predictors of resilience and are important to showing that they are likely to play key roles in the processes involved in people’s responses to risk circumstances. Risk and
Protection have been defined in numerous ways in the literature. For the purposes of this study, a risk factor is a characteristic of the person or the environment that renders the person vulnerable to adverse outcomes. A protective factor is defined as “individual or environmental characteristics that reflect the absence of risk factors or the presence of ameliorative factors” (Kaplan, 1999, p. 46).

The broad construct of mental health is operationalized following the conventions established by the assessments utilized to measure mental health outcomes in this study; specifically, the Child Behavior Checklist and the Trauma Symptom Checklist for Children. These instruments and their psychometric properties are discussed in the Instruments subheading in Chapter 2. Social functioning is measured utilizing the Child Behavior Checklist, again, as presented in Chapter 2, and incorporates social competence, school competence and competence in daily activities. Hope is defined in this study as expectations for a positive future event, state, or relationship.

Nation-wide, methamphetamine lab seizures increased in 2008, the first increase in lab seizures since 2003 (National Drug Intelligence Center, 2009). Further, the national cost of methamphetamine use is $23.4 billion (RAND, 2009) and these costs are particularly problematic for the State of Illinois, which ranks #4 in the country for methamphetamine-related arrests and for methamphetamine lab seizures (U.S. Department of Justice, 2008). Moreover, the growing problem of methamphetamine production (Federal Bureau of Investigations, 2006) and misuse in the United States is particularly problematic in rural areas. In a study using data from the 2002, 2003, and 2004 National Survey of Drug Use and Health conducted annually by the U.S. Department of Health and Human Services, researchers at the University of Maine (Muskie School of Public Service, 2007) found that young adults (age 18-25) in rural areas use
methamphetamine at nearly twice the rate as their urban counterparts. Similarly, Hutchison and Blakely (2003) found that a higher percentage of rural children in 8th and 12th grade misused methamphetamine (13.5% and 6.4% respectively) than did urban children in the 8th and 12th grade (2.2% and 4.2% respectively). Furthermore, rural individuals who misuse methamphetamine may be at heightened risk for poor mental health functioning for example, due to limited access to substance misuse treatment and mental health centers in rural areas.

Methamphetamine is a powerful central nervous system stimulant. The user of methamphetamine experiences enhanced mood, feelings of intense pleasure, satisfaction, and energy associated with the release of the neurotransmitter, dopamine (Swetlow, 2003). Addiction to methamphetamine occurs quickly as repeated use lowers the brain’s ability to manufacture dopamine. Decreases in dopamine levels in the brain lead to increased cravings for the drug and depression (Hohman, Oliver, & Wright, 2004). Methamphetamine use is associated with heart and brain damage, impaired thinking and memory problems, aggression, violence, and psychotic behavior (Otero, Boles, Young, & Dennis, 2006; Hohman, et al., 2004; Fleming, 2005; Swetlow, 2003; Pach & Gorman, 2002). People who have recently stopped misusing methamphetamine may have brain abnormalities similar to those seen in people with mood disorders such as depression and anxiety (National Institutes of Health, 2004).

Although parental misuse of any drug poses risks for children, there are a number of reasons why professionals are particularly concerned about parental misuse of methamphetamine. First, methamphetamine is highly addictive and, relative to other substances, users may become rapidly disabled both physically and mentally (Fleming, 2005; Rawson, Gonzales, & Brethen, 2002; Cretzmeyer, Sarrazin, Huber, Block, & Hall, 2003). Rapid parental deterioration can be both frightening and dangerous to children who have little time to adapt, for
example, to find other sources of food, safety and psychological support. Second, methamphetamine may be produced in and around the home exposing children to toxic chemicals as well as explosions and fires (West, McKenna, Stuntz & Webber-Brown, 2000; Meredith, Jaffe, Ang-Lee, & Saxon, 2005). Third, compared with cocaine, the effects of methamphetamine on the user last longer—hours, rather than minutes. In the short-term, these longer-lasting effects of methamphetamine suggest that parents are incapacitated for longer periods of time compared to cocaine. Moreover, methamphetamine has a longer-term impact on brain functioning and behavior than other illicit drugs and research suggests the need for longer periods of treatment and monitoring following treatment (Rawson et al., 2002). Although methamphetamine misusers respond similarly to treatment as cocaine users, detoxification and healing from the structural and chemical effects of methamphetamine misuse on the brain requires ample time ranging from 6 to 12 months (Lukas, 1996; Rawson et al., 2002). Parents with children need treatment programs that consider the needs of children during their parents’ treatment and recovery. Finally, parents are likely to receive stiff prison terms for methamphetamine misuse and production: In 2001, the average federal methamphetamine-related prison sentence was 88.5 months (National Association of Counties, 2005). Furthermore, the Comprehensive Methamphetamine Control Act of 1996 includes a provision that creates a penalty of up to 20 years in prison for people who sell or cook methamphetamine in a home where a child lives. Thus, children whose parents are involved with methamphetamine and entering into foster care likely will remain for prolonged periods of time.

Mental Health of Children from Methamphetamine-Affected Homes

Research is just beginning to consider the mental health and psychological functioning specifically of rural children whose parents misuse methamphetamine. In 2005, we (Haight,
Jacobsen, Black, Kingery, Sheridan & Mulder, 2005) completed an ethnographic study of the contexts in which children from methamphetamine-involved families are reared. In this study, we sought to identify the experiences and needs of children of methamphetamine misusers in rural Illinois. Results from the study indicate that many children whose parents use methamphetamine are brought up in environments characterized by antisocial beliefs and practices, environmental danger, chaos, neglect, isolation, abuse, trauma, and loss. Findings from our study are consistent with other research which indicate children whose parent(s) misuse methamphetamine often are exposed to toxic chemicals, violence, criminal behavior and neglect as well as physical, sexual and emotional abuse (Anglin, Burke, Perrochet, Stamper, & Dawad-Noursi, 2000; Cretzmeyer et al., 2003).

Adult informants from our study described the effects of parent methamphetamine misuse on children as disturbed psychological, social, and educational development. In addition to these descriptions of risk, protective factors suggested by our study included individual factors such as intelligence and sociability, social and interpersonal factors such as the availability of another supportive, non-parent adult, and community factors such as emotionally supportive school teachers.

We also combined qualitative interviews and standardized assessments to describe the psychological functioning of children from methamphetamine-involved families. We described beliefs, experiences, and performance on standardized psychological assessments of 18 children (aged 6-14) in foster care because of parent methamphetamine misuse (Haight, Ostler, Black, Sheridan, & Kingery, 2006; Ostler, Haight, Black, Choi, Kingery, & Sheridan, 2007). Children described emotional pain; few social resources for coping with emotions, problem solving, or talking about their experiences; and avoidant or passive coping skills. Half of the 18 participating
children (9) experienced internalizing, externalizing or trauma symptoms in the clinical or sub-clinical range on both the Child Behavior Checklist and Trauma Symptom Checklist for Children. Sixty-five percent of children evidenced significant dissociative or posttraumatic symptoms on standardized assessments; 57% had other significant emotional and behavioral problems on the CBCL.

In semi-structured interviews, most children (13) did report traumatic experiences associated with observing parents’ active substance misuse (11), violence between adults at home (9), and parents’ criminal behavior and its consequences (e.g., drug busts) (9). Some children (6) also expressed distress at participation in anti-social activities associated with parents’ methamphetamine misuse, e.g., stealing precursors and lying to teachers. These reports are consistent with adult reports from the ethnographic study.

Unlike adult reports, however, children did not report neglect as an issue. Many (9) did, however, spontaneously report traumatic separation from and loss of parents, an issue not emphasized by knowledgeable adults. Most children (10) spontaneously described their parents’ methamphetamine misuse as a taboo topic. Very few children (3) reported discussing their experiences within their families with an adult outside of the family. Not surprisingly, then, many children expressed beliefs about themselves and their families that may inhibit positive development, for example, that they and their families are “bad,” that it is their fault that their parents use methamphetamine, and that other families do not experience similar struggles. Findings from our ethnographic study are consistent with a study of children from methamphetamine-involved families in rural Tennessee, as reported below.

In a 2008 study of psychological outcomes of children from methamphetamine-producing homes, Asanbe and colleagues assessed child behavior and emotional adjustment among a group
of 58 preschoolers living in 12 rural counties in Tennessee. Thirty-one children (mean age 4.53 years) had been removed from their homes because of their parents’ methamphetamine misuse. They had been removed from at least 3 months prior to study participation; currently were living with a family member and not in foster care; had no major medical illness; and, no child history of prenatal exposure to methamphetamine. Twenty children (mean age 4.59 years) served as a comparison group. Participants from both groups were similar across socioeconomic status.

The Behavioral Assessment Scale for Children-Parent (BASC-PRS-P) was utilized to assess behavioral and emotional adjustment. The questionnaire was completed by mothers of children in the comparison group and grandmothers or aunts of the children from the methamphetamine-involved families. The BASC-PRS-P produces four broad domain scores including Externalizing Problems, Internalizing Problems, Behavioral Symptoms Index, and Adaptive Skills that are computed from 8 subscales of hyperactivity, aggression, anxiety, depression, somatization, atypicality, withdrawal, and attention problems and 2 adaptive scales of adaptability and social skills.

Findings from the study indicated a rate of behavior problems 3 times higher for children from methamphetamine-producing homes compared to children in the comparison group. Forty percent of children from methamphetamine-involved families scored in the clinically significant range on externalizing behavior and forty-two percent evidencing aggressive behavior problems while 14.8% of comparison children scored in the clinically significant range on externalizing behavior and 4.7% evidenced aggressive behavior problems. Asanbe and colleagues posit that child participants from methamphetamine-involved families could be modeling violent behavior, responding to troubled home environments, and/or reacting to trauma.
Children whose parents misuse illicit drugs face a number of psychosocial risk factors. Parenting by substance misusing parents has been associated with neglect, physical and emotional abuse, excessive control and punishment, inconsistent discipline, and lack of emotional involvement (Hans, Bernstein, & Henson, 1999; Suchman & Luthar, 2000; Klee, 2002). A study conducted by the National Center on Addiction and Substance Abuse at Columbia University (CASA) found that in the period from 1986 to 1997, children whose parents misuse substances are almost three times likelier to be physically or sexually assaulted and more than four times likelier to be neglected than children of non-substance abusing parents (CASA, 1999).

Children raised in drug-using homes are at higher risk for early pregnancy, dropping out of school, and involvement in criminal and other antisocial behavior than children without these stressors (Millar & Stermac, 2000). Research shows also that children of parents who misuse drugs are more at risk than their peers whose parents do not misuse drugs for delinquency, depression, poor school performance, and alcohol and drug use (Markel, 2005; Cretzmeyer et al., 2003). Familial influences, such as a history of parent substance misuse and a family history of intergenerational substance misuse, have been identified as major contributors to adolescent drug use and misuse (Cretzmeyer et al., 2003; CASA, 1999). Research that has supported intergenerational transmission models of drug and alcohol abuse indicates a genetic component may partially explain a person’s increased sensitivity to psychoactive substances (Phillips, 1997; Hoffman & Cerborne, 2002). Environmental factors which may also explain the role of intergenerational substance misuse includes problematic parenting (Hans, 2002; 2004). Moreover, many substance abusing parents are themselves children of substance abusers (Hoffman & Cerborne, 2002). It may be that children whose families are characterized by
Intergenerational substance misuse do not have a readily available protective resource of a non-substance misusing adult in their extended family.

The mechanisms by which parenting is affected by drug use include pharmacological factors and psychosocial risk (Hans, 2002; 2004). Pharmacological factors include drug intoxication or withdrawal. A parent under the influence of a substance may lack the motivation or ability to provide care to children. Withdrawal or abstinence from substance use may result in irritability or mood swings as the parent becomes pre-occupied with physical and psychological symptoms (Miller, Maguin, & Downs, 1997; Klee, 2002). Irritability in the form of harsh criticism and emotional or verbal abuse is often tempered with the use of cannabis (Klee, 2002). Among methamphetamine addicts experiencing withdrawal and abstinence, seriously aggressive acts associated with paranoid delusions and amphetamine psychosis are common (Rawson, et al., 2002).

Additional psychosocial risk factors include limited emotional and social resources as well as psychopathology. Drug-dependent parents experience limited social support (Luthar & Walsh, 1995) and many drug-dependent women may also limit their engagement in social networks due to anti-social behavior such as prostitution, theft, or drug-dealing (Suchman, McMahon, Slade, & Luthar, 2005).

Given these risk factors, it is not surprising that children whose parents misuse illicit drugs are at an increased risk for mental health problems including substance misuse disorders. In a study regarding pre-adolescent sons of fathers with substance misuse problems, Moss and colleagues reported that the sons had increased rates of anxiety disorders (Moss, Mezzich, Yao, Gavaler, & Martin, 1995) than offspring of non-substance abusers. In a 1992 study by Gabel and Shindledcker (1992) sons of substance-abusing parents had more conduct disorder than sons of
non-substance abusing parents. Further, daughters of substance-abusing parents were more likely to receive a diagnosis of attention-deficit hyperactivity disorder or conduct disorder than the female offspring of non-substance-abusing parents.

Evidence from the substance misuse literature, however, suggests that not all children exposed to parent substance misuse will develop mental health and substance misuse disorders. For example, some school-aged children raised by methamphetamine-misusing parents develop positive relationships with peers and community members, and perform well in school (Ostler et al., 2007). One factor underlying such diversity may be the quality of adult–child relationships. A small but growing body of qualitative research (e.g., Kearney, Murphy, & Rosenbaum, 1994; Rosenbaum & Murphy, 1987) suggests that many chemically dependent parents love their children (Hans, 2004); and that some are concerned about their children’s exposure to adult substance misuse (Woodhouse, 1992), attempt to protect them from such exposure (Kearney et al., 1994), and provide environments that meet their basic needs (Hans, 2004). In addition, a stable, caring relationship with a supportive adult such as a grandparent or teacher is a social protective factor for substance misuse and mental health disorders in traumatized children (e.g., Lynskey & Fergusson, 1997; Pynoos, Steinberg, & Goenjian, 1996) and children whose parents misuse substances (Kroll, 2004). Adults may provide comfort to children in times of distress, and also help them to understand their experience in a way that facilitates more positive development, e.g., that their parents’ addiction is not their fault, that their parents are ill, and that a better future is possible (Haight et al., 2005).

Social Functioning of Children from Methamphetamine-Affected Homes

No studies to date have examined the social functioning of children from methamphetamine-involved homes. The literature regarding social functioning of children from
other substance-affected homes suggest that such children face numerous challenges. Peleg-Oren and Teichman (2006) report that children of illicit drug abusers are more likely than other children to demonstrate immature, impulsive, or irresponsible behavior, to have lower IQ scores, and poorer school attendance. Children of alcoholics are nearly 10 times more likely to develop an alcohol use disorder as other children, and often develop behavior problems such as depression, anxiety, attention deficit hyperactivity disorder, conduct disorder, and oppositional defiant disorder. Further, children of drug users are at higher risk than children of alcoholics for psychopathology and functional impairments.

Children of parents who misuse drugs score lower on tests measuring school achievement and they exhibit other difficulties in school. One study comparing children of addicts and children living in the same neighborhood without an addicted parent, reported that over half of the children aged 3 to 7 of addict parents had a diminished capacity for school success or adequate social development. These problems were related to the lack of parental supervision and attention. Children of addicts, 8 to 17 years old, had more problem behaviors in school including truancy. Substantially more of the children of addicts had been placed in foster or surrogate care at one time; up to 30% compared to the estimated 2.3% of American children who do not live with either parent (Kolar, Brown, Haertzen, & Michaelson, 1994). Further, children of addicted parents compared to children of non-addicted parents were found at significant disadvantage on standard scores of arithmetic. Sons of addicted parents performed worse compared to daughters on all domains measuring school achievement, using the Peabody Individual Achievement Test-Revised (PIAT-R), including general information, reading recognition, reading comprehension, total reading, mathematics and spelling (Moss et al., 1995).
Studies regarding the social functioning of children from substance-affected homes focus on group trends. Individual variation in social functioning suggests that, for some children, strengths in social functioning serve as a protective factor. Understanding the sources of such diversity is important information for the development of effective prevention interventions and research explicating social functioning as a source of protection is needed.

**Social Context of Children from Methamphetamine-Affected Homes**

Family-of-origin experiences, including exposure to methamphetamine misuse and manufacture, are important to understanding child functioning. Many children whose parents misuse methamphetamine are brought up in environments characterized by antisocial beliefs and practices, environmental danger, chaos, neglect, isolation, abuse, trauma, and loss (Haight et al., 2005). Parental methamphetamine misuse first affects children’s development through prenatal exposure. Prenatal exposure to methamphetamine is associated with small for gestational age birth weights (Smith et al., 2006), spontaneous abortion, preterm births, small head circumference, cerebral infarctions, and congenital abnormalities (see Hohman et al., 2004; Stewart & Meeker, 1997), growth retardation, premature birth, developmental disorders in neonates, enduring cognitive deficits in children, and brain lesions (Amatetti & Young, 2006; Anglin et al., 2000). It is also associated with neurobehavioral outcomes, such as lags in academic and physical development in early adolescence, which may reflect the neurotoxic effects of methamphetamine on the developing central nervous system (Cernerud, Eriksson, Jonsson, Steneroth, Zetterstorm, 1996; Wouldes, LaGasse, Sheridan & Lester, 2004). Compared to pregnant crack/cocaine and heroin users, pregnant methamphetamine users know less about the potential harm of their drug-of-choice to the fetus (Brecht, O’Brien, von Mayrhofer, & Anglin, 2004). Compared to women who do not use methamphetamine, women who use
methamphetamine during pregnancy face an increased risk of poly-drug use, poverty, delayed prenatal care, and out-of-home placement of their children (Brunk, 2004).

Children are also impacted by the postnatal contexts in which they are reared. Understanding these contexts first involves understanding how methamphetamine affects the parent. The physical and psychological effects of methamphetamine misuse pose formidable obstacles to adequate parenting (Amatetti & Young, 2006; Hohman et al., 2004; Anglin et al., 2000, Haight et al., 2005). The initial effect of methamphetamine is a “rush” from the release of high levels of the neurotransmitter, dopamine (Rawson et al., 2002). The user experiences euphoria, decreased fatigue and appetite, and increased energy, alertness and libido that last approximately 10-12 hours (Anglin et al., 2000). As the effects of methamphetamine wear off, users begin “tweaking,” a combination of restless anxiety, irritability, fatigue and dysphoria. Further use of methamphetamine temporarily improves the symptoms, reinforcing the cycle of addiction, until the user “crashes” into a deep sleep that may last for days (Cretzmeyer et al, 2003; Lineberry & Bostwick, 2006).

Regular use of methamphetamine is associated with serious health effects including damage to the teeth, lungs, heart, kidneys and brain (Lineberry & Bostwick, 2006; Meredith et al., 2005). Several psychological effects occur including psychosis, depression, paranoia, rapid mood changes, violent behavior (Anglin et al., 2000; Cretzmeyer et al., 2003) and PTSD (Cohen, Dickow, Homer, Zweben, Balbais, Vanderstoot et al., 2003) as well as deficits in memory, learning and information processing (Meredith et al., 2005). The various cognitive and psychiatric symptoms associated with regular methamphetamine use are related to neurological effects of methamphetamine. With regular methamphetamine use, the brain adapts and the user experiences a “dopamine depletion syndrome” in which a normal good mood, energy level or
attention cannot be experienced (Volkow, Chang, Wang, Fowler, Yee et al., 2001). In addition, high resolution magnetic resonance imaging reveals significant structural abnormalities in the brains of methamphetamine users (Thompson, Hayashi, Simon, Geaga, Hong et al., 2004). Methamphetamine’s ability to disrupt normal brain functioning can be long lasting; psychotic symptoms have been reported to persist for months or years after use of methamphetamine has ceased (Copeland & Sorensen, 2001; Rawson et al., 2002; Cretzmeyer et al., 2003; Brecht et al., 2004).

In a case-based study of rural mothers in recovery from methamphetamine addiction, four women participated in in-depth, semi-structured interviews (Haight, Carter-Black, & Sheridan, 2009). They vividly portrayed the rapid loss of control that can occur with methamphetamine misuse, as well as the power of addiction. They became “obsessed” with the drug and nothing was more important to them, not even the children whom they loved. They lost the ability to think “rationally,” experienced serious lapses in judgment, lost motivation, and lived in a “fog.” They described their illness as impacting their children’s physical and psychological well-being including through exposure to domestic violence, adult substance abuse and other anti-social behavior, and loss of important relationships. They expressed concern that their children would abuse drugs. Women described recovery as possible only with significant external support, and they reported lasting physical, psychological and social side effects of their illness. The information and insight regarding mothers’ experience of methamphetamine addiction is useful to increasing awareness of this illness thereby reducing stigma and suggesting strategies for engaging them in intervention.

Risks to safety and well-being of children are related to the intensity and type of exposure to the manufacture and use of the drug. For example, children may live in a situation where
parents (1) use or misuse methamphetamine, (2) are dependent on methamphetamine, or (3) manufacture small amounts of methamphetamine in the home (“cooking”). Each of these situations poses different risks for children and requires different responses from child protection services.

The greatest numbers of children are exposed to parental use or dependence on methamphetamine and relatively few parents “cook” the drug (Young, 2005). Brecht, et al. (2004) found that only eleven percent of women and fifteen percent of men “ever made meth”. Risks to safety and well-being of children whose parent uses methamphetamine include inadequate supervision, a chaotic home life, exposure to second hand smoke, accidental ingestion of the drug, the possibility of physical or sexual abuse by the parent or by another adult frequenting the home to use drugs, inconsistent parenting, and parenting influenced by the use of methamphetamine such as poor judgment, confusion, irritability, paranoia, and violence (Amatetti & Young, 2006; Hohman, et al., 2004; Anglin et al., 2000, Haight et al., 2005).

When a parent is dependent on methamphetamine, defined in the DSM-IV (1994) as a, “maladaptive pattern of substance use leading to clinically significant impairment or distress” (p. 191), the risks for the safety and well-being of the child expand. The child is exposed to the effects of the drug on their parents more often and for longer periods of time, chronic neglect is more likely, the household may lack food, water, and utilities, lack of dental and medical care for the child, a greater risk for abuse, and a greater risk for sexual abuse of the child if the parent has multiple partners (Young, 2005, Anglin, et al. 2000).

When a parent manufactures small quantities of methamphetamine in the home for their personal use or to supplement income the risks for the safety and well-being of children increase to include the exposure to chemicals and toxic fumes and a risk of fire or explosion from the
processes involved in “cooking”. Risks also may include the presence of weapons, a higher likelihood of violence, and the possibility of long-term incarceration of parents and the resultant permanency issues for children (Young, 2005).

**Significance**

Methamphetamine and amphetamine-related stimulants have become the most widely used illicit drugs in the United States and in much of the world (Bemberg, 1997; World Health Organization, 2008) and the most prevalent synthetic drug manufactured in the United States (Swetlow, 2003). In 2005, an estimated 10.3 million Americans (4.3 percent of the U.S. population) had used methamphetamine at some time in their lives (Substance Abuse and Mental Health Services Administration, 2006). The group experiencing the greatest increase in use of methamphetamine is women of child-bearing age (Hohman et al., 2004). Further, substance misuse and addiction are the primary causes of the dramatic rise in child abuse and neglect since the mid-1980s with substance misuse a factor in 70% of child maltreatment cases nationally (CASA, 1999).

The rapid growth of methamphetamine use and production in the U.S. continues to be an urgent public health, criminal justice, and child welfare problem affecting whole families, particularly in rural areas. At the turn of the 21st century, methamphetamine production and misuse had increased dramatically in Illinois. In 1997, police seized 24 labs statewide. In 2001, they seized 666 methamphetamine labs (ICJIA, 2004). Nation-wide, methamphetamine lab seizures increased in 2008, the first increase in lab seizures since 2003 (National Drug Intelligence Center, 2009). In Illinois, methamphetamine misuse and production is largely a rural problem. One of the counties included in this study had 220 drug crime arrests in 2001, more than a 100% increase over the previous year’s 101 arrests for crimes associated with drugs
This county “boasts” the largest number of methamphetamine labs seized in the state of Illinois in 2001 (97 labs) (ICJIA, 2004). The rise of methamphetamine production and misuse in rural Illinois has taken a serious toll on children. At the time in which data for this study were collected, the Charleston Field Office of the Illinois Department of Children and Family Services handled between 95 and 100 child abuse hotline reports of child maltreatment per month. Approximately 25% of these cases involved parent methamphetamine misuse. Indeed, the most frequently cited reason for opening a case at the Charleston Field Office was parent substance misuse (27%) (U.S. Department of Health and Human Services, 2004).

Little empirical research is available to guide elaboration of preventive and intervention services to rural families involved with methamphetamine. Understanding the context of methamphetamine misuse in predominantly white, rural communities is necessary to the elaboration of any effective preventive and intervention services within this distinct cultural context. Social workers are fundamentally interested in understanding human behavior in the social environment and many social work interventions aim to address the social context of the individual. This research has contributed to the knowledge base in substance misuse prevention research concerned with modifying generic, family-centered prevention interventions to culturally-sensitive prevention interventions for distinct, high risk groups. Given the paucity of data on children of parents who misuse methamphetamine, it is difficult to differentiate the unique needs of methamphetamine-misusing families from those of other highly disrupted and/or substance-misusing families.

There is some evidence that children whose parents misuse methamphetamine are at high risk for health, substance misuse and mental health disorders (Haight et al., 2005, 2006). Existing
research suggest that parent methamphetamine misuse is associated with children’s stress and trauma (Rawson et al., 2002; Swetlow, 2003; Haight et al., 2005; 2006; Ostler et al., 2007). Findings from this research reveal individual variation in the mental health, social competence, and the social contexts of children exposed to parent methamphetamine misuse, suggesting the presence of protective factors. Understanding the sources of such diversity is important information for the development of effective prevention interventions. The basic descriptive data resulting from this study is an essential first step in identifying sources of resilience.
CHAPTER 2

RESEARCH METHODOLOGY

This study describes the mental health and social competence as well as the social context of rural children from methamphetamine-involved families and interprets how social context may provide protection from risks to children’s mental health and social competence posed by parent substance misuse. It is part of a larger study (Haight, Ostler, Black, & Kingery, 2009) funded in part by a grant from the National Institute on Drug Abuse (1R21DA020551-01A2) and the Illinois Department of Children and Family Services. The mixed method approach utilized in this study is particularly appropriate for addressing the research aims as it is widely recognized as critical for understanding children from diverse cultural communities (e.g., Heath, 1996; Miller, 1982; Ogbu, 1974; Phillips, 1983), including children who grow up in contexts that place them at risk (e.g., Jessor, Colby, & Shweder, 1996). The qualitative component of mixed methods research design allows for the idiographic exploration of children reared in methamphetamine-involved homes and their subjective experiences. This component is particularly important when those involved in the research— the children, researchers, and professionals— come from different communities. The quantitative component allows for a nomothetic understanding of children’s social competence and mental health in relation to other samples of children. Taken together, the qualitative and quantitative aspects of this study aids in developing a contextualized understanding of this unique group of children.

Design

This study utilizes an inductive, mixed methods research design with an emphasis on the qualitative component (notated as QUAL + quan) (Morse, 2003). The qualitative and quantitative methods of data collection in this study occurred concurrently. Qualitative methods included an
ethnographic approach aimed at developing culturally-relevant descriptions of children’s perspectives and experiences in their families of origin. Sources of data include semi-structured, in-depth interviews with children and reviews of their records from the state child protection agency. Quantitative methods were employed to understand children’s mental health and adaptive functioning in relation to the general population and to other foster children as well as children exposed to parent substance misuse. Sources of quantitative data are standardized, clinical assessments of child behavior and mental health and receptive language.

Setting

Child participants resided within a nine county area served by several rural outposts of the Illinois Department of Children and Family Services (IDCFS). According to the U.S. Census Bureau (2009), the region served by these field offices is predominantly rural and working-class and covers a total of 4,457 square miles. The estimated 2008 population in these nine counties is 202,439 and more than 95% of the population is white. The median annual family income in these counties in 2008 ranged from $36,007 to $48,033 and the percentage of the population with at least a high school education ranged from 79% to 86%; 10% to 21% of residents in the nine-county area graduated from college.

Data collection occurred in the homes of child participants including foster homes and homes of the family-of-origin, depending upon the status of the family case with IDCFS as an intact family case or a placement (foster care) case. An intact family case is defined as a case in which families are receiving family preservation services in order to maintain the family unit. These services include weekly monitoring of the home environment and substance abuse treatment for parents. In intact family cases, the parent(s) continue to be the legal custodian and guardian of their children. A placement case is one in which the state has full custody and
guardianship of a child and the child’s living arrangements are with kin, a traditional foster home, or a group or residential care setting.

Participants

Children aged 6 to 15 whose families had an open case (either as an intact family case or as a placement case) with the IDCFS and whose parents were involved with methamphetamine were eligible to participate in the study. Following Institutional Review Board approval, eligible families were referred by IDCFS caseworkers to research staff after receiving permission from caretakers to do so. Upon referral, consent for child participation was obtained from the IDCFS guardian for those children who were wards of the State of Illinois. Consent for children who were not wards of the State of Illinois was obtained from their parents. Research staff contacted eligible families to provide information about the study and to schedule an initial meeting to answer questions about the study, discuss the rights and protections afforded in the informed consent procedures, and to provide an opportunity for children and their caretakers to sign consent/assent forms.

Of the 60 children referred to participate in the study, research staff members were able to contact 54. Thirteen children (or their caregivers) declined to participate and 2 children withdrew participation before data collection was completed. Thirty-nine children and their caregivers agreed to participate, an acceptance rate of 72%. Child participants’ ages range from 6 to 15 years (̅= 9.9 years).

Table 2.1 presents a description of the sample of children for this study. Twenty-one (54%) child participants are male. Ten children (26%) remained under the guardianship of their parent (i.e. intact family cases). Of those children with open placement cases, 17 (44%) children were living in traditional foster homes and the average length of time in care ranged from 5 to 39 months (̅= 18 months) with an average of 1.7 placements. Seven children (18%) were placed
with kin and 5 (13%) children were reunified with their families at the time of assessment, although a placement case was still open for their families. No children were residing in a group- or residential-care setting. Additional participants included 39 caregivers, who completed an assessment of their child’s behavioral functioning. Informants were 15 (38%) biological parents (2 fathers and 13 mothers); 8 (21%) grandparents (2 grandfathers and 6 grandmothers); and, 16 (41%) foster parents (1 foster father and 15 foster mothers). The indicated reason for case opening with child protective services was approximately equal for neglect (33%) and abuse (28%).

Fischer’s Exact Chi-Square tests revealed no significant differences between the intact and placement case groups on gender or age. As would be expected, however, there were some significant differences between placement and intact cases on several variables related to families’ ability to keep children at home. Table 2 shows that children in foster care were more likely than children in intact families to have been exposed to methamphetamine production in their home ($\chi^2 (1, 35)= 8.32, p= .009$). Compared to children remaining intact, children with placement cases in foster care were also more likely to have a parent or parents incarcerated because of methamphetamine-related offense ($\chi^2 (1, 35)=17.40, p= .000$), which, obviously, prohibits or disrupts their ability to remain intact.

Table 2.2 also shows that children with placement cases and those with intact cases may vary in their exposure to parent misuse of methamphetamine and other substance misuse. Children with placement cases in foster care were significantly more likely than children with intact cases to have had both parents/caregivers misusing other substances rather than one parent or caretaker ($\chi^2 (1,35)= .756, p= .308$). Similarly, children in foster care are significantly more likely than children in intact families to have been exposed to both parents/caregivers misusing
methamphetamine rather than one parent ($\chi^2 (1, 35)= .756, p=.308$). On the mental health and social competence measures, children in foster care and intact families look similar. There were no significant differences on social competence scores or mental health scores, with one exception: children in intact families’ scored significantly higher on the TSCC Anger scale ($\chi^2(1, 35)= 20.48, p= .199$).

Table 2.3 presents data summarizing children’s intensity and duration of exposure to methamphetamine misuse while residing with their families of origin. Fifty-two percent of children were aware of their parents’ methamphetamine misuse, and the majority of children (69%) were school-aged when their parent began misusing meth. In the majority of families (74%) both parents used methamphetamine, and they did so for longer than three months of continuous use (90%). Parents were involved with methamphetamine production in the home in seventy-four percent of cases, and over half of the children had a parent in jail or prison for a methamphetamine related offense.

Table 2.4 presents data regarding the children’s intensity and duration of exposure to alcohol and illegal drugs other than methamphetamine while residing with their families of origin. The majority of children (89%) were five years old or younger when their parents began using illegal substances. In the majority of cases, both parents used alcohol (59%) as well as other illegal drugs (64%). All parents who used illegal drugs used for a period of time greater than 3 years (100%) as identified by a review of the child’s IDCFS records. It is not clear from those records whether or not parental use of drugs was classified as drug misuse or drug dependence. Intergenerational substance misuse was characteristic in the families of 21 children (54%). At the time of the assessment, 64% of children had been removed from exposure to their
parents’ substance misuse for greater than 1 year. Seven children (18%) residing with their families of origin or their parent reported on-going substance misuse at the time of assessment.

**Instruments**

*Child Behavior Checklist*

Mental health functioning and social competence of children in this study was assessed using the Child Behavior Checklist (CBCL) and was completed by caregivers. Developed for children between the ages of 6 and 18, the CBCL is a checklist of children’s internalizing and externalizing symptoms as well as children’s social competence. The CBCL consists of 118 specific problem items concerning the child’s behavior within the past 6 months. The form takes about 15 minutes to complete. Separate norms are provided by specific age groups and by child gender. The CBCL is a widely used standardized assessment with adequate reliability and validity (Achenbach, 1991).

The CBCL is scored to yield a Total Problems score as well as 2 broad-band scale scores, Internalizing and Externalizing behaviors, and eight narrow-band scale scores (Anxious/Depressed, Withdrawn/Depressed, Somatic Complaints, Social Problems, Thought Problems, Attention Problems, Rule-Breaking Behavior and Aggressive Behavior). The broad-band Internalizing score represents problems within the self and includes the narrow band scales of Anxious/Depressed, Withdrawn/Depressed, and Somatic Complaints. The Externalizing scale represents problems that involve social conflicts and includes the narrow-band syndrome scales of Rule-Breaking Behavior and Aggressive Behavior (Achenbach, 1991). The Total Problems score includes both the Internalizing and Externalizing scales and also includes the narrow-band scales of Social Problems, Thought Problems, Attention Problems, and Other Problems.
The CBCL also yields a Total Competence score comprised of three subscales: Activities Competence, Social Competence, and School Competence. The Activities Competence score is derived from the number of organizations, clubs, teams, or groups the child belongs to as well as the number of close childhood friends and the frequency of time spent with friends outside of school. The Social Competence subscale includes caregiver’s assessments of how well their children get along with siblings, other children, and parents compared with others of the same age (worse; average; better). The School subscale is comprised of the caregiver’s estimation of their child’s mean performance in school (Failing; Below Average; Average; Above Average), as well as whether or not a child received special education or a remedial service, repeated a grade, or had academic or behavioral problems in school.

Trauma Symptom Checklist for Children

Mental health was also assessed using the Trauma Symptom Checklist for Children (TSCC) which is a self-report measure of post-traumatic distress and related acute and chronic posttraumatic symptoms. The TSCC consists of 44 items that yield two validity scales, Under-response and Hyper-response, as well as 6 clinical scales designated Anxiety, Depression, Anger, Posttraumatic Stress, and Dissociation. The child is asked to indicate how often they experience a variety of different thoughts, feelings and behaviors (see Appendix A). The questionnaire takes approximately 10 minutes to complete. The TSCC is a widely-used standardized assessment with adequate reliability and construct validity (see Briere, 1997; Ebert & Fairbank, 1996).

Peabody Picture Vocabulary Test

The Peabody Picture Vocabulary Test (PPVT) was utilized as a measure of basic cognitive and language competence. The PPVT is a norm-referenced, individually administered
measure of receptive vocabulary for individuals from age 2-1/2 to adult (Dunn & Dunn, 1997) and takes approximately 11-12 minutes to administer. It requires that children point to pictures as words are read aloud to them by testers. It has excellent reliability and validity and is positively correlated with the Wechsler Intelligence Scale for Children’s (WISC) full-scale IQ score (Dunn & Dunn, 1981) and with the WISC Verbal, Performance, and Full Scale IQ among emotionally disturbed children (Himelstein & Herndon, 2006).

*Children’s Experience in Their Family-of-Origin Interview*

Children participated in semi-structured interviews that were approximately 30-45 minutes long and were audio-taped. Because not all children were fully aware of their parents’ methamphetamine misuse, the interview began with some open-ended questions: Tell me about your family, and tell me about a time in your family that was happy. Children were also asked to, “Tell me about a time in your family that was sad or scary.” It is in this context that several probes for beliefs about methamphetamine were included: What is methamphetamine (or crystal, meth, ice or speed)? Sometimes adults use methamphetamine. How does that make them act? How about your mom/dad? Tell me about when they used methamphetamine. What did you do? How did you feel? What advice can you give to other kids whose parents use methamphetamine? The interview concluded with an invitation for children to “Tell me about a time in your family that was fun” (see Appendix B).

*Record Review*

A review of the child participant’s IDCFS record (Appendix C) identified information related to children’s social context such as length of time in care, placement history, exposure to adult methamphetamine and other substance use, intergenerational substance misuse, the reason
for DCFS involvement with the family, and child level of formal support including current and past participation in mental health treatment.

Field Notes

Field notes were completed after each contact with the families. By design, they were less structured and more narrative-like than other instruments and were intended to raise important questions, allow for correction of methods, and elaborate instruments such as the CBCL and TSCC. Examples of field notes include descriptions of the child’s interactions with family, friends and the researcher; as well as the type and condition of home and property.

Procedures

Data were collected from thirty-nine child participants from January 2004 to June 2009. At an initial meeting with eligible children and their caretakers, the study was explained in detail including its purpose, nature, procedures and risks and potential benefits. Information provided to children was done so in a child-centered way and using language appropriate for children. The provisions for confidentiality were described. Participants were told that their participation was voluntary and that refusal to participate would not affect their status or relationship with the IDCFS in any way, and that consent, once given, could be withdrawn at any time. Participants were informed that certain information (e.g., evidence of child abuse) is mandated by law to be reported to IDCFS. Further, the provisions for confidentiality and restrictions on these provisions afforded by the obtained National Institutes of Health Certificate of Confidentiality were explained.

At a second meeting lasting 45 minutes to one-hour, children worked with Masters-level professionals experienced in working with children to complete assessments and interviews. These professionals were supervised by a licensed, board-certified psychiatrist experienced in
working with traumatized children in foster care. The order of administration of the interview, TSCC, CBCL, and PPVT with child participants was counter-balanced. While the interview was conducted, caretakers completed the CBCL. Upon completion, researchers reviewed the CBCL responses and sought clarification from caregivers.

Children were given the opportunity to choose among a variety of expressive toys (puppets, dollhouse and props) and art supplies (clay, drawing materials). As the interviewer and the child engaged in an activity of the child’s choosing the interviewer invited the child to respond to interview questions. Children were given the option of having the TSCC items read aloud to them or answering on their own. In either case, responses were reviewed with the child and clarification sought.

Child participants selected a small toy such as a book, art material, or a game for remuneration for their participation and also selected a gift for any sibling present. Children selected and kept their thank you gift regardless of whether or not they answered questions or refused to participate. Caregivers received a $25 gift card for remuneration for completing the CBCL. Upon completion of the data collection, research staff spoke with caregivers to ensure that all questions regarding the study and their child’s participation had been answered.

Data Analysis

This study is cross-sectional, exploratory, descriptive and primarily case-based (Stake, 2000). As little is known about children from methamphetamine-involved families, the analysis begins with a description of mental health, social competence, and social context of the children and includes bivariate analysis of social context and children’s mental health and social competence functioning. Patterns, or case clusters, are expounded through a presentation of cases exemplifying relatively more or less resilient children.
Research Aim 1: To describe the mental health and social competence of children from methamphetamine-involved families.

The first research aim is addressed through a “variable-oriented” descriptive analysis (Ragin, 1987), organized by variable (or construct) and method. The variable-based analysis provides descriptive information about the participants, including indicators of central tendency and dispersion as appropriate, as well as information about where these samples are located in the broader population of youth on specific variables, again as appropriate. Descriptive findings regarding children’s mental health and social competence as assessed by standardized assessments including the CBCL and TSCC are presented in Chapter 3.

Mental health functioning was assessed using the CBCL Problems scales and the TSCC. As recommended by Achenbach and Rescorla (2001) and Briere (1997), CBCL Problems and TSCC raw scores were transformed to T-Scores and entered into the data set. High T-Scores on the CBCL Problems scales and TSCC scales indicate clinically important deviance. T-Scores fell into one of three clinical range categories, Borderline-Clinical (BC), Clinically Significant (CS), and Normal (N), depending upon percentile rank. T-Scores from the Total, Internalizing, and Externalizing scales on the CBCL ranging from 34 to 59 fall within the Normal range (80th to 84th percentile), while T-Scores of 60-63 are considered Borderline Clinical (84th to 90th percentile), and T-Scores of 64 and above indicate Clinical functioning (98th percentile and above). Scores in the Borderline-Range are high enough to be of concern, but are not as clearly deviant from the normative sample as scores falling within the Clinical range. Scores from the TSCC were entered into the data set based on T-Scores and included Borderline-Clinical scores (T= 50-65, 81st to 93rd percentile), Clinically Significant scores (T ≥ 66, 98th percentile and above), and Normal range scores (T ≤ 49, 15th to 80th percentile). As recommended by
Achenbach and Rescorla (2001), raw scores, rather than T-Scores, were utilized across the eight CBCL narrow-band Syndrome scales. Clinical range scores (T ≥ 70) on the TSCC Under-reporting and Hyper-reporting scales were eliminated from analysis as they were invalid.

Child social and school competence was assessed using the CBCL Competence scales. Total Competence scores were utilized to group children in one of three clinical range categories, Borderline-Clinical (BC), Clinically Significant (CS), and Normal (N), depending upon percentile rank following the conventions for the CBCL Problems scales previously described. As recommended by Achenbach and Rescorla (2001), raw scores were utilized in the data analysis of narrow band scores including the Activities, Social, and School competence scales to capture variation in scores, with low scores being clinically significant on the CBCL Competence scales. Cognitive functioning was assessed using the PPVT raw score, standardized scores, and age-equivalent scores.

Research Aim 2: To describe the social context of children from methamphetamine-involved families.

Children’s perspectives of their family-of-origin experiences were described through a qualitative content analysis of transcribed child interviews. The interview with children was transcribed verbatim by trained research assistants. All transcripts were coded by me and the project principal investigator, Wendy Haight. Independently, and then through discussion, we generated emic codes based on repeated readings of the interview transcripts using analytic induction techniques (Denzin, 1989). These codes will be described in Chapters 3 and 4. We independently coded 100% of interviews. Percent agreement on individual codes ranged from 90% to 100% and disagreements were resolved through discussion. Social context codes including children’s perception of problematic family-of-origin experiences and positive family-
of-origin experiences are described in results Chapters 4 and 5. Only the codes indicated by three or more children (8%) were included in analysis.

A review of the child’s IDCFS record identified children’s exposure to parent’s and other adults’ substance (methamphetamine, alcohol, and other substances) misuse, the age of the child when their parents began using substances; age of the child when parents began using methamphetamine; the length of time elapsed since last exposure to parent substance misuse; length of time of parent substance misuse and methamphetamine misuse; criminal background of parent(s), including methamphetamine production in the home; and, the indicated reason for coming into care.

Research Aims 3 & 4: To identify any relationships among mental health and social competence functioning and social context variables; and, to explore, using case cluster analysis, any patterns emerging across children pertaining to possible risk and protective factors for mental health and social competence outcomes. Simple bivariate correlations were used to identify relationships between social context and child functioning variables. Significant findings from these analyses are presented in chapter 3. I then developed a case-oriented descriptive portrait of the sample organized by the child as the case. Children were first grouped into clusters according to whether or not they were experiencing clinically significant mental health and social competence problems according to the CBCL and TSCC. Clustering of cases revealed groups of relatively resilient and relatively vulnerable children. These groups were then explored in depth through presentations of case studies in Chapter 4.

Methodological Strengths and Limitations

Methodological strengths of this study include triangulation of data sources, peer audits, and member checks. Triangulation in this study was achieved by employing multiple data
collection methods and multiple data sources such as interviews with children, a self-report measure of mental health functioning, caregiver reports of mental health and social competence functioning, and review of records compiled by DCFS workers. Utilizing multiple sources of data as well as multiple means of data collection allowed for on-going assessment and contextualization of my emerging interpretations.

Member checks included asking children for clarification and expansion on responses during the interview and the administration of assessments in order to clarify misunderstandings and to establish an accurate understanding of the child’s response. Caregiver’s responses on the CBCL were reviewed and clarification sought. Any questions regarding the record review were answered by the child’s DCFS caseworker.

Peer audits also enhanced the accuracy of data analysis and interpretation. The standardized instruments were scored and entered into the dataset by research assistants unfamiliar with child participants and all assessment scores and entered data were checked for accuracy. Peer audits included monthly research team meetings to discuss on-going findings from the standardized assessments and interpretations of interview content and disagreements regarding interpretations were discussed until a consensus was reached.

The temporal relationship between social context variables from family-of-origin experiences and mental health and social competence assessments complicates the development of understanding children from methamphetamine-involved families. At the time of assessment, children’s functioning had been affected by the additional trauma of placement, in the case of children in foster care, as well-as varying levels of on-going trauma which may not be related to methamphetamine misuse in the case of children with intact family cases. It is not possible with this cross-sectional view into the lives of these children to assess causal relationships among
social context and mental health and social competence functioning. Future studies utilizing more complex data analysis models are needed to better understand causal relationships as well as mediating and moderating effects among mental health, social functioning, and social context variables.

Reports on family-of-origin experiences were retrospective and relied upon children’s memory. Although clarification was sought, retrospective reports could not be confirmed except through the DCFS records, which varied in quality depending upon the caseworker. Caregivers completing the CBCL included foster parents, who may have a less comprehensive or biased knowledge of child mental health and behaviors compared to a biological parent. Further, it is optimal to acquire CBCL data from more than one adult in the life of a child. CBCL assessments were sought from the child’s DCFS caseworker, but the response rate was too low to include this second source of CBCL data. Moreover, many children in this study had multiple case workers resulting in caseworker’s limited knowledge of child behavior.

The socio-cultural context of this research focuses on the rural Midwest from about 2004-2009. The extent to which these findings are transferable to other cultural contexts, for example, urban communities, is an open empirical question. The extent to which the findings are transferable to other historical contexts also is an open empirical question. The cross-sectional nature of this study prevented an interpretation of changes in patterns of use over time. The convenience sampling technique did not result in representative samples of user populations.
### Table 2.1 Demographics and Description of Child Participants (n=39)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>54</td>
</tr>
<tr>
<td>Female</td>
<td>46</td>
</tr>
<tr>
<td>Placement Type</td>
<td></td>
</tr>
<tr>
<td>Intact family</td>
<td>26</td>
</tr>
<tr>
<td>Traditional foster home</td>
<td>44</td>
</tr>
<tr>
<td>Kinship placement</td>
<td>18</td>
</tr>
<tr>
<td>Reunified</td>
<td>13</td>
</tr>
<tr>
<td>Reason for Case Opening</td>
<td></td>
</tr>
<tr>
<td>Neglect</td>
<td>34</td>
</tr>
<tr>
<td>Abuse</td>
<td>28</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean (SD)</th>
<th>Range (min-max)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>9.9 (2.4)</td>
<td>(6-15)</td>
</tr>
<tr>
<td>Months in placement (n=17)</td>
<td>19.88 (13.23)</td>
<td>(5-39)</td>
</tr>
<tr>
<td>Number of foster care placements</td>
<td>1.7 (1.05)</td>
<td>(1-5)</td>
</tr>
</tbody>
</table>
Table 2.2 Comparison of participant characteristics of children in foster care and intact families:
Chi-square

<table>
<thead>
<tr>
<th>Variable</th>
<th>No. of Children</th>
<th></th>
<th>No. of Children</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Methamphetamine produced in the home</td>
<td>25</td>
<td></td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Parent in jail/prison for meth-related conviction</td>
<td>22</td>
<td></td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Both parents/caregivers misused Methamphetamine</td>
<td>19</td>
<td></td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Both parents/caregivers misused alcohol or other substances</td>
<td>19</td>
<td></td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

p≤ .05
Table 2.3 Children’s Exposure to Methamphetamine in Their Families-of-Origin\(^a\) (n=39)

<table>
<thead>
<tr>
<th>Exposure to methamphetamine</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age of child when parent(s) began using meth</td>
<td></td>
</tr>
<tr>
<td>Infant or Toddler</td>
<td>10</td>
</tr>
<tr>
<td>Preschool</td>
<td>21</td>
</tr>
<tr>
<td>School age</td>
<td>69</td>
</tr>
<tr>
<td>One parent used meth</td>
<td>26</td>
</tr>
<tr>
<td>Both parents(^b) used meth</td>
<td>74</td>
</tr>
<tr>
<td>Parent(s) used meth more than 3 months</td>
<td>90</td>
</tr>
<tr>
<td>Parent(s) involved with meth production in the home</td>
<td>74</td>
</tr>
<tr>
<td>Parent(s) in jail/prison for meth related offense</td>
<td>56</td>
</tr>
</tbody>
</table>

Note: “In their families-of-origin” refers to the period of time when the child was living at home with their parents prior to entry into foster care for placement cases and the child’s current family-of-origin experiences for intact family cases. \(^b\) “Parents” refers to either a biological parent’s spouse or paramour.
Table 2.4 Children’s Exposure to Alcohol and Illegal Drugs\textsuperscript{a} in Their Families-of-Origin\textsuperscript{b} (n=39)

<table>
<thead>
<tr>
<th>Exposure to alcohol and illegal drugs</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age of child when parent(s) began using illegal drugs</strong></td>
<td></td>
</tr>
<tr>
<td>Infant or toddler</td>
<td>39</td>
</tr>
<tr>
<td>Preschool</td>
<td>41</td>
</tr>
<tr>
<td>School age</td>
<td>21</td>
</tr>
<tr>
<td><strong>One parent used alcohol</strong></td>
<td></td>
</tr>
<tr>
<td>Both parents\textsuperscript{c} used alcohol</td>
<td>59</td>
</tr>
<tr>
<td><strong>One parent used illegal drugs</strong></td>
<td></td>
</tr>
<tr>
<td>Both parents used illegal drugs</td>
<td>64</td>
</tr>
<tr>
<td><strong>Of those parents using illegal drugs, use was &gt; 3 years (n= 34)</strong></td>
<td>100</td>
</tr>
<tr>
<td><strong>Intergenerational substance misuse</strong></td>
<td>54</td>
</tr>
<tr>
<td><strong>Child’s last exposure to parent substance misuse</strong></td>
<td></td>
</tr>
<tr>
<td>On-going</td>
<td>18</td>
</tr>
<tr>
<td>&lt;6 months</td>
<td>18</td>
</tr>
<tr>
<td>&gt;1 year</td>
<td>64</td>
</tr>
</tbody>
</table>

Note. \textsuperscript{a} “Illegal drugs” include other illegal substances other than methamphetamine. \textsuperscript{b} “In their families-of-origin” refers to the period of time when the child was living at home with their parents prior to entry into foster care for placement cases and the child’s current family-of-origin experiences for intact family. \textsuperscript{c} “Parents” refers to either a biological parent’s spouse or paramour.
CHAPTER 3

A DESCRIPTION OF CHILDREN’S MENTAL HEALTH, SOCIAL COMPETENCE, FAMILY-OF-ORIGIN EXPERIENCES, SOCIAL SUPPORT, AND HOPE

This chapter describes children’s complex and varied experiences and functioning (Research Aims 1 and 2). Children in this study described problematic family-of-origin experiences during the interview and have been challenged by poor mental health outcomes as revealed by scores on the CBCL and TSCC, which I explore in the first part of this chapter. Children in this study also have much strength. They have experienced positive family-of-origin experiences and have developed competence in school, with peers, and in their daily activities as assessed with the CBCL. Some children also described various sources of social and emotional support as well as a sense of hope for the future. These strengths are explored in the second part of this chapter.

In this chapter, I also explore relationships among mental health and adaptive functioning scores and social context (Research Aim 3), variables focusing on extended family, an important context in the rural culture within which participants lived (Hoffman & Cerborne, 2002). Previous research has shown that intergenerational substance misuse is problematic (Cretzmeyer et al., 2003; CASA, 1999. Findings from this study also suggest that a family history of intergenerational substance misuse is a risk factor for children as revealed by lower mental health and adaptive functioning scores on the CBCL compared to children who had no such family history. Additionally, knowledgeable adult participants from our ethnographic study (Haight et al., 2005; 2006) suggested that one factor distinguishing relatively resilient children from methamphetamine-involved families is the presence of a grandparent. Both intergenerational substance misuse and grandparent support were associated with mental health and adaptive functioning scores and are presented in this chapter.
Problematic Experiences and Mental Health

Social Context: Children’s Descriptions of Problematic Family-Of-Origin Experiences

Table 3.1 summarizes children’s experiences in their families-of-origin that they viewed as problematic. All children described events in their families that they felt were “sad” or “scary” as part of the interview. Most children also described such events when completing the TSCC, especially when indicating how often they felt angry, sad, or afraid. Many themes of problematic experiences emerged from coding the interviews. Perhaps the most salient issue for children was loss. Loss was mentioned by the majority of children (87%) and included separation from parent(s) related to foster care placement or incarceration, as described by one child who reported that he hid under the bed after hearing his grandmother on the phone with DCFS:

Child: My grandma knew they were going to take us because they called my grandma’s house and told her, and I heard what she said.
Interviewer: What did she say?
Child: She told my cousin, quietly, that they’re going to take us, and I knew that. I was in the room hiding because I didn’t want them to come get us.
Interviewer: Right. Well, it must have been very frightening for you.
Child: My dad said they’re not taking us, either.
Interviewer: But then they did.
Child: (quietly) yeah.

Parent abandonment (38%) also was described by some children. In the following excerpt, a child described a time when he was living with his father, who chose to live with his girlfriend, who did not want the child:

Interviewer: Did you live with your dad for the rest of the time?
Child: Sometimes, and then she (father’s girlfriend) got mad again. She said “You take him home… or you won’t get me.” And he took me to (mom’s house) instead of keeping me.
Interviewer: How did that make you feel?
Child: That made me real mad, and I got real mad… when he (dad) got back and said, “I’m real sorry”, and we got all my stuff . . .
Interviewer: And then you went back to (mom’s house)?
Child: Yeah, before we went back to (mom’s house) he went and got some stuff with me and did some things. And then when we got there at (mom’s house), umm, we, I got real
mad and yelled at him and said, “Why didn’t you take me instead of her?” And, that was the end of it.

The death of a family member was also a significant experience of loss for many children (21%), for example, one child’s father died due to complications from untreated diabetes prior to her coming into care. Children also described loss in terms of separation from a sibling related to placement in foster care (15%), and loss or harm to a family pet (13%).

The majority of children (69%) also described experiences which can be characterized as threats to the well-being of self or family members. Such concerns included worrying about the physical health of family members (46%), as described by one girl who was concerned that something would happen to her mom while she was at school:

My mom will die because she has diabetes herself and sleep apnea, and asthma, and emphysema and I worry about her all the time at school and I miss her at school and want to be there with her every day so I’ll know what happens.

Other perceived threats to the well-being of children and their family included strangers who threatened the child in the home or community (13%). Children described being followed and verbally assaulted by strangers in the community, as well as in their homes. They also participated, sometimes unwillingly, in other risky or dangerous behavior (10%) such as riding in a car with an intoxicated driver.

The majority of children (62%) described adult substance misuse as problematic including 21 (54%) who described some aspect of adult substance misuse as causing problems for their family and 3 (8%) who reported that their parent involved them in their substance misuse. Substance misuse is described by one participant as being the reason he came into care, “I was with DCFS for my parents doing meth and smoking weed. And they always lied to me. They didn’t care what I did. They wouldn’t care if I came home the next day.”
Adult involvement of their children in the use of drugs was described as a “scary” time by one girl who reported that, at the age of 5, her mother got her high, “She was, her and a man were smoking dope under a blanket and they put me under there and they got me high”.

Violence was another salient issue described by over half of children (59%). Descriptions of violence were described as “sad” or “scary” times and many children discussed family violence, domestic violence, and sibling violence openly. Domestic violence was described by one child, who reported:

My real dad…he was an abuser ya know, drug addict, and he abused my mom and my brother a lot and my sister, but never me. I always remember him grabbing my mom by the throat leaving hand bruises, picking her up, slamming her on the floor, locking my brother in the closet for a couple days.

Some children (8%) also described sibling violence as particularly problematic in their families, as described by one girl who would punch her brother until he bled:

I like getting into fights, when I can, that’s all of the time cause I just like to see the blood pour from people… my brother, because he took my purse and kept running all over the house so I kept on punching him until he was bleeding because um, I just get sick of him doing things and doing it and doing it and doing it.

Many children discussed their painful experiences of abuse and neglect. For instance, one boy described his life at home in describing a “scary” time in his family:

At one time, I was scared. They (parents) wouldn’t let us come down the stairs or nothing. So, I usually just took my mom and dad’s money and went to the store. I bought soda for whenever they kept us upstairs. And then I hid it upstairs.

Other serious experiences described by children included physical and sexual abuse. As one boy reported, physical abuse occurred when his mom was using drugs:

My mom would hit us kids and she would, I mean hit us when she was taking the drugs, and I don’t think she expected to hit us that hard because she didn’t know what she was doing but sometimes, you know, it got out of hand.
Family conflict, such as adult arguing (31%) and child arguments with parents (8%), also was described as problematic by children. Additional problematic family-of-origin experiences included other types of adult anti-social behavior related to drug misuse such as stealing precursors for methamphetamine production, vandalism, and running away from police. One child described a time when she was questioned by DCFS and the police at school and then got in trouble with her father because she didn’t lie:

…everyday for the past week I would come to school with red eyes because I was crying because of my dad every morning… and these workers or whatever, they were there with the police or whatever, I think they were DCFS people, they were there and they were asking me questions and my dad didn’t tell me that morning or whenever not to tell them the truth so I told them about all the bad stuff. And then when they called my brother in next, he told them a whole different story and then when I went home that day, my dad yelled at me and told me that I was crying, because I told the truth and I didn’t tell a lie. And then like ever since when I talk to people like that he told me to lie.

*Children’s Mental Health: Child Behavior Checklist for Children (CBCL)*

Table 3.2 presents CBCL mental health outcomes for 36 children. CBCL data is missing for three children including one child whose parent declined to complete the CBCL and two CBCLs which were determined to be invalid as the parent report indicated no problems across any of the 118 items. These parent reports were inconsistent with record reviews, tester’s direct observations of children, and children’s own reports suggesting multiple, significant mental health problems.

As a group, children were functioning in the borderline-clinical range (T= 60-63, 84th to 90th percentile) on the CBCL Total Problems scale (\( \bar{x} = 61.64, \ SD = 11.79, \ range \ 31-82 \)) as well as the Externalizing scale (\( \bar{x} = 61.03, \ SD = 12.75, \ range \ 33-83 \)) compared to the CBCL norm-reference group of children aged 6-18 years old. Children from this study, as a group, were functioning within the normal range (T=34 to 59, 80th to 84th percentile) on the Internalizing scale (\( \bar{x} = 58.00, \ SD = 11.71, \ range \ 33-80 \)). Overall, 26 children (72%) scored in the borderline-
clinical (T=65-69, 93rd to 97th percentile) or clinical (T≥ 70, 98th percentile and above) range on one or more of the CBCL subscales including 9 children (25%) on 1 or 2 subscales; 11 children (31%) on 3-5 subscales; and, 6 children (17%) on 6-8 subscales.

Twenty-two children (61%) scored in the clinical (T≥ 64, 90th percentile and above) and borderline-clinical range on the CBCL Total Problems scale. Borderline-clinical or clinical Internalizing symptoms were experienced by 18 children (50%), and 20 children (55%) were experiencing borderline-clinical or clinical externalizing symptoms. Among these children, 13 (36%) scored in the borderline-clinical or clinical range on both the Externalizing and Internalizing subscales.

Among the eight narrow-band CBCL syndrome scales in the borderline-clinical and clinical ranges, the greatest numbers of children (17, 47%) were experiencing Thought Problems; 16 children (44%) manifested Aggressive behavior; 15 children (41%) were experiencing Attention Problems; 13 children (37%) demonstrated Rule-Breaking behaviors; and, 12 children (33%) each were experiencing problems with Anxious/Depression and Withdrawn/Depression. Other findings reveal 11 children (31%) with Social problems and 4 children (11%) with Somatic Complaints.

Children’s Mental Health: Trauma Symptom Checklist for Children

Table 3.3 presents children’s mental health outcomes as assessed by the TSCC (n=28). TSCC data is missing for one child. Further, 9 children (4%) scored in the clinical range (T>70, 98th percentile) on the Under-Reporting scale and 2 children (5%) scored in the clinical range (T>70, 98th percentile) on the Hyper-Reporting scale (one child scored in the clinical range for both hyper- and under-reporting scales). These scores were eliminated from the analysis.
As a group, children’s T-scores were in the normal range ($T \leq 49$, 15th to 80th percentile) on each of the five TSCC subscales including Dissociation ($\bar{x} = 47.03$, SD = 9.15, range 35-66); Anger ($\bar{x} = 48.32$, SD = 13.74, range 35-99); Anxiety ($\bar{x} = 47.03$, SD = 11.41, range 35-74); Post-Traumatic Stress ($\bar{x} = 46.03$, SD = 9.24, range 35-70); and, Depression ($\bar{x} = 46.95$, SD = 11.25, range 35-81). There was, however, considerable variation in individual scores. Indeed, 18 children (64%) scored in the borderline-clinical ($T = 60-65$, 81st to 93rd percentile) or clinical range ($T \geq 65$, 94th percentile) on one or more of the five TSCC subscales. Among the TSCC subscales, 13 children (47%) scored in the borderline-clinical or clinical range on the Dissociation subscale. Thirteen children (47%) also were experiencing borderline-clinical or clinical symptoms of anger. Twelve children (43%) scored in the borderline-clinical or clinical range on the Anxiety scale and the Post-Traumatic Stress scale each. Eleven children (40%) scored in the combined range on Depression. Further, the TSCC Anger scale was significantly different between children in intact homes and those in foster care ($\chi^2 (1,15) = 20.48$, $p = .199$), with children in intact families having higher scores on that scale.

**Positive Experiences, Social Support, Social Competence and Hope**

*Social Context: Children’s Descriptions of Positive Family-Of-Origin Experiences*

Table 3.4 summarizes children’s perceptions of positive family-of-origin experiences. Most children were able to describe “happy” and “fun” times with their families during the interview as well as when discussing past memories during the TSCC assessment. A number of themes emerged from discussions with children which reflected children’s positive memories of time spent with family. These memories, as well as on-going opportunities to spend time with family, can be a source of strength for children during difficult times. The majority of children
(79%) described sharing hobbies and activities with their families such as playing games, going to the park, and sports, as described by one boy:

Interviewer: Who would be there at the ball games?
Child: My dad and mom. And I got to see them at basketball games too. They got to talk to me and come down and talk to us.

Children’s descriptions of shared family activities also were reflective of the rural culture in which they lived and included time spent outdoors (15%) such as at the river or lake and in the forest. In response to the interviewer’s prompt to describe a fun experience, one boy described family time spent at the river:

Child: When we went to the river.
Interviewer: To the river?
Child: Mm-hmmm (yes)
Interviewer: Did you do that a lot?
Child: Yeah because it was so close to our house.
Interviewer: And what did you do when you went to the river?
Child: We like swam and stuff. Looked for toads.

During another interview, one boy described how his uncle taught him about the outdoors, “(Uncle’s name) taught me a long time ago how to get away from snakes and mud pits from snakes, and all, and find what kind of mushrooms you should pick and not pick.” Other salient positive family-of-origin experiences included children who reported loving and nurturing interactions (38%) with their parents and siblings, as one boy describes:

I remember when all us kids was together and it was for a week…and my brothers came down for a week and, to visit with us, and they had like this arcade place and we all skipped school that day. I thought it was funny, and my mom skipped work just to be with us. And she played arcade games and we played games and we had this game, we had pizza… we had a bunch of fun.

Children perceived family trips and vacations (33%) as positive experiences including trips to local fairs as well as to area amusement and water parks. One child described that his family enjoyed going to the water park for an annual family vacation:
Child: Yeah, we go to (name of Water Park) every year. We just went, it was last week, and we just went there.
Interviewer: Oh OK.
Child: We go there with (grandmother) every year.

Holidays and birthday celebrations were also remembered by children (31%) as being a positive time with their families, as described by one child:

Oh, last Christmas. Everybody was surprised. I was the first one to wake up on Christmas. I went to the living room. I had a light with me. The whole room was filled with presents. When everybody woke up, they were surprised.

Many children (26%) also described reunification with family and visitation with parents as positive experiences, as revealed by one girl who describes her mom coming home from prison:

Child: I was like so happy. I had tears coming out of my eyes when she came back, I was so happy. My dad said that he was happy too and so was my brother. And when she came back, we all spent the night except for my dad because he had his girlfriend, so he didn’t spend the night, but then, I brung some clothes up there because I was going to spend some time with her…
Interviewer: Was that when she came back from (name of town)?
Child: Um hmm. But she came back, she didn’t come back from (name of town), she came back from prison because she was in there twice.

Another source of positive memories for children was events associated with family pets and animals. Some children (23%) talked about animals that were found during family outings to the river, lake or forest, such as turtles and toads, which the family cared for in some capacity. Other children discussed family pets, which was a source of pride for one boy who shared his enthusiasm for his pets with me during an interview:

Interviewer: Do you have any pets?
Child: Two dogs and no cats, but we used to have fish, we have chickens, I can show you the pets…And I have a horse, a pony.
Interviewer: Wow that’s neat.
Child: She’s sixteen months old. She’s full grown and she’s really big- you can ride her, I can take her around the house, she’s real big.

Another girl described her family pets as a hobby she shares with her father:
My dad brung out, let me hold, see the lizards but you have to take them one at a time. Especially because the two bearded dragons, we don’t know if that one’s a boy or a girl yet. Because if that’s a boy, we um, they would fight, but if it’s a girl, we’d put it in there with him. But we’ll find out whenever it gets older.

Children’s Descriptions of Social Support

Table 3.5 presents data regarding children’s perceptions of social support. Children reported social support from their immediate and extended family including aunts, uncles and cousins (67%); biological parents (62%); and, grandparents (49%). As one boy described during the interview, his grandmother’s home was a place of refuge from his parents’ substance misuse:

I wasn’t even at their house (his parent’s). Usually I was at my grandma’s helping her. I went over there and I played on the computer and stuff… usually (brother) was at the trailer (parent’s home) while I was at my grandma’s house. I’d stay the night at grandma’s house usually.

Other sources of social support described by children included siblings (38%), friends (31%), and professionals, such as mental health professionals and clergy, (23%); and school personnel including teachers, guidance counselors, and Drug Abuse Resistance Education (D.A.R.E.) officers at school (18%). In an account from an adolescent boy, the D.A.R.E. officer at school was a life line of sorts during the time his parents were arrested:

On Tuesday, it was church night, I went to church and I came back and I seen cop cars and everything and I already knew. I already knew that this was going to happen. Cuz (sic) I already told Officer R (D.A.R.E. officer) before this… and Officer R already told me what was going to happen and told me that he was going to be there.

Some children (18%) also reported receiving social support from non-relative adults in their lives such as a friend’s parent, neighbors or babysitter. As one girl describes, her neighbors are meaningful adults in her life, “I like goin there all the time, they’re like my family over there… I, yeah, act like they’re my aunt and uncle too so, they’re like my family”. Other sources of social support described by children (15%) included guardians, such as step parents, and foster parents. One boy described the impact his foster family has had on his life.
Child: When I moved here (foster home) my attitude just completely changed. 
Interviewer: Why did it change? 
Child: Because I wanted to give these people a chance and they gave me a chance…If I 
didn’t come here I would’ve went to juvie.

Children’s Social Competence: Child Behavior Checklist for Children

Some children manifested competence in school, socially, and in their daily living activities. Competence among child participants in this study was assessed with the CBCL Social Competence scales (n=36), as summarized in Table 3.6. As a group, children scored in the normal range (T=34 to 59) on the CBCL Total Competence scale (\( \bar{x} = 40.87, \ SD= 9.81, \ range \ 28-69 \)) as well as each of the three subscales including School competence (\( \bar{x}= 41.42, \ SD= 8.50, \ range \ 26-55 \)); Social competence (\( \bar{x}= 41.66, \ SD= 9.60, \ range \ 28-64 \)); and, Activities competence (\( \bar{x}= 45.18, \ SD= 8.27, \ range \ 31-65 \)). When examining raw scores, 20 children (56%) scored in the borderline-clinical or clinical range on one or more of the three Social Competence subscales.

Nineteen children (53%) scored in the borderline-clinical or clinical range on the Total Competence scale. Twenty children (55%) were experiencing borderline-clinical or clinical range problems related to School competence, and 12 children (33%) were experiencing problems related to Social Competence. No children scored in the clinical range for Activities Competence; however, 4 children (11%) scored in the borderline-clinical range on that scale.

Children’s Competence: Peabody Picture Vocabulary Test

Results of PPVT scores for 38 children are presented in Table 3.7. One child declined to complete the PPVT. The mean standardized score was 99.24 with an age equivalent mean of 10.31 years. The mean age for the sample was 9.93 years. These data suggest that, as a whole, the sample was not experiencing language delays and was of average intelligence. There was, however, some individual variation with 5 children (13%) scoring 1 or more standard deviations
above the population mean and 5 children (13%) scoring 1 or more standard deviations below the population mean.

*Children’s Sense of Hope*

A sense of hope for the future was a source of strength for some children (48%). Hope was identified in the interviews as talk in which someone is portrayed as acting out of expectations for a positive future event. Children described hope for the future in response to describing a “happy” or “fun” time in their family as well as when asked to give advice to other children who may have similar problems. Children also conveyed a sense of hope when describing their family and during the TSCC.

In giving advice to other children who may be facing similar challenges, children often conveyed a sense of hope for their own lives. Hope was manifested as a desire to one day reunite with parents or other family members as well as a belief that parents could and would one-day overcome their addiction, as explicated in the following excerpt:

I’d tell them to try to go to church regularly, everyday that they have church. Pray to God about it, see and listen to God because I think that’s the most important thing. If you listen to God, you pray to God, stuff will happen, stuff will happen tremendously for you. And most kids don’t believe prayer works, most believe that God’s not there, but God is there and prayer works. It really does. He’s helped me- He’s helped me a lot. So, I give advice for that and if this stuff is still happening, I would say that they need to go tell somebody so they don’t have all this pressure and stuff and they’ll feel much better.

Children also expressed hopes in terms of positive expectations for their lives in the future, as one girl described what she wants to be when she grows up during the TSCC:

Interviewer: Do you pretend you are someone else?
Child: Yeah, a veterinarian.
Interviewer: Oh, I see.
Child: I want to be a vet when I grow up.

Another girl described her belief that her relationship with her mother had improved, and she expected that it would continue to do so:
And then my mom came back last year, I moved in with my mom because I knew that she’s gonna be there for me and she wouldn’t leave me alone at the house all by myself and no phone or anything like that. When I was with my mom, I always had someone to go to if I was scared or anything.

In the interviews with 13 children (33%), a sense of the child’s hope was unclear due to their young age (7 years old or younger) or because they were not asked to give advice for other children which was the interview question which most frequently prompted hopeful talk. Children without hope (19%) for the future were children who were given the clear opportunity to discuss their past experiences and discuss future events during the interview but did not communicate expectations of positive future events. For example, one girl described her hope to be able to join her friends who attended a different school than she did. Her hope was dashed by her mother, who was unable or unwilling to sign the necessary documents that would allow her daughter to change schools:

Child: So, I wanted to try to go up to (name of school) 6th grade. Cause I would have a lot more friends there that, ya know, like me for who I am.
Interviewer: And where, where’s the school you go to now?
Child: I go to (name of school). The bus takes the seventh graders and the eighth graders to the other school.
Interviewer: That’s where you want to go.
C: Yeah, they will take us all you have to do is sign the paper to say what school you want to go to.
Interviewer: What does your mom say?
Child: She says that she will try to do it, you know, she’ll work on it. But she can’t do it, she says she is sorry but she can’t, she’s got to do it for me.

Extended Family: Sources of Risk and Protective Processes

Two social context variables related to extended family, including a family history of intergenerational substance misuse and the presence of a supportive grandparent, were significantly shown to be related to children’s mental health and adaptive functioning as summarized in Table 3.8. As presented in the discussion of study participants in Chapter 2, 54% of children had family histories indicative of intergenerational substance misuse. A one-tailed,
independent samples t-test revealed Social Competence scores on the CBCL were associated with family history of intergenerational substance misuse \([t(1,35)= 2.85, p \leq .05]\). Children whose families did not have intergenerational substance misuse scored significantly higher than those with a family history of intergenerational substance misuse on the CBCL Social Competence scale \([t(1,35)= 1.84, p \leq .05]\)

As presented in Chapter 2, 20 children (51%) reported a supportive relationship with a grandparent. The presence of social support from a grandparent, but not other extended family members including aunts, uncles, or cousins, was associated with better mental health outcomes. Two tailed, independent samples t-tests revealed CBCL Social Problems \([t=2.15(36), p= .039]\); Thoughts Problems \([t (1,35)= 1.86, p=.070]\); Aggressive behaviors \([t (1,35)= 2.57, p= .014]\); and Externalizing behaviors \([t (1, 35)=1.77, p= .085]\) scores were associated with the presence of a supportive grandparent such that children who had never been psychiatrically hospitalized were more likely to have a supportive relationship with a grandparent.

Summary

All of the children from this study elaborated on “sad” or “scary” times in their family of origin and most discussed experiences that they perceived as problematic. Experiences of loss were the most frequently discussed problematic experiences, particularly separation from parents and parent abandonment. Children also discussed threats to their well-being or the well-being of their families stemming from strangers in the community or in their homes and concern for the health and medical well-being of their family. Additional salient themes emerging from the interviews and perceived as problematic by children included adult substance misuse, violence, and contact with the criminal justice system, adult anti-social behavior, and family conflict.
Children’s problematic experiences in their families-of-origin were likely to have some negative effect on children’s mental health. This was evidenced by the findings from the mental health assessments. According to the CBCL, half of children were experiencing internalizing symptoms and over half were experiencing externalizing problem behavior. On the CBCL narrow-band scales, nearly half of the sample experienced thought problems. Slightly less than half of the sample experienced problematic behavior related to aggression and attention. One-third of the sample exhibited rule-breaking behaviors as well as symptoms of depression. These results were supported by findings from the TSCC which indicate slightly less than half of children in this study were experiencing mental health problems, especially problems associated with dissociation, post-traumatic stress, anger, and depression. However, individual variation in scores on the TSCC subscales indicate over half of children scored in the borderline-clinical or clinical range on one or more of the five TSCC subscales.

Despite the presence of problematic experiences, most of the children described positive family-of-origin experiences and sources of social and emotional support. Further, some children had developed competence in school, with peers and siblings, and in their ability to carry out routine activities. In discussing positive experiences with their families, the majority of children experienced shared family hobbies and activities such as spending time outdoors and school-related activities. Children also benefited from loving and nurturing interactions, which they described in their interviews, as well as family trips and vacations. Holidays and birthday celebrations, visits and reunification with parents, and family pets and animals were also sources of positive memories.

In the assessment of social and school competence, children seemed to be functioning best in the area of Activities Competence, with only 11% of children scoring in the clinical or
borderline-clinical range. More children experienced problems in other areas of adaptive functioning. More than half of the children in the sample scored in the clinically significant or borderline-clinical range in School Competence, and one-third in Social Competence. However, as a group, children scored in the normal range on the CBCL Total Competence scale and slightly less than half of the children did not score in the borderline-clinical or clinical range on any of the three competence subscales. Importantly, children who did not have intergenerational substance misuse in their family history demonstrated better adaptive functioning as measured by the CBCL Total Competence and Social Competence scales.

Sources of social and emotional support were reported by over half of the children. Children indicated that they received such support from a variety of sources including, most frequently, immediate and extended family members such as aunts, uncles, cousins, parents, grandparents, and siblings. One-third of the children described a supportive relationship with a close friend. Professionals involved in the lives of children, such as counselors and school personnel, were also sources of support for children. Children reported supportive relationships with non-professional adults as well such a friend’s parent, neighbors, or babysitters. Some children also reported that they received social support from step-parents, adoptive parents, and foster parents. Slightly less than half of the children reported a sense of hope for the future, another important source of support.

Some important relationships emerged in the variable analysis regarding the presence of a supportive grandparent and mental health outcomes. Children who benefited from a supportive relationship with a grandparent had better scores on several CBCL scales measuring social and thought problems, aggression, and externalizing behaviors.
### Table 3.1 Children’s Descriptions of Problematic Experiences in Their Family-Of-Origin \(^a\) (n=39)

<table>
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<tr>
<th>Problematic Experience</th>
<th>Percent</th>
<th>Category Total Percent</th>
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<tbody>
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<td><strong>Loss</strong></td>
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<td>Separation from parents/ Parent abandonment</td>
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<tr>
<td>Drug bust/other police contact</td>
<td>49</td>
<td></td>
</tr>
<tr>
<td>Visiting jail/prison</td>
<td>8</td>
<td></td>
</tr>
</tbody>
</table>
Table 3.1 (continued)

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other adult anti social behavior</td>
<td>49</td>
</tr>
<tr>
<td>Other adult anti social behavior</td>
<td>26</td>
</tr>
<tr>
<td>Child involvement in adult anti social behavior</td>
<td>23</td>
</tr>
<tr>
<td>Family Conflict</td>
<td>38</td>
</tr>
<tr>
<td>Adult arguing</td>
<td>31</td>
</tr>
<tr>
<td>Arguing with parent</td>
<td>8</td>
</tr>
</tbody>
</table>

Note. “In their families-of-origin” refers to the period of time when the child was living at home with their parents prior to entry into foster care for placement cases and the child’s current family-of-origin experiences for intact family cases.
Table 3.2 Results from the Child Behavior Checklist for Children (n=36)

<table>
<thead>
<tr>
<th>CBCL Scale</th>
<th>CBCL Score</th>
<th>Percent of Children Scoring in the Borderline Clinical (BC) or Clinically Significant (CS) Range</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>T-Scores Mean (SD)</td>
<td>BC</td>
</tr>
<tr>
<td>Total Score</td>
<td>60.11 (13.25)</td>
<td>8</td>
</tr>
<tr>
<td>Externalizing</td>
<td>59.79 (13.52)</td>
<td>8</td>
</tr>
<tr>
<td>Internalizing</td>
<td>56.68 (12.72)</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>Raw Scores Mean (SD)</td>
<td>BC</td>
</tr>
<tr>
<td>Thought Problems</td>
<td>62.45 (9.86)</td>
<td>19</td>
</tr>
<tr>
<td>Aggressive Behavior</td>
<td>62.55 (12.61)</td>
<td>22</td>
</tr>
<tr>
<td>Attention Problems</td>
<td>62.37 (8.99)</td>
<td>22</td>
</tr>
<tr>
<td>Rule-Breaking Behavior</td>
<td>60.61 (9.51)</td>
<td>6</td>
</tr>
<tr>
<td>Anxious/Depressed</td>
<td>57.82 (11.27)</td>
<td>19</td>
</tr>
<tr>
<td>Withdrawn/Depressed</td>
<td>60.08 (9.73)</td>
<td>14</td>
</tr>
<tr>
<td>Social Problems</td>
<td>58.61 (13.63)</td>
<td>14</td>
</tr>
<tr>
<td>Somatic Complaints</td>
<td>55.53 (7.31)</td>
<td>3</td>
</tr>
</tbody>
</table>
Table 3.3 Results from the Trauma Symptom Checklist for Children (n=28)

<table>
<thead>
<tr>
<th>TSCC Scale</th>
<th>T- Score Mean (SD)</th>
<th>Percent of Children Scoring in the Borderline Clinical (BC) or Clinically Significant (CS) Range</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>BC</td>
</tr>
<tr>
<td>Dissociation</td>
<td>47.03 (9.15)</td>
<td>43</td>
</tr>
<tr>
<td>Anger</td>
<td>48.32 (13.74)</td>
<td>36</td>
</tr>
<tr>
<td>Anxiety</td>
<td>47.03 (11.41)</td>
<td>32</td>
</tr>
<tr>
<td>Post Traumatic Stress</td>
<td>46.03 (9.24)</td>
<td>39</td>
</tr>
<tr>
<td>Depression</td>
<td>46.95 (11.25)</td>
<td>29</td>
</tr>
</tbody>
</table>

Table 3.4 Children’s Descriptions of Positive Experiences in Their Family-of-Origin (n=39)

<table>
<thead>
<tr>
<th>Positive Experience</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shared Hobbies and Activities</td>
<td>79</td>
</tr>
<tr>
<td>Trips to river, forest, lake</td>
<td>15</td>
</tr>
<tr>
<td>School related activities and sports</td>
<td>13</td>
</tr>
<tr>
<td>Love/Positive/Nurturing Interactions</td>
<td>38</td>
</tr>
<tr>
<td>Family Trips and Vacations</td>
<td>34</td>
</tr>
<tr>
<td>Holidays and Birthdays</td>
<td>31</td>
</tr>
<tr>
<td>Visits and Reunification</td>
<td>26</td>
</tr>
<tr>
<td>Pets and Animals</td>
<td>23</td>
</tr>
</tbody>
</table>
Table 3.5 Children’s Descriptions of Social Support (n=39)

<table>
<thead>
<tr>
<th>Source of Support</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aunt/Uncle/Cousin</td>
<td>67</td>
</tr>
<tr>
<td>Parent</td>
<td>62</td>
</tr>
<tr>
<td>Grandparent</td>
<td>49</td>
</tr>
<tr>
<td>Sibling</td>
<td>38</td>
</tr>
<tr>
<td>Friend</td>
<td>31</td>
</tr>
<tr>
<td>Other Professional</td>
<td>23</td>
</tr>
<tr>
<td>School Personnel</td>
<td>18</td>
</tr>
<tr>
<td>Non-Professional Adult</td>
<td>18</td>
</tr>
<tr>
<td>Guardian</td>
<td>15</td>
</tr>
</tbody>
</table>

Table 3.6 Child Behavior Checklist: Social Competence Scales (n=36)

<table>
<thead>
<tr>
<th>CBCL Scale</th>
<th>T-Score Mean (SD)</th>
<th>Percent of Children Scoring in the Borderline Clinical (BC) or Clinically Significant (CS) Range</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>BC</td>
</tr>
<tr>
<td>Total Competence</td>
<td>40.87 (9.81)</td>
<td>11</td>
</tr>
<tr>
<td>School</td>
<td>41.42 (8.50)</td>
<td>8</td>
</tr>
<tr>
<td>Social</td>
<td>41.66 (9.60)</td>
<td>22</td>
</tr>
<tr>
<td>Activities</td>
<td>45.18 (8.27)</td>
<td>11</td>
</tr>
</tbody>
</table>
### Table 3.7 Children’s Receptive Vocabulary: Peabody Picture Vocabulary Test (n=38)

<table>
<thead>
<tr>
<th>PPVT Score</th>
<th>Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Raw Score</td>
<td>122.66 (29.18)</td>
</tr>
<tr>
<td>Standard Score</td>
<td>99.24 (13.75)</td>
</tr>
<tr>
<td>Age Equivalent (in years)</td>
<td>10.31 (4.47)</td>
</tr>
</tbody>
</table>

### Table 3.8 Correlations among CBCL Scores, Intergenerational Substance Misuse, and Grandparent Support: T-Tests

<table>
<thead>
<tr>
<th>Scale</th>
<th>Intergenerational Substance Misuse Mean (SD)</th>
<th>Supportive Relationship with Grandparent Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Social Competence (Raw score)</td>
<td>5.9 (2.05)*</td>
<td>7.31 (2.66)*</td>
</tr>
<tr>
<td>Externalizing (T-Score)</td>
<td>61.25 (11.19)*</td>
<td>58.17 (15.89)</td>
</tr>
<tr>
<td>Social Problems (Raw score)</td>
<td>4.9 (3.29)</td>
<td>7.11 (11.78)</td>
</tr>
<tr>
<td>Thought Problems (Raw score)</td>
<td>5.00 (4.01)</td>
<td>4.11 (4.89)</td>
</tr>
<tr>
<td>Aggressive Behavior (Raw score)</td>
<td>10.75 (7.65)</td>
<td>11.44 (10.55)</td>
</tr>
</tbody>
</table>

*p< .05
CHAPTER 4
CASE STUDIES

In order to better understand the lives of children from methamphetamine-involved families, I identified and examined extreme cases utilizing case clustering and case analysis techniques (Research Aim 4). Children were first grouped into clusters according to whether or not they were experiencing clinically significant mental health and social competence problems according to the CBCL. I then selected 2 cases for an in-depth, longitudinal, and descriptive examination in order to elucidate the constructs presented in Chapter 3. I selected one girl, Kim, with both clinically significant mental health and social competence problems, and one boy, Brad, with neither clinically significant mental health problems nor social competence problems. 

Identifying Cases: Case Clustering

The 34 children with valid CBCL scores were grouped into one of four clusters, as presented in Table 4.1. Fourteen children (41%) had both clinically significant mental health and social competence problems including 8 females and 6 males are included in Group 1: BOTH. At the other end of the continuum, 7 children (21%) had neither clinically significant mental health nor social competence problems including 2 females and 5 males and are in Group 4: NEITHER. Nine children (27%) with clinically significant mental health problems but no social competence problems (including 5 females and 4 males) are in Group 2: MH ONLY. Four children (12%) had no clinically significant mental health problems but had clinically significant social competence problems, including 1 female and 2 male children, are in Group 3: SOC ONLY.

As expected, t-Tests (see Table 4.2) revealed that children in Group 1 scored significantly higher on the CBCL Total Problems scale \( t(1, 35)=2.68, p \leq .05 \), Externalizing \( t(1. 35)=3.1, p \leq .05 \) and Internalizing scales \( t(1, 35)=1.46, p \leq .05 \) compared to children in Group 4.
Statistically significant differences between Groups 1 and 4 were also found on 6 of the 8 narrow-band problem scales on the CBCL including the Aggressive Behavior scale \([t(1, 35)=2.51, p \leq .05]\); Attention Problems scale \([t(1, 35)=3.51, p \leq .05]\); Rule-Breaking Behavior scale \([t (1, 35)=2.42, p \leq .05]\); the Social Problems scale \([t (1, 35)=1.83, p \leq .05]\); Anxious Depression \([t (1, 35)=2.01, p \leq .05]\); and, Thought Problems \([t (1, 35)=1.86, p \leq .05]\). Group 1 children also performed worse on the CBCL Total Competence scale \([t (1, 35)= -2.83, p \leq .05]\); Social Competence \([t (1, 35)= -2.71, p \leq .05]\); and, the School Competence scale \([t (1, 35)= -2.71, p \leq .05]\); compared to Group 4 children.

Selecting and Binding the Case

Case selection was first based on the clustering of children. Once groups of children were identified, I selected one case from each extreme group (Group 1 and 4) based upon the availability of longitudinal data for that child as well as whether or not I have had personal, prolonged engagement with the child during the course of the research. The case analysis will elucidate the themes presented in Chapters 3 including problematic family-of-origin experiences and mental health, positive family-of-origin experiences, social support, competence, and hope from the perspective of the individual child. Thus, these cases are bounded by construct. I further bind these case analyses by time; these case exemplars are presented chronologically.

Group 1 Case: Kim

Kim was clustered in Group 1 and had clinically significant scores in both mental health and social competence. Kim is an important case because she experienced high risk including a family history of intergenerational substance misuse. Kim also scored 1 standard deviation below the norm on the PPVT. Moreover, she did not benefit from the protective factor of
grandparent support. From a longitudinal perspective, Kim’s mental health and social competence functioning declined once she was returned to her mother’s care.

I enjoyed prolonged engagement with Kim including the opportunity to interview her twice during the time period of 2005-2007. I present Kim’s case beginning with the time before she was in foster care. The information from this period of time was garnered from the interviews I conducted with her as well as the record review. I then discuss the period of time that Kim was in foster care, and conclude with the last time I saw her utilizing the interviews I conducted with her as well as the mental health assessments and the record review.

When I first interviewed Kim in July of 2005, she was 11 years old and had been in foster care just over 6 months. She had one placement in a traditional foster home before being returned to her mother in October of 2005. Although Kim had been referred to a mental health counselor by her DCFS caseworker, she had not been attending regularly.

Kim is an engaging young girl of whom I was quite fond. When we first met, she was approximately 5 feet tall, with short, wiry, red hair which was naturally curly. She has blue eyes and freckles, which I found endearing, but which she “hated”. Throughout the course of our relationship, Kim often asked me to help her dye her hair, which I did eventually with her mother’s permission. Her goal was to look “goth” and she wanted black hair and she eventually began wearing black eyeliner and dark eye shadow.

I also perceived that Kim had low self-esteem. On one noteworthy day, after returning to her mother’s care, she was wearing a homemade t-shirt: a plain white man’s undershirt on which she had written the word “LOSER” in black permanent marker. She used that marker to decorate her shoes, as well as her arms and hands with doodles and artsy sketches, all of which made me
feel sad for her, but which she found to fun. She had, at times, also scratched the skin on her arms with sharp objects in an attempt to make tattoos.

**Kim Age 0-10: Before Foster Care**

Kim lived in a rural town with a population of approximately 10,000 people. From the ages of 9-10, she lived with her mother, father, and brother, who was 7 years her senior, in a dilapidated, although livable, 2-bedroom home. She had her own room, and her brother lived in the converted garage. Kim’s family moved frequently, approximately once every 2 years since her birth, due to financial instability. She attended a local elementary school from kindergarten until the fourth grade. Kim reports a chaotic home life characterized by her parent’s frequent arguments. She described a close relationship with her father, a somewhat disengaged relationship with her older brother, and an often contentious relationship with her mother who, by her own report, had a difficult time controlling Kim’s behavior. From the time she was approximately 9 years old, Kim reports staying up as late as she wanted, leaving the house without her parent’s knowledge, and frequently missing school.

Kim’s problematic behavior is exemplified by an incident she described to me about a time that she snuck out of the house, at age 11, in the middle of the night and took the family car to another town, approximately 15 miles distance from their home. She picked up 5 of her friends, all middle-school aged, to bring them back to her house. She was spotted by the police, but did not know how to react when they pulled behind her with the police lights on. So, she drove very slowly, but did not pull over until she reached her driveway. She reported that 5 police cars were behind her by that point in time. The police woke her mother and Kim reported to me that she didn’t get into “any trouble” with her mom or the police. She explained to me that taking the car was a normal activity for her and that she had been driving to the grocery store, on
her own, since she was 9 years old to buy food when her parents were incapacitated by substance misuse.

**Kim’s Problematic Family-Of-Origin Experiences**

Kim was an infant or toddler when both of her parent’s began misusing alcohol and other illegal substances. There also was a history of intergenerational substance misuse in Kim’s family with her parental grandparents and her mother’s siblings. Kim’s last exposure to her parents’ misuse of substances was approximately 6 months prior to when I first interviewed her. Both of Kim’s parents began misusing methamphetamine when Kim was a school-aged child. Kim reported that her parents started using meth about 6 months before they were arrested. While her father was arrested for methamphetamine production, this did not occur in the home. Kim’s father was sentenced to 6 months for methamphetamine production. He was released when Kim was in care, and then re-arrested for methamphetamine-production and sentenced to prison for 2 years. Kim’s mother was in jail for a period of one month while Kim was in foster care.

Kim’s child protection case with DCFS was opened due to neglect. One weekend, Kim had her best friend stay the night because her friend’s father had been arrested on methamphetamine-related charges earlier that day. Kim and her friend and Kim’s mother had gone to Kim’s doctor appointment the following day. When they returned, the police were at their home. Her father had already been taken to the police station, and her mother was arrested when they arrived. The case was unrelated to Kim’s friend’s father. Kim went into foster care that same evening and Kim’s older brother went to live with his biological father. Kim described these events as something that made her “afraid” during the TSCC:

Interviewer: Can you tell me about a time when you might feel afraid?
Kim: Like the day I got taken away. I got back from a doctor’s appointment with my friend and we pulled up to my house and the cops were there and they took me to (foster parent’s name). Early in the morning, I got up and my friend stayed the night and her dad went to jail that night.

Interviewer: Your friend’s dad?
Child: And we woke up the next morning and, at 9:00 was my appointment. So we woke my mom up at, I think it was 8, and we left at 8:30 because it only took like 15 minutes to get there. And when we got done with the doctor’s appointment we went to Walmart, we first went to McDonald’s to get our lunch then we went to Walmart, and then we went home. There was like fifteen cops there.
Interviewer: At your house?
Child: Cause my dad was doing methamphetamines.

Interviewer: So your dad had been at home while you’d been gone.
Child: With four friends.

Interviewer: And were they making methamphetamine?
Child: (indicates yes)

Interviewer: And using it?
Child: Yes. They were already at jail when we got there. And when my mom got home, they took her in the police car. And they took us in a different one. They went and got my brother from school—oh no, from one of his friend’s. And then when we got to the police station it was like 1:00 and we stayed there until 10 that night waiting for the DCFS.

Interviewer: So you were there all afternoon and most of the night.
Child: And then when I got here (foster parent’s home) I went to the bedroom and I just cried and cried and cried.

Kim further elaborated on the events surrounding her parent’s arrest and her experience with entering foster care during the interview when discussing a “sad” or “scary” time in her family:

Child: They (police) told us that I wouldn’t get taken away and that I’d go back home with my mom.

Interviewer: And when did that change?
Child: Whenever the investigator spoke to my mom.

Interviewer: Do you have any idea why it changed?
Child: Because my mom let, she went to jail. There was no other place for me to go, except a foster home.

Interviewer: What’s your dad up to now?
Child: He got out of jail. And he went back to jail for doing the same thing. And then, now he’s going to prison. The first time he only got probation.

Interviewer: Do you know how long his sentence is?
Child: I think 2 years.
Kim described a number of other problematic family-of-origin experiences including loss. Loss was a theme that emerged from the interview as well as during the TSCC, particularly loss related to her separation from her parents, as is exemplified in the following excerpt:

Interviewer: Is there anything in particular that makes you feel sad?
Kim: When I think about my mom and why I’m here.
Interviewer: How long have you been in foster care?
Kim: It’ll be 7 months the 28th.
Interviewer: And have you been with this foster mom the whole time?
Kim: (indicates yes)
Interviewer: How is your mom?
Kim: She’s doing good, but she has to take all these classes and everything and it’s hard to get her working.

Kim also indicated that the separation from her mother was hard in response to giving advice to other children during the interview:

Interviewer: If you were meeting a kid who was just getting put into foster care today, what would you want to tell them.
Child: That it’s hard. That eventually they’ll get back with their mom.
Interviewer: What do you think in particular is hard?
Child: Being put away from your mom. Separated.

Kim also experienced the loss of a grandparent, with whom she was close and with whom the family lived for some time before moving into their own home. Kim’s grandmother died the day of their family reunion:

Interviewer: Can you tell me about a time that was sad or scary?
Child: When my grandma died.
Interviewer: Tell me more about that.
Child: We lived with her for about 2 years. And she was really sick. She had cancer. And, two years after we lived with her she died. And all of her family members and her friends, it was a family reunion, and she died on our family reunion.

Kim also described being scared for her mother’s health when her mother was suddenly hospitalized. Kim described this medical scare to me during the TSCC when she was elaborating on times she has felt afraid:
Interviewer: What other kinds of things might you be afraid of?
Child: Like going to school, coming back and my mom’s not there.
Interviewer: Is that something that’s happened before?
Child: She went to the hospital when I was at school, yeah.
Interviewer: She did. What did she get taken to the hospital for?
Child: For her back and she can’t breathe very well.
Interviewer: So you got home from school and she was gone. How did you find out what happened?
Kim: My grandma. She was there.

Kim often spoke of her parents’ substance misuse and described it as problematic in the interview as well as in response to the TSCC. In the following excerpt, Kim describes one of her memories of her parent’s substance misuse as something she would like to forget during the TSCC assessment:

Kim: Like my mom and dad going in their room and shutting—locking the doors.
Interviewer: Can you tell me a little bit more about that?
Kim: Like they did that whenever they got home from work.
Interviewer: What do you think your mom and dad were doing?
Kim: They were doing drugs; I knew that.

Kim further described her parents’ substance misuse as well as their antisocial behavior related to domestic violence, in which she became involved as a time that was “scary” during the interview:

Interviewer: What kind of things might you remember that are scary?
Kim: Like my dad used to leave at night, lock out my mom and stuff. And then, one night, my mom had to go to work cause she got called in and he knew what time she was coming back and he locked the door on purpose. He locked her out.
Interviewer: So she couldn’t get back in. What happened after that?
Child: I let her in.
Interviewer: Was your dad pretty angry about that?
Kim: (indicates yes)
Interviewer: What did he do when he got angry?
Kim: He’d like throw things. He has a bad anger problem.
Kim’s Positive Family-Of-Origin Experiences and Social Support

Kim also described a number of positive family-of-origin experiences. In describing a “happy” time with her family during the interview, she described a family trip:

Interviewer: Can you tell me about a time that was happy?
Child: When my dad was working on a semi, he took all of us and we went up to Chicago. And, we went to Navy Pier. And when he got his pay check we stayed at Holiday Inn. That’s when he wasn’t on drugs. He never did drugs until like probably six months before he got caught.

Kim also described having social support from a number of sources. Her relationship with her mother, although contentious at times, was also an important source of emotional support, as Kim described in response to the TSCC item regarding anger:

Interviewer: What happens when you start feeling mad?
Kim: Like if somebody called me a name or something.
Interviewer: And then what would probably happen?
Kim: I probably would go after them or my mom would calm me down.
Interviewer: So what kind of the things would your mom do to try to calm you down?
Kim: To try to get me to play a game or something.

Kim’s best friend, with whom she shared the experience of growing up in a substance-involved family, was also a source of support for her. Her best friend’s parents also were involved with methamphetamine, at times with Kim’s parents, as exemplified in the following excerpt:

Interviewer: Can you tell me about when they started using or how you first knew something was different?
Child: Because usually they never went in the bedroom and locked it. And, me and my friend, her mom was in there too. And we knocked on the door and we asked if we could come in and they said no. So we went around and we opened the window and we said, “Let us in”.
Interviewer: So you went around the outside of the house? What did they say when they saw you?
Kim: They go, “Fine, come around to the door”.
Interviewer: So what happened when you went back into the house?
Kim: It (the door) stuck and everything and we just left and went downtown.
Interviewer: Did you know, at that point, what was going on?
Kim: (indicates yes)
Interviewer: How did you know what was going on?
Child: Because it never used to stink like that. And then we found where they were hiding the stuff- in the closet. At the top of it.
C: So then you saw the stuff and you knew what was going on. Once you knew how did you handle it? Did you tell anyone?
Kim: Only my best friend.
Interviewer: And it was her mom that was using it too. Did you guys talk to each other about it?
Kim: (indicates yes)
Interviewer: You did. And when you would talk together what kind of things would you talk about?
Kim: Like her mom has been using it for like over, she was using it for like 4 years.

Kim Age 11-12: During Foster Care

When I first met with Kim, she had been in foster care for 6 months. Her foster family included her foster mother and father as well as an older foster sister in her late teens and a younger foster brother who was a toddler. Kim expressed that she liked having an older sister and, at times, enjoyed having a younger foster brother. She expressed that she felt as if she was unfairly expected to care for her younger foster brother, such as changing his diaper and babysitting.

On the first occasion that we met, I conducted the CBCL and TSCC assessments with Kim. The results from those assessments suggest that Kim was experiencing multiple mental health problems as well as problems in her adaptive functioning. On the CBCL Total Problems Scale and Externalizing Scale, Kim scored in the clinical range, (T=65) and (T=70), respectively. Her scores on the CBCL Internalizing scale were within the normal range (T=56). Kim’s score on the CBCL Total Competence scale was in the clinical range (T=32) and she was also experiencing borderline-clinical problems in Social Competence (T=32). Her score on the School Competence scale was within the normal range (T=50). Her standardized score on the Peabody Picture Vocabulary Test was one standard deviation below the norm. According to the TSCC,
Kim was also experiencing borderline-clinical symptoms on the Anger (T=60) and Post Traumatic Stress (T=62) subscales.

**Kim Age 12: After foster care**

Kim was returned to her mother’s care after approximately 9 months of being in care. I last saw Kim in February 2007, 19 months after I met her for the first time and 4 months after returning home. Kim returned to the same home the family had been living in prior to her coming into care along with her mother, and her older brother. During the second interview, I enjoyed the opportunity to talk with her mother who was struggling to find work due to her criminal record. Kim’s mother was fiercely determined to be a support for Kim and to turn their family’s life around. She and her husband had decided to live a clean and sober life and to rebuild their family life. She expressed that they were biding their time until Kim’s father returned from prison, at which point they would move to a different town where there were more job opportunities.

After returning home, Kim was frequently truant from school; attending approximately 2 days a month and missing all days of school for months at a time. Her mother had been working with the school as well as the police to avoid receiving any more fines associated with her daughter’s truancy. In order to show that she, as a parent, was making every effort to get her daughter to school, Kim’s mom would walk to school every morning to check in when school began. Kim reported that she did not want to be in school and so she did not go with her mom in the mornings. On very few occasions, Kim’s mom convinced her to go to school. Kim and her mom argued frequently, even throughout the course of our second interview. I ended the second interview prematurely, as their arguing was quite heated.
In addition to the truancy issue, Kim’s mom was concerned about Kim’s sexual activity. Kim had been dating another girl from her neighborhood, and Kim’s mom was convinced that Kim was only doing so for attention. For her part, Kim reported that she did not want to complete school and that she was just waiting until she turned 16 to be emancipated. Kim was not attending mental health counseling and had been diagnosed with bipolar symptoms, for which she refused to take medication.

Kim’s scores on the CBCL and TSCC after she returned home indicate some stabilization in mental health functioning on the TSCC and a decline in mental health and social competence functioning on the CBCL. Her CBCL Total Problems score remained in the clinical range (T=70) as did her Externalizing scale score (T=79). Her score on the Internalizing scale at Time 2 was in the borderline-clinical range (T=62). According to Kim’s Time 2 CBCL assessment, her scores on the Total Competence scale indicated clinical range functioning (T=25) as did her score on School Competence (T=20). Kim was also functioning in the borderline-clinical range on Activities Competence (T=32). In the area of Social Competence, Kim’s score indicated normal range adaptive functioning (T=40). Her scores on the TSCC scales were normal, although her scores may have been under-reported at time 2 (T=57).

Kim’s mental health remained clinically significant upon her return to her biological mother as revealed by her scores on the CBCL Problems scales and TSCC scales from Times 1 and 2 (see Figure 4.3). Her CBCL Total Problems and Externalizing scores remained in the clinically significant range. Although her scores improved on the TSCC Anger and Post Traumatic subscales on the TSCC at Time 2, her CBCL Internalizing scale score rose from the normal range to the borderline-clinical range. Moreover, her scores on the TSCC may have been under-reported at Time 2 as she scored in the borderline-clinical range on the Under-Reporting
Kim’s Time 1 mental health and competence was measured approximately 6 months after her coming into care. While in foster care, she was experiencing a number of problems associated with externalizing problems including rule-breaking behavior and aggressive behavior, both of which are reflected in her Externalizing scale score. She also was experiencing a number of problems associated with clinical-range functioning on the CBCL Total problems scale such as jealousy of her school mates and feeling like she wasn’t liked by her new peers; sleeping less and self-injurious behaviors, and attention problems.

Her scores on the Time 1 TSCC reflected that she was experiencing anger as well as symptoms of post-traumatic stress, problems which were borne out in our discussions. Kim’s borderline-clinical score in the area of social competence may have been a reflection of the fact that she had been separated from her friends from her hometown and that she was a new student at her current school at the beginning of mid-term, an awkward experience particularly for a pre-teen girl.

Upon being returned to her mother’s care, Kim continued to exhibit behaviors associated with clinical range scores on the CBCL Total Problems scale including feeling lonely, trouble sleeping, and attention problems, particularly at school. Her score on the Externalizing Scale also remained in the clinical range including rule-breaking behavior and aggressive behavior. It may be that Kim’s anger towards her mother as the reason she had to go into foster care, a sentiment
she described to me during the interview, was the impetus for her continued problems. It may be that some of her problems were simply a continuation of problems that she was experiencing prior to coming into foster care. As this was a time period that was not assessed, there is no way of knowing for certain; although, it is likely some combination of both.

One area of Kim’s life that had changed upon her return was that many of her former friends had moved into the next grade. Kim’s truancy problems resulted in her being moved to an alternative school, where she once again had to make new friends. Although she spent time with her best friend, whom she hadn’t seen while in foster care, all of her new friends had significant behavior problems as they too attended the alternative program. Kim began spending a great deal of time with her new friends, staying out all night and leaving the house whenever she wanted, as reported to me by her mother at the Time 2 interview. Thus, her improved Social Competence score may simply be a reflection of an increased number of friends and more time spent with them. As the CBCL Social Competence scale does not capture a full-range of quality of friendship issues, this is a shortcoming to be taken into consideration when looking at Kim’s Social Competence.

The decline in Kim’s Activities Competence scale score is also a reflection of the change in environments from foster care to her return to her family home. While in foster care, Kim had a structure regarding her activities such as chores and after school events. Kim was determined to do whatever she needed to do in order to be returned to her mother’s care and so she was mindful of following the rules, as she revealed to me during our discussions. Upon returning to her mother, that structure was gone and it may be that Kim’s motivation to do well was gone too. The fact that Kim began having significant truancy problems reflects a change in her motivation, as is captured in the change in her School Competence scores from Time 1 to Time 2.
Kim Age 13: Follow-Up

I received a phone call from Kim in November 2008. She reported that her father had been released from prison a few months prior to our phone call and that she and her family had indeed moved to a larger town. Both of her parents had found employment, as had her 19 year old brother. They were renting a 3 bedroom home. Kim reported that she had been attending school every day that semester, and was on track to graduate from the 6th grade. She reported that she broke off her relationship with her girlfriend when her father was released from prison. She told me she was happy that her family was back together and that she had been taking her medication regularly.

Group 4 Case: Brad

Brad was clustered in Group 4 and had no clinically significant mental health or social competence problems. Brad’s case is important because he experienced the protective factor of a close relationship with a grandparent. Brad also scored 2 standard deviations above the norm on the PPVT. Moreover, he did not have a family history of intergenerational substance misuse. From a longitudinal perspective, Brad’s mental health and social competence functioning declined at the time of his second foster care placement and improved during his placement at his third foster home. I also enjoyed prolonged engagement with him including the opportunity to interview him twice during the time period of 2004-2006. I present Brad’s case beginning with the time before he was in foster care. The information from this period of time was garnered from the interviews I conducted with him as well as the record review. I then discuss the period of time that Brad was in foster care at his second placement, and conclude with the last time I saw him after he moved to a third foster home. Information from these later periods of time came
from the interviews I conducted with him as well as the mental health assessments and the record review.

Brad is a very likable boy with sandy brown hair and brown eyes. He was polite and soft-spoken, but direct and open to discussing his life. Brad is intelligent and had a variety of interests which he enjoyed talking about with me including his affinity for computers, the sports teams he was involved with, and his church youth group. Brad had goals for his future, and his desire was to go to college where he believed he would study computers.

*Brad Ages 11-12: Before Foster Care*

Brad was well-liked in his community, was in the gifted-program at school, and was involved in several activities such as sports and youth groups at church. Several community informants from our ethnographic study identified Brad as a resilient child, including the State’s Attorney, his school principal and teachers, and DCFS workers. Brad lived with his mother and father and younger brother in a rural town with a population of approximately 1,000 people. His family lived in a 2 bedroom trailer. His grandparents on both his mother’s side and his father’s side of the family lived within a couple of blocks from his home. Brad’s parents were significantly involved with the production of methamphetamine; to the point that law enforcement had surveillance cameras focused on their home. Despite this level of involvement, Brad told me that he was unaware that his parents misused and produced methamphetamine.

Brad remembers his life prior to coming into care as “normal” and “fun”. He explained during the interview, that he had a lot more freedom than he did at his foster home:

Brad: I liked being with them because I had more freedom than I do now.
Interviewer: Right. Like how would, what would you do?
Brad: Like there, I usually didn’t stay at the house as much. Like, I’d usually be out riding my bike around and going over to my friend’s house and stuff.
Interviewer: Right. So you had more freedom.
Brad: Yeah, usually I’d ride over to my friend’s houses and I’d play with them usually all day. I mean, I got, I only think maybe I got grounded once my whole life there. I never, and that one time I got grounded they didn’t even ground me for the full time that, so I usually didn’t get in trouble that much usually there, compared to how much I do there because I like to argue a lot. And, see I don’t have as much freedom, like there I didn’t have to tell them usually a specific place. I’d usually be riding, I’d just ride around and look for whoever was, whoever was just outside playing or could play. And here, yeah, she (foster parent) has to know where I’m at and yeah, stuff like that. And what time I’ll be home and stuff like that, and I usually just came home (to parent’s home) whenever I got hungry and ate.

Brad and his brother lived an “idyllic” rural life, as described by Brad. The DCFS investigator on the case described Brad’s life as reminiscent of “Tom Sawyer and Huck Finn”, pointing to the fact that Brad’s grandparents worked to protect Brad and his younger brother from their parents’ problems. For example, both Brad’s mother and father had several encounters with the police, and at times were arrested. The grandparents would bail them out and the kids would stay with them under the guise of some other excuse.

The protective presence of his grandparents was noted in an interview I conducted with Brad’s teacher. My first introduction to Brad was during an interview I conducted with one of his teachers at school many months before Brad had been recruited for the study. His teacher described Brad as “resilient” in response to an interview question regarding why some children from methamphetamine-involved families do better than other children from the same environment. In the following quote, Brad’s teacher explains why she felt Brad, and his brother, were more resilient than other children she has known whose parents were misusing methamphetamine:

I just feel that these boys are very fortunate because they’ve had a good family upbringing from their extended relatives. They have one grandma that, basically, the mom and dad lived with grandma and the grandma made sure the oldest one got to school every day and that he had his homework done. And she bought him a skateboard pass at the YMCA, she just made sure she took care of him, but she’s an elderly lady and now her health has deteriorated.
Brad’s Problematic Family-Of-Origin Experiences

Brad’s parents misused alcohol and other substances since their adolescence. Brad was a preschooler when both of his parents first began misusing methamphetamine including the production of methamphetamine in the family home. There was no history of intergenerational substance misuse in Brad’s family. His DCFS case was opened due to neglect.

From his perspective, Brad’s family-of-origin experiences were largely unproblematic. Brad discussed the events surrounding his parent’s arrest and his coming into care as a time that was “scary” during the interview:

Brad: I was, yeah the day that they were uh, the day that they took them to jail, I was out with one of my other friends somewhere, and we were out in the, like, we went a little bit out of town to use my friend’s metal detector, test it out, and yeah, and when we came back there was a whole bunch of cars there and stuff and we didn’t know what was going on.
Interviewer: Yeah. What did you think was going on?
Brad: I didn’t know, I thought it might have been the neighbors.
Interviewer: The neighbors. And then what happened?
Brad: Well they, we went up there and the police were there and they told us to stay there and wait for (DCFS) to come and get us and we just waited there. And then my friend came over after that, the one I was using the metal detector with, and I talked to him some.

Although he described these events as problematic, he indicated that he was unaware of his parents’ substance misuse:

Brad: They didn’t really act any different. They didn’t, I usually, they didn’t act really that much different.
Interviewer: Did you know they were on it?
Brad: (indicates no)
Interviewer: You didn’t.
Brad: And ah, yeah, they usually, I just wasn’t home much usually.
Interviewer: You were just out a lot. Could you ever smell it? Or did you have an idea about it?
Brad: Not usually.
**Brad’s Positive Family-Of-Origin Experiences and Social Support**

Brad described positive experiences with his family including family trips to an area amusement park, as he described in response to a “happy” time with his family:

We go to (Amusement Park) every year and yeah, we did that. We just went, it was last week, and we just went there. We go there with (grandmother) every year.

In addition to benefiting from social and emotional support from his grandmother, Brad also indicated that he had social support from other extended family members including his Aunt and cousin:

We’ll go over to our Aunt’s, which is my grandma’s daughter, we’ll go over and see my grandma and stuff all the time. And usually when we go over to (grandma’s home) we have our cousin Austin, he’s usually over there.

**Brad Age 12-13: During Foster Care, Second Placement**

Brad was a 12 year, 8 month year old boy when I first interviewed him in 2004. By the time I saw him for the final time in 2006, he was 15 years old. In 2004, Brad had been in foster care for 13 months and was living at his second traditional foster home, along with his brother, who was 9 years old at that time. Brad had been referred to a mental health counselor by his DCFS caseworker, and was attending regularly. He had never been psychiatrically hospitalized. Both of his parents were in prison on meth-related offenses; his mother was serving a 14 year sentence and his father, a 4 year sentence.

Although Brad described his family-of-origin experiences as unproblematic as a whole, Brad was parentified. He was accustomed to little structure and few rules as well as to making decisions regarding his younger brother and himself. This contributed to problems in his first and second foster care placements. In the first placement, the foster family terminated the foster care placement because they struggled to manage Brad’s autonomy and the foster parent’s relationship with Brad was contentious. Brad’s second foster placement was also characterized
by frequent arguments between Brad and his foster mother. In response to the conflict between herself and Brad, his second foster mother frequently grounded him from the sports he was involved with, as well as other activities such as church youth group, television watching and using the computer. The DCFS caseworker became so concerned about their contentious relationship, noting Brad’s continual sad affect and his foster mother’s hostility towards Brad, she recommended the termination of the foster placement and, eventually, Brad and his brother were moved to a third placement. In the following excerpt, Brad describes his relationship with his second foster parent:

Interviewer: Sometimes kids whose parents get involved with meth get really down and they might feel angry or sad or distressed. Have you had any of those feelings?
Brad: Angry, but that’s just because I just argue all the time and I get in trouble and get grounded from games all the time and stuff. So I just try to avoid arguing now.
Interviewer: Right. Is that hard or easy?
Brad: That’s hard.
Interviewer: It’s hard isn’t it? What makes you mad?
Brad: Just getting grounded or sometimes like, I think the problem is why I argue is, (foster parent) likes to argue too, which, we’ll argue back and forth and everything and (foster parent) is a lot like me.

Brad’s scores on the CBCL and TSCC at Time 1 were within the borderline-clinical range. It may be that these scores reflected the stress he was feeling in his current foster placement as he had been in foster care for one year, and in his current placement for a few months. On the CBCL Total Problems scale, Brad scored within the borderline-clinical range (T=60) as he did on the Externalizing scale (T=62). His score on the Internalizing scale fell within the normal range. Brad also exhibited borderline-clinical range symptoms on the TSCC Anger scale (T=60) and Dissociation scale (T= 60).

Brad’s scores on the CBCL Competence scales were all within the normal range including the Total Competence, Activities Competence, Social Competence, and School
Competence scales. Brad’s PPVT standardized score, 126, was 2 standard deviations above the sample mean.

Brad Age 15: Third Placement and Guardianship

I last interviewed Brad in October of 2006. He and his younger brother had moved to a third foster placement. At the current foster home, Brad had 2 foster brothers, both around his age. He said that his new foster parents were more “laid back” and he also enjoyed a close relationship with his foster brothers. Brad’s foster parents were in the process of obtaining guardianship of Brad and his brother.

At Time 2, Brad’s mental health functioning had improved. His scores on the CBCL Total Problems scale (T=51), Externalizing scale (T=46), and Internalizing scale (T=50) were all within the normal range. Further, his scores on the TSCC subscales were within the normal range. Brad scores remained within the normal range on each of the CBCL competence scales, including Total Competence, Activities Competence, Social Competence, and School Competence.

Brad’s third foster placement was an environment which allowed Brad to have more autonomy than he experienced in his first two foster homes. His scores on the CBCL and TSCC improved from Time 1 to Time 2, and the environment in his third foster home may be related to his improved scores. His CBCL Total Problems and Externalizing scales scores improved from the borderline-clinical range to the normal range, as did his TSCC subscales scores (see Figure 4.4).

Although the issue of parentification can be problematic for children, it can also be a source of strength and protection for children. Brad’s parentification was perceived as problematic by his first two foster parents, who tried to control Brad’s autonomy and decision-
making by grounding him. These groundings typically involved prohibiting Brad from sports, after school activities and time on the computer; activities which Brad enjoyed and in which he showed competence. It may be that his second foster parent’s decision to prevent Brad from participating in these activities eroded the very sources of his strength and protection, resulting in borderline-clinical mental health symptomatology captured in his Time 1 CBCL and TSCC scores.

For many children, parentification is closely related to identity. From Brad’s perspective, his life prior to coming into care was largely unproblematic, including the fact that he accepted responsibility for his own care as well as the care of his younger brother. While his foster parents may have wanted Brad to have a “normal” childhood, or perhaps they had controlling personalities or authoritarian parenting styles, their attempts at controlling Brad’s behavior was confusing to him. From his perspective, he was a competent young man. This sentiment was also reflected by many adults who knew Brad, including his teacher at school and the DCFS workers involved with his case.

*Brad Age 17: Follow-Up*

The DCFS investigator working on Brad’s family’s case saw Brad and his younger brother at the younger brother’s 8th grade graduation ceremony. The investigator reported that Brad’s father had been released from prison and he had attended the graduation. Brad’s mother was also in attendance. The investigator reported that Brad’s father had maintained contact with Brad and Brad’s foster parents, who now were his legal guardians, throughout the time he was incarcerated and was supportive of their relationship as a family. At the graduation, Brad’s mother and father were included in group photos and the investigator reported that Brad was happy that his two families could get along well together.
Summary and Discussion

Kim and Brad’s cases are important because they reflect differing levels of risk and protection. While Kim’s parents were not as significantly involved with methamphetamine as Brad’s parent’s were and were involved with methamphetamine for a shorter period of time, Kim was aware of her parent’s methamphetamine misuse and did not benefit from the protective resource of extended family as did Brad. Kim also had a family history of intergenerational substance misuse. This may, in part, explain why she did not have relatives available for support.

Brad’s grandparents provided daily structure for him, an experience that was lacking in Kim’s life after her grandmother died. Brad’s grandparents also served as a protective factor in that they provided a place for him to escape his parent’s substance misuse as well as emotional support. Again, Kim did not benefit from this level of protection.

Kim’s perceptions of her family-of-origin experiences also differed from Brad’s. Her perception was that there were multiple problems in her family including adult substance misuse, adult anti-social behavior in which she was directly involved, loss with the death of her grandmother, and on-going concern for her mother’s medical condition. While Brad’s relatively sparse description of problematic family-of-origin experiences may be due, in part, to differences in their response to the interview itself, Brad was largely unconcerned or unaware of the problems in his family. This may be due to the protective presence of extended family living in close proximity to Brad’s family home. Kim and Brad did both benefit from supportive relationships with friends.
Table 4.1 Case Clusters: Mental Health and Social Competence (n=34)

<table>
<thead>
<tr>
<th>Group 1: BOTH Mental Health Problems and Social Competence Problems</th>
<th>Group 2: MH ONLY Mental Health Problems but NO Social Competence Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>n=14 (41%) Males- 6 Females- 8</td>
<td>n=9 (27%) Males- 4 Females- 5</td>
</tr>
<tr>
<td>Group 3: SOC ONLY NO Mental Health Problems but Social Competence Problems</td>
<td>Group 4: NEITHER NO Mental Health Problems and NO Social Competence Problems</td>
</tr>
<tr>
<td>n=4 (12%) Males- 3 Females- 1</td>
<td>n=7 (21%) Males- 5 Females- 2</td>
</tr>
</tbody>
</table>
Table 4.2 CBCL Scores Associated with Children With and Without Mental Health and Social Competence Problems: T-Tests

<table>
<thead>
<tr>
<th>Instrument</th>
<th>Group 1</th>
<th>Group 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBCL (T-Scores)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Problems</td>
<td>69.14***</td>
<td>48.86</td>
</tr>
<tr>
<td>Internalizing</td>
<td>63.71**</td>
<td>50.43</td>
</tr>
<tr>
<td>Externalizing</td>
<td>67.86***</td>
<td>46.71</td>
</tr>
<tr>
<td>Total Competence</td>
<td>38.90*</td>
<td>49.57</td>
</tr>
<tr>
<td>CBCL Raw Scores</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxious/Depressed</td>
<td>7.29**</td>
<td>2.00</td>
</tr>
<tr>
<td>Social Problems</td>
<td>7.57**</td>
<td>.86</td>
</tr>
<tr>
<td>Thought Problems</td>
<td>7.14*</td>
<td>1.86</td>
</tr>
<tr>
<td>Attention Problems</td>
<td>10.36***</td>
<td>3.14</td>
</tr>
<tr>
<td>Social Competence</td>
<td>8.64*</td>
<td>6.10</td>
</tr>
<tr>
<td>School Competence</td>
<td>5.14*</td>
<td>3.79</td>
</tr>
</tbody>
</table>
Figure 4.3 Kim’s Mental Health and Social Competence: CBCL and TSCC Scores
Figure 4.4 Brad’s Mental Health and Social Competence: CBCL and TSCC Scores
CHAPTER 5

DISCUSSION AND CONCLUSION

This research has contributed to the knowledge base in substance misuse prevention research concerned with modifying generic, family-centered prevention interventions for culturally-sensitive prevention interventions for distinct, high risk groups. Findings from this study reveal that children from methamphetamine-involved families have complex and varied family-of-origin experiences, mental health and social competence functioning, sources of social support, and sense of hope for the future. Children described problematic family-of-origin experiences and were challenged by poor mental health outcomes. They also described positive family-of-origin experiences and have developed social competence. Developing an understanding of both aspects of children’s lives is necessary to the formulation of prescriptive programming and to developing a more complete description of their needs as well as their sources of strength.

Extended family members can significantly impact children’s mental health and social functioning, especially in rural cultures where children may be isolated from friends and lack opportunity to access other forms of informal support. Characteristics of extended family, specifically, intergenerational substance misuse emerged as a possible risk factor for children in the sample. A supportive relationship with a grandparent emerged as a possible protective factor. Both intergenerational substance misuse and grandparent support were associated with mental health and social functioning scores in this study. Future studies utilizing more complex data analysis models are needed to better understand causal relationships as well as mediating and moderating effects among mental health, social functioning, and social context variables.
Summary

Mental Health

Most children in this study experienced significant mental health problems. Based on the CBCL scores, half of the children in this study were experiencing internalizing symptoms and over half were experiencing externalizing problem behavior. On the CBCL narrow-band scales, nearly half of the sample experienced thought problems. Slightly less than half of the sample experienced problematic behavior related to aggression and attention. One-third of the sample exhibited rule-breaking behaviors as well as symptoms of depression.

Other studies using the CBCL estimate that between 34% and 50% of children in foster care may exhibit significant behavioral or emotional problems (Clausen, Landsverk, Ganger, Chadwick, & Litrownik, 1998; Halfon, Mendonca, & Berowitz, 1995; McIntyre & Keesler, 1986). The literature regarding scores on the CBCL among foster children in the United States, Europe, and Australia indicates that the mental health problems of children in care more closely resemble clinic-referred children in the CBCL normative sample rather than children who were not referred for mental health assessment (Armsden, Pecora, Payne, & Szatkiewicz, 2000; Pilowsky, 1995; Tarren-Sweeney & Hazell, 2006; Burns, Phillips, Wagner et al, 2004; Cappelletty, Brown, Shumate, 2005). Specifically, distributions of CBCL Social Problem, Thought Problems, Attention Problems, Rule-Breaking Behavior, and Aggressive Behavior scale scores among children in foster care approach those of clinic-referred groups (Achenbach & Rescorla, 2001; Tarren-Sweeney & Hazell, 2006). The prevalence of clinically significant CBCL Total Problems and Externalizing scores is between three to four times higher among foster children compared to children who are not in care; the prevalence of internalizing problems is about 1.5-2 times higher (Tarren-Sweeney, 2008). The children in this sample had
higher rates of mental health problems compared to those reported in the literature with 72% of children scoring in the borderline-clinical or clinical range on one or more of the CBCL subscales.

Results from the CBCL among this sample were also consistent with research regarding the mental health of children exposed to domestic violence and those prenatally exposed to cocaine. Research has shown that children who witness domestic violence (McFarlane, Groff, O’Brien, & Watson 2003) or who are directly victimized during domestic violence disputes and who witness domestic violence (Kernic, Wolf, Holt, McKnight, Huebner, & Rivara, 2003) score higher on the CBCL Internalizing, Externalizing, and Total problems scales than children who are not exposed to domestic violence. In a longitudinal study of 415 children, those children exposed to cocaine prenatally and who were in adoptive or foster care at age 6, had more externalizing symptoms on the CBCL compared to children who had not been prenatally exposed to cocaine (Linares, Singer, Kirchner, Short, Min, Hussey, Minnes, 2006).

The mental health functioning of children from this study also resembled that of children from other substance affected homes. In a 1999 study, Stanger and colleagues examined the association between parental drug abuse and children’s problems as assessed with the CBCL. Four hundred and ten children, aged 2 to 18, were evaluated and the results indicate that one third of children of drug abusers had clinically significant scores for delinquent behavior and higher rates of aggressive behavior problems, attention problems, anxiety, and depression compared to the control group of children whose parents were not drug abusers.

Results from the TSCC also revealed problematic mental health functioning among children in this study. Slightly less than half of the children were experiencing problems associated with dissociation, post-traumatic stress, anger, and depression and over half of
children scored in the borderline-clinical or clinical range on one or more of the five TSCC subscales. These findings were consistent with research regarding the mental health outcomes of children receiving child protective services as assessed with the TSCC. In a longitudinal study utilizing a sample of 1,435 children receiving child protective services in the United States, English, Bangdiwala, & Runyan (2005) report maltreated children have significantly higher mean scores on all five of the Trauma Symptom subscales compared to a matched sample of non-maltreated children.

It is not possible to discern whether the scores on the CBCL and TSCC reflect longstanding behavioral and emotional problems or more transient problems related to placement in foster care and/or having an open child protective services case. Most likely it is a combination of traumatic family history and the disruption of the family unit. Prospective, longitudinal CBCL and TSCC scores would help to distinguish among the various pathways to problem behavior among children from methamphetamine-involved families. Regardless of whether the scores on the CBCL and TSCC reflect continuity in behavioral problems or a situation-specific set of responses, the high scores indicate that many children exhibited clinically significant problems. It appears, however, that the results from this study may be more heavily influenced by longstanding problems given the similarities in functioning among children in intact families and those in foster care. Only the TSCC Anger scale was significantly different between these groups, with children in intact families having higher scores on that scale.

Social Functioning

Children in this study, as a group, performed well on the CBCL Competence assessment and scored in the normal range on the CBCL Total Competence scale, School Competence scale,
Social Competence scale, and Activities Competence scale. This finding suggests that children had some level of protection from the risks associated with substance-affected homes. However, individual variation in scores on the CBCL Competence scales indicate 56% of children in this study scored in the borderline-clinical or clinical range on one or more of the three Social Competence subscales. Forty-one percent of children with problems in the area of social competence also had poor scores on the CBCL problems checklist. Children seemed to be functioning best in the area of Activities Competence, with only 11% of children scoring in the clinical or borderline-clinical range.

Achieved competence in childhood serves as marker of development and prognosis for psychopathology (Garmezy & Masten, 1991). Academic, social, and peer competence has been associated with feelings of psychological well-being versus distress or depression, fewer symptoms on problem checklists, and positive social skills (Blechman, Tinsley, Carella, & McEnroe, 1985; Masten, 1989). Incompetency, rather than competency, predicts depression among elementary school children (Keller, Wetherbee, Le Prohn, Payne, Sim, & Lamont, 2001; Benard & Marshall, 2001).

As a whole, the children in this study were not experiencing language delays and were of average intelligence as assessed using the PPVT. Individual variation in PPVT scores of children in the study indicate that 13% scored 1 or more standard deviations below the normative mean. Low cognitive functioning in children has been associated with externalizing behaviors (Werner & Smith, 1982; Hinshaw, 1992), antisocial behavior (Moffitt, 1990) and aggression (Conners, Bradley, Mansell, Liu, Roberts, et al., 2003) as well as with childhood neglect and abuse (Pears, Kim, & Fisher, 2008). Moreover, 13% of the children in this study scored 1 or more standard deviations above the normative mean, suggesting that higher cognitive functioning may serve to
protect these children from the adverse effects of living in methamphetamine-affected homes. Indeed, some literature suggests that higher cognitive functioning has been shown to protect against antisocial behavior and aggression (White, Moffitt, & Silva, 1989).

**Social Context**

Academic and social competence has also been shown to be related to the presence of psychosocial resources (Masten, Hubbard, Gest, Tellegen, Garmezy et al., 1999). School-aged children raised by methamphetamine-misusing parents reportedly can develop positive relationships with peers and community members (Ostler et al., 2007). This finding from our earlier research was borne out in this current study, with over half of the children reporting having important sources of social and emotional support. Children indicated that they received such support from a variety of sources including, most frequently, immediate and extended family members such as aunts, uncles, cousins, parents, grandparents, and siblings. One-third of the children described a supportive relationship with a close friend.

Family-of-origin experiences, including exposure to methamphetamine misuse and manufacture, are important to understanding child functioning. Many children whose parents use methamphetamine are brought up in environments characterized by antisocial beliefs and practices, environmental danger, chaos, neglect, isolation, abuse, trauma, and loss (Haight et al., 2005; 2006). These findings from our prior research were commensurate with findings from this current study. In this study, loss was a salient issue for the majority of children including separation from parent(s) related to foster care placement or parent abandonment. The majority of children also described adult substance misuse as problematic. Violence was another salient issue described by over half of children, and half of the children in this study described adult
antisocial behavior as problematic such as stealing precursors for methamphetamine production, vandalism, and running away from police.

*Relationships between Mental Health, Social Competence and Social Context Variables*

Family history of intergenerational substance misuse and the presence of a supportive grandparent were shown to be related to children’s mental health and adaptive functioning. The majority of children in this study had family histories indicative of intergenerational substance misuse. Further, children in this study who did not have a family history of intergenerational substance misuse had better Social Competence scores. Research that has supported intergenerational transmission models of drug and alcohol abuse indicates a genetic component may partially explain a person’s increased sensitivity to psychoactive substances (Phillips, 1997; Hoffman & Cerborne, 2001).

Environmental factors which may also explain the role of intergenerational substance misuse include parenting. The mechanisms by which parenting is affected by drug use is attributed to several factors including psychosocial risk (Hans, 2002; 2004). Psychosocial risk factors include limited emotional and social resources and limited social support (Luthar & Walsh, 1995; Conners et al, 2003). In a study of 2,746 mothers in residential treatment in the U.S. from 1993 to 2000, three-fourths of women reported that their family members were involved in alcohol or drug related activities, and less than half reported having fewer than two friends that did not use drugs. Moreover, many substance abusing parents are themselves children of substance abusers (Hoffman & Cerborne, 2002). It may be that children whose families are characterized by intergenerational substance misuse do not have a readily available protective resource of a non-substance misusing adult in their extended family.
Consistent with the literature regarding the protective role of grandparents (e.g., Lynskey & Fergusson, 1997; Pynoos et al., 1996; Kroll, 2004), children who benefited from a supportive relationship with a grandparent in this study had better scores on several CBCL scales measuring social and thought problems, aggression, and externalizing behaviors. Further, children who had never been psychiatrically hospitalized were more likely to have a supportive relationship with a grandparent.

Case Studies

The two extreme cases examined in this study, Kim and Brad, are important because they reflect differing levels of risk and protection. While Kim’s parents were not as significantly involved with methamphetamine as Brad’s parent’s were and were involved with methamphetamine for a shorter period of time, Kim was directly exposed to her parent’s methamphetamine misuse and did not benefit from the protective resource of a grandparent, as did Brad. Kim also had a family history of intergenerational substance misuse. This may, in part, explain why she did not have relatives available for support. Kim also scored 1 standard deviation below the norm on the receptive vocabulary test whereas Brad scored 2 standard deviations above the sample norm. From a longitudinal perspective, Kim’s mental health and social competence functioning declined once she was returned to her mother’s care. Brad’s mental health and social competence functioning declined at the time of his second foster care placement and improved during his placement at his third foster home.

Discussion

Implications for Social Work Practice

The misuse of methamphetamine by rural adults poses risks to their children. Social workers must confront a number of significant challenges as front-line workers in their efforts to
provide appropriate prevention and intervention services to children from methamphetamine-involved families. Ideally, we would identify at-risk families and children prior to their involvement with methamphetamine and concomitant hardship and trauma. Infants, toddlers and young children who cannot attend to their own basic needs, live in isolated rural areas, do not see medical professionals on a regular basis, and do not yet attend school are especially vulnerable if parents abuse methamphetamine. One preventive approach to intervention with infants and young children could be to target and then intervene with parents who are at-risk for methamphetamine abuse during pregnancy or delivery. Once vulnerable parents are identified, services may be initiated to reduce their risk of becoming involved with methamphetamine. Reaching out to rural families to refer at-risk adults and children may be another viable strategy, especially for mothers who do not seek medical care during pregnancy and delivery.

Unfortunately, methamphetamine misuse occurs across a wide demographic and unless rural parents have a history of substance misuse, identifying those at risk is difficult. In general, there are a number of risk factors for substance misuse including poverty, unmet mental health needs and a history of substance abuse problems. Identified factors related to methamphetamine misuse also include a history of childhood physical and sexual abuse, parental substance misuse, and interpersonal violence (Brecht et al., 2004): risks present for a wide variety of disorders. Clearly, more research is needed to identify risks specific to methamphetamine misuse.

Given the high level of trauma symptomology in children in foster care because of parent methamphetamine abuse, quality mental health interventions may be paramount. Rural communities have particular cultural strengths and vulnerabilities, and members have particular socialization beliefs and practices, that must be considered when developing and implementing mental health interventions for children. Furthermore, mental health intervention may need to
address not only parent methamphetamine abuse per se and associated traumas, but ongoing psychological distress. By the time children enter into mental health care, many will be living away from one or both parents. Family disruptions, especially if the child is placed in foster or other substitute care, often result in additional, ongoing and pressing psychological stress (Haight et al., 2006).

An initial goal of any intervention with children whose parents abuse methamphetamine is likely to be the creation of a safe, nurturing and stable home environment; and the fulfillment of unmet health and educational needs. Finding quality substitute care for children is critical during parents’ active drug use so that their basic physical needs for clothing, shelter, and safety are met. Children from methamphetamine-involved families have significant medical and dental needs due to neglect and exposure to toxins and these needs must be attended to for optimal intervention to support children’s psychological development. Indeed, more than one-third of the children found in homes during methamphetamine laboratory seizures tested positive for illicit drugs because of environmental exposure (Hohman et al., 2004).

If children have not attended school on a regular basis, and have lived with significant stress and chaos in the home, they may lag behind their peers in educational achievement. Staying and succeeding in school is viewed by knowledgeable professionals as a realistic gateway for children from methamphetamine-involved families to a better life (Haight et al., 2005). Children may benefit not only from encouragement to stay in school, but from thorough educational testing, tutoring, and ongoing monitoring.

It is also important to build interventions and preventative programs based upon the strengths and perspectives of children from methamphetamine-involved homes. Most of the children in this study described positive family-of-origin experiences and sources of social and
emotional support. Importantly, children most often discussed shared family hobbies and activities. All too often in the child welfare system, visitations among children and their families involve activities that are convenient to caseworkers, such as having meetings at child welfare offices or local restaurants. Children could benefit from having visits with their parents and families which focus on an individual family’s shared hobbies and activities.

Finally, foster parents need resources. In particular, quality services including mental health care need to be available for rural foster children whose parents abuse methamphetamine. Those services that are available are provided by counselors and do not address issues of trauma. No child in this study had been seen by a child psychiatrist and, indeed, there were no child psychiatrists in the immediate area.

Implications for Social Work Policy

Inadequate services to address urgent mental health and other needs can result, in the disruption of the foster care placement and further harm to vulnerable children. The most positive future for some children whose parents abuse methamphetamine would result if their parents recovered and assumed responsibility for their care. Some parents who abuse methamphetamine have parented adequately when not abusing substances (Haight et al., 2005; 2006). Methamphetamine misusers respond similarly to treatment as cocaine users (Lukas, 1996; Rawson et al., 2002). Social workers can advocate for adequate substance abuse intervention for individuals abusing methamphetamine, as well as resources to alleviate rural poverty, unmet mental health needs, and other general risk factors for substance abuse. Research indicates that individuals receiving high quality substance abuse treatment can and do recover from methamphetamine addiction (Rawson et al., 2002; Roll, Petry, Sitzer, Brecht, Peirce, McCann et al., 2006; Hser, Evans & Huang, 2005).
Federal and state timelines for social work practitioners to establish permanency plans for children whose parents are substance-involved in the child welfare system are challenging to meet. The CASA (1999) study revealed that few social work practitioners in the child welfare system in the United States appeared to be effectively meeting the old timeline of eighteen months and few expect to be able to do so in a shorter timeframe of twelve months (CASA, 1999). Substance-affected families benefit from policies which allow for flexibility to take into account individual variation in treatment outcomes. The National Center on Substance Abuse and Child Welfare (NCSACW) (2003) has also identified best practices envisioned by professionals. The goals for best practice begin with a clarification of the underlying values and principles of collaborative relationships. Professionals in alcohol and drug (AOD) treatment, child welfare services (CWS) and the dependency court systems view issues related to values and principles as (1) a value of family strengths and how family systems, gender, and culture are related to addiction and recovery as well as effects on the family, (2) the priority or political will to address the integration of services and, (3) the critical issue of differing timelines for child development and recovery.

Best practices envisioned by professionals also include the negotiation of roles across the three systems to identify responsibility for daily practices of client screening and assessment, joint decisions about permanency plans and risk assessments, collaborative efforts to engage and re-engage parents in treatment, collaborative development of after-care planning, joint monitoring of case plans and after-care, and joint efforts at assessing and providing referrals for children affected by substance abuse. Demonstration programs and policy development sensitive to issues surrounding substance affected families involved with child welfare are experiencing success and need to be expanded.
Several programs in the U.S. have begun to utilize many of these approaches in their delivery of services and to the coordination of systems of treatment and child welfare. The New Jersey Division of Youth and Family Services hired certified drug and alcohol counselors from local drug treatment programs to work with their caseworkers to assess risk and develop case plans. Further, paraprofessional home visitors were hired to monitor and provide support to parents in treatment. One report on this program indicates that parents have been drug free and sober for a minimum of 2 years (CASA, 1999).

In Maryland, Child Welfare Services and the Adult Addiction Services in Montgomery County have addressed organizational missions to include a shift towards collaboration in staff development and training, the development of practice standards for assessment and monitoring of progress, and the sharing of alcohol and drug specialists and child welfare specialists by co-locating them across agencies. The co-location of professionals has aided in consultation, evaluation and treatment of clients.

Family drugs courts have also been implemented in many states including Nevada, Florida, and New York. In Nevada, judges place treatment as a condition of retaining or regaining custody. Sanctions including short prison sentences are imposed for missed treatment appointments and failed drug tests. Participants in Parent Drug Court in Florida face similar sanctions and are required to participate in treatment, submit to random drug testing, and appear weekly at court hearings. Repeated failure and non-compliance can result in imprisonment. In New York, parents must acknowledge the need for treatment and consent to have their treatment records accessed. Services provided by the court include assessment and treatment as well as access to housing, transportation, and medical services.
As part of a Title IV-E Alcohol and Other Drug Abuse Waiver Demonstration Project, four states have received permission to bypass federal regulations for foster care financing to develop integrated service delivery programs including Illinois, Delaware, Maryland, and New Hampshire. Under federal law, states receive unlimited funding for foster care as long as they are able to match federal funds. One problem with this approach has been the potential to skew child welfare practice toward foster care and away from intact family services (CASA, 1999). These demonstration programs aim at developing and testing improved strategies.

Implications for Future Research

It is important to underscore the fact that cultural contexts both vary and evolve. The socio-cultural context of this research focuses on the rural Midwest from about 2004-2009. The extent to which these findings are transferable to other cultural contexts, for example, urban communities, is an open empirical question. The extent to which the findings are transferable to other historical contexts also is an open empirical question. Because this study was exploratory in nature, many variables were included and the results were primarily descriptive. Although the statistical interpretation of results was presented with appropriate adjustments for probability, differences among the sample should be explored in other samples across various contexts and points in time as the ecology of methamphetamine use varies.

This study is cross-sectional. More complex research models that take into account moderating effects and interactions among mental health, social competence, and social context variables is needed. This report has also focused on school-aged children. Younger children, however, may be at especially high risk due to their age and due to more extreme isolation from professionals (e.g., teachers) who may observe risks on a daily basis. Adolescents are also likely to have unique developmental needs and many may be at high risk for or already abusing
substances. To inform the development of effective and targeted services, much more research will be needed on the mental health, social competence and social context of children of methamphetamine-abusing parents, including the identification of needs of very young children and adolescents.

Current research reflects a dearth in understanding methamphetamine misuse from the perspectives of parents themselves. Moreover, the group experiencing the greatest increase in methamphetamine use is women of child-bearing age (Hohman et al., 2004). Since women who use drugs are more likely to be the primary caretaker of children (Klee, 2002), the implication is that increasing numbers of children are likely affected by the mother’s abuse of methamphetamine (Otero et al. 2006). Research regarding the developmental histories, parenting practices, and psychological well-being of parents who misuse methamphetamine is needed.

Clearly, there are no easy answers to the question of how to best support children in foster care because of parent methamphetamine abuse. The importance of clear communication with foster parents, sensitive child welfare and legal interventions, responding to individual variation, and access to quality mental health services are several strategies that emerge from considering the experiences and perspectives of children.
REFERENCES


Muskie School of Public Service. (June 2007). Research & Policy Brief- Substance abuse among rural youth: A little meth a lot of booze. Maine Rural Health Research Center, University of Southern Maine.


Young, N. (July 26, 2005). Testimony before the US House of Representatives Government Reform Sub-Committee on Criminal Justice, Drug Policy, and Human Resources.
### Appendix A: Trauma Symptom Checklist for Children

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Never</th>
<th>Sometimes</th>
<th>Lots of Times</th>
<th>Almost all of the Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Bad dreams or nightmares</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling afraid something bad might happen</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Scary ideas or pictures just pop into my head</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Pretending I am someone else</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Arguing too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling lonely</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Feeling sad or unhappy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Remembering things that happened that I didn’t like…</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Going away in my mind, trying not to think</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>10. Remembering scary things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>11. Wanting to yell and break things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>12. Crying</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>13. Getting scared all of a sudden and don’t know why…</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>14. Getting mad and can’t calm down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>15. Feeling dizzy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>16. Wanting to yell at people</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>17. Wanting to hurt myself</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>18. Wanting to hurt other people</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>19. Feeling sacred of men</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>20. Feeling scared of women</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>21. Washing myself because I feel dirty on the inside…</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>22. Feeling stupid or bad</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>23. Feeling like I did something wrong</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>24. Feeling like things aren’t real</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>25. Forgetting things, can’t remember things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>26. Feeling like I’m not in my body</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>27. Feeling nervous or jumpy inside</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>28. Feeling afraid</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>29. Can’t stop thinking about something bad that happened to me…</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>30. Getting into fights</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>31. Feeling mean</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>32. Pretending I’m somewhere else</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>33. Being afraid of the dark</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>34. Worrying about things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>35. Feeling like nobody likes me</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>36. Remembering things I don’t want to remember…</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>37. My mind going empty or blank</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>38. Feeling like I hate people</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>39. Trying not to have any feeling</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Statement</td>
<td>Score Codes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>-------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling mad</td>
<td>0 1 2 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling afraid somebody will kill me</td>
<td>0 1 2 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wishing bad things had never happened</td>
<td>0 1 2 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wanting to kill myself</td>
<td>0 1 2 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Daydreaming</td>
<td>0 1 2 3</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix B: Children’s Experience in Their Family-of-Origin Interview

1. Tell me about your family.
   (Probes:
   - Who lived in your home?
   - What were their relationships? What kinds of things did you do together? Who did you spend the most time with?
   - Who were you closest to? Tell me about your brothers and sisters. Who would you say you were closest to? Why?

2. Tell me about a time in your family that was happy.

3. Tell me about a time in your family that was sad or scary.
   (This section includes probes for beliefs about methamphetamine including:
   - What is meth (or crystal, ice or speed)?
   - Some adults use meth. How does that make them act?
   - How about your (mom/dad)?
   - Tell me about when they used meth. What did you do? How did you feel?
   - What advise can you give other kids whose parents use meth?

4. Sometimes children whose parents get involved with meth get really down—they might feel sad, angry or upset. Have you ever had these feelings? Tell me about that.
   - Sometimes it can be helpful to talk with an adult. Who would you talk with if you were feeling down?
     (Probes:
     - Someone at school? Grandparent or other relative? Church member? Caseworker? How could you approach that person?

5. Tell me about a time in your family that was fun.
Appendix C: Record Review Form

Date of Birth
Reason in Care
Date entered care
Date returned home (if applicable)
Number of placements
Type of placement (current) (kinship/traditional/intact/group home)
Length of time in care
Number of siblings
# Psychiatric Hospitalizations
Age of child when parent began using methamphetamine
Age of child when parent began using substance
Parent Substance Abuse treatment (Specify)

<table>
<thead>
<tr>
<th>Exposure to Meth</th>
<th>YES</th>
<th>NO</th>
<th>Don’t Know</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother Abused Meth</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Father Abused Meth</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent's romantic partner abused meth</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother Abused Meth</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exposure to Other Substances</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother Abused Alcohol</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Father Abused Alcohol</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent's romantic partner abused Alcohol</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother Abused other illegal substances (Specify)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Father Abused other illegal substances (Specify)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent's Partner Abused other illegal substances (Specify)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Intensity of Exposure</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent(s)/in jail/prison for meth related offense (Specify Mother, Father, Partner)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Duration of Parent Substance Abuse</strong></td>
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