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Trauma, attachment and parental self-efficacy in substance abusing fathers: An exploratory study and feasibility trial of a parenting program

Marianne Torres
University of Wollongong

Trauma, Attachment and Parental Self-efficacy in Substance Abusing Fathers: An Exploratory Study and Feasibility Trial of a Parenting Program.

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Thesis Certification

I, Marianne Torres, declare that this thesis, submitted in partial fulfilment of the requirements for the award of Doctor of Psychology, in the Department of Psychology, University of Wollongong, is wholly my own work unless otherwise referenced or acknowledged. The document has not been submitted for qualifications at any other academic institution.

(Signature)

Marianne Torres

Abstract

This dissertation presents three papers and is divided into five chapters. Chapter 1 provides a review of the literature linking complex posttraumatic stress, attachment and parental self-efficacy in the context of parental substance abuse. Parental drug use is associated with harmful effects on children. Substance abusing parents experience significant conflict between meeting the needs of their children and sustaining their addiction, compromising their ability to care for them and to serve as appropriate role models. These parents often have multiple, interrelated and complex problems. The Chapter provides a general introduction to the needs of fathers in residential alcohol and other drug treatment centres and describes the studies that form the major components of the thesis.

Chapter 2 presents the first empirical study that explores current trauma-related psychological symptoms, adult attachment anxiety and the relationship of these variables to parental self-efficacy, in 100 fathers with substance abuse problems. Fathers receiving residential treatment for substance abuse completed self-report measures of trauma symptoms, adult attachment and parental self-efficacy. The study tested whether attachment style mediated the relationship between trauma and parental self-efficacy. Avoidant and Disorganised attachment (the latter operationalised as Helplessness) mediated the association between trauma symptoms and parental self-efficacy. Results support theoretical accounts implicating attachment disruptions in the pathway from the experience of trauma to impaired parental self-efficacy.

Chapter 3 describes a systemic, trauma and attachment informed model for a parenting program for fathers, embedded in residential substance abuse treatment. This paper emphasises the complex nature of delivering parenting programs in such a treatment context and the importance of going beyond the simple linear principles of reward and punishment,

upon which many other parenting programs are predicated. Using the findings of the cross-sectional study described in Chapter 2, the paper also emphasises the importance of addressing issues of trauma and attachment disruption in any program aimed at this population.

Chapter 4 describes the feasibility of supplementing residential substance abuse treatment for fathers with a brief group parenting program called the *Black Box Parenting program*. This parenting program aims to improve parental self-efficacy, quality of father-child relationships and motivation to engage in parenting help. The program focuses on the particular issues of trauma and attachment disruption found to be inhibiting healthy parenting in these fathers (as described in Chapter 2). The *Black Box Parenting Program* was offered to eight programs with three agreeing to trial it. Ultimately, four groups were conducted involving 19 participants. Feasibility was assessed by describing demand, acceptability, implementation, integration within existing services and preliminary efficacy. Pre and post quantitative measures were taken as well as conducting qualitative interviews to understand the impact of the program on fathers' views of their parenting. Pre to post intervention assessments revealed significant increases in fathers' satisfaction in parenting. Fathers reported feeling motivated to attend further parenting groups. Satisfaction with treatment was related to changes in parenting self-efficacy and closeness with their child.

Chapter 5 of the dissertation provides concluding remarks and conceptual model to summarise the findings of the research.

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Style of Dissertation

This dissertation is comprised of three papers that have been submitted for publication in peer-reviewed journals in the area of family therapy and substance abuse. The second and fourth chapters of this dissertation presents two papers based on the collection, analysis and interpretation of data from two related but separate studies. The first study aimed to explore the relationship between post-traumatic symptoms, adult attachment and parental self-efficacy in a sample of fathers or male caregivers attending rehabilitation program for substance abuse problems. The objective of Study Two was to test the feasibility of The *Black Box Parenting Program*, a brief trauma and attachment informed group-parenting program developed for fathers in substance abuse treatment settings. The paper presented in Chapter 3 has been published (see Torres, Sng, & Deane, 2015). This paper links Study One and Two in that it presents a rationale for the components of the *Black Box Parenting Program* based on Study One findings and a synthesis of the literature on the interventions addressing parenting problems. It is conceptual in nature and describes the importance of recognizing and addressing the needs of fathers in residential substance abuse treatment settings.

List of Publications

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Principal Author

Name of Principal Author (Candidate)	Marianne Torres		
Contribution to the Paper	Review of the literature, development of argument, wrote manuscript		
Overall percentage (%)	85 %		
Signature		Date	13/10/2016

Co-Author Contributions

By signing the Statement of Authorship, each author certifies that:

i. the candidate's stated contribution to the publication is accurate (as detailed above);
ii. permission is granted for the candidate in include the publication in the thesis; and
iii. the sum of all co-author contributions is equal to 100% less the candidate's stated contribution.

Name of Co-Author	Dr. Rebecca Sng		
Contribution to the Paper	Supervised in development of argument, 'Black Box' parenting concept including diagram, editing and manuscript evaluation.		
Signature		Date	

Name of Co-Author	Professor Frank Deane		
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Co-Author Contributions

By signing the Statement of Authorship, each author certifies that:

i. the candidate's stated contribution to the publication is accurate (as detailed above);
ii. permission is granted for the candidate in include the publication in the thesis; and
iii. the sum of all co-author contributions is equal to 100% less the candidate's stated contribution.

Name of Co-Author	Professor Frank Deane		
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Signature		Date	

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By signing the Statement of Authorship, each author certifies that:

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Name of Co-Author	Dr. Rebecca Sng		
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1 General Introduction

1.1 Prevalence of Parental Substance Abuse

Parental substance abuse is an under-reported problem in Australia but it has been recognised as one of the most serious issues facing children and families (Dawe, Atkinson, Frye, Evans, Best, Lynch, Moss & Harnett, 2007). Data from the largest Australian study on parental substance abuse conducted by Australian National Council on Drugs, estimates that more than 230,000 children in Australia are raised by adults who misuse substances (Dawe et al., 2007). This is equivalent to around 13% of Australian children living in a household with at least one parent who consumes substances at a problematic level. According to Odyssey Institute of Studies (2004) an estimate of around 1.5% of Australian children (60,0000) have parents seeking treatment for substance abuse through treatment programs and this is without accounting for those seeking treatment through primary health providers. Children are impacted by parental substance abuse at various stages of their development.

In a substantial proportion of Australian families where there are child protection concerns, drug and alcohol problems present as a predominant feature. Child protection agencies report alcohol abuse as one of the top contributors in child protection cases (Leek, Seneque, & Ward, 2009; NSW Department of Community Services, 2013; De Bortoli, Coles & Dolan, 2013). In NSW, up to 17,602 risk of harm reports were made between 2012 and 2013 where the primary issue was drug and or alcohol abuse by parents (New South Wales Department of Community Services, 2013). Similar concerns are reported across Australia. A cohort of 273 child protection cases from the Victorian Children's Court was reviewed and revealed parental substance misuse was present in 51% of child protection cases (De Bortoli, Coles, & Dolan, 2013). In Western Australian Child protection systems, 57% of children were living with substance abusing parents (Leek, Seneque, et al., 2004). International studies are consistent with Australian data citing parental substance abuse as a factor in 33% to 50%

of child protection cases (Forrester & Harwin, 2006; McAlpine, Courts, Harper, & Doran, 2001).

1.2 Impact of Parental Substance Abuse on Children

Children of substance-abusing parents are considered at high risk for a multitude of biological, developmental and behavioural problems (Barnard & McKeganey, 2004; Dawe et al., 2007, Landare, Howsare, & Byrne, 2013; Neger & Prinz, 2015; Solis, Shadur, Burns, & Hussong, 2012; Stith, Liu et al., 2009; Williams, Tonmyr, Jack, Fallon, & MacMillan, 2011, Wells, 2009). Poor outcomes for children of substance abusing parents have been observed across their development. The negative consequences can contribute to problems in adulthood, since children are at significantly higher risk for developing substance use disorders themselves due to genetic and environmental factors (Zimic & Jakic, 2012). For example, in a large longitudinal study of males with and without ADHD exposed to parental substance abuse, parental substance abuse predicted substance abuse disorder in the offspring after controlling for ADHD and family history (Biederman et al., 2000).

The addictive nature of substances combined with the stressors associated with the demands of parenting children contributes to an environment where children are vulnerable to neglect or abuse. Pre-occupation with drug use and drug seeking can compete for parents' attention leading to poor supervision of children and potential victimization by someone outside the family (Kroll & Taylor, 2003; Widom & Hiller-Sturmhofel, 2001). For example children of alcoholic mothers are at increased risk for sexual abuse by someone outside the family (Fleming et al., 1997). Substance abuse also impedes a parent's ability to be nurturing, consistent and emotionally responsive (Schuler et al., 2002). Parental substance abuse is associated with coercive, demanding and punitive parenting practices (Hien & Honeyman,

2000; Kandel, 1990; Miller, Smyth, & Mudar, 1999) that can elevate the risk of child abuse and neglect (Ammerman et al., 1999; Dube et al., 2001). Cumulative stressors can create greater marital discord and conflict increasing the likelihood of children being exposed to violence within the home (Dong, 2004; Hartley, 2002). Studies have reported that adults with substance abuse problems are more than twice as likely as their counterparts to abuse or neglect their children (Chaffin, Kelleher, Hooengerg, & Fischer, 1996). A Canadian study, consisting of 8,472 respondents to a mental health survey, reported that parental substance abuse was associated with more than twofold increase in the risk of exposure to both childhood physical and sexual abuse (Walsh, McMillan, & Jamieson, 2003). Kelley (1992) investigated the relationship between parental substance abuse and child maltreatment in a longitudinal study of substance abusing mothers of infants. About 60% of the infants born with positive toxic screens for maternal cocaine use were the subject of subsequent substantiated reports of child abuse or neglect compared with just 8% of children in the control condition. All children in the control condition remained with their parents compared with 42% of drug-exposed children who were placed in foster care by child protection services. The intergenerational transmission of substance abuse (Biederman et al., 2000; Ritter et al., 2002;) and child maltreatment (Ertem, Leventhal, & Dobbs, 2000; Nurco, 1999) also increases the potential for violent behaviour and criminal activity to be repeated across the generations (Kolar et al., 1994; Widom & Hiller-Sturmhofel, 2001).

Under these conditions of unpredictability, hostility and violence, unavailability and loss, the child's ability to attach and regulate their affect will be affected. In a child's first three years of life, attachment problems particularly the insecure and disorganized attachments are associated with parental substance abuse (Barnard & McKeganey, 2004; Beeghly, Frank, Rose-Jacobs, Cabral, & Tronick, 2003; Pajulo, Suchman, Kalland, & Mayes, 2006). Severe and ongoing parental substance abuse, can lead to disruptions to living

arrangements, children being separated from their parents and receiving inconsistent care (Kolar et al., 1994; Tyler et al., 1997). This separation could be because parents are engaged in long-term treatment, parental incarceration or due to intervention from Child Protection services placing children in foster care when the family environment has become unsafe or high-risk. Negative consequences of long-term separation, child abuse and neglect further impair attachment and can lead to the trauma responses commonly observed in children in foster care such as hypervigilance, dissociation and numbing (Tarren-Sweeney, 2008).

1.3 Parenting Concerns of Substance Abusing Fathers

Compared with the research on substance abusing mothers, there has been relatively limited research on the parenting responses of substance abusing fathers (Fals-Stewart, Fincham, & Kelley, 2004; Twomey, 2007). Fathers who abuse substances impact on the psychosocial development and well-being of their children, in their daily presence and also in their absence (Clark et al., 1997; Hill et al., 1999; Kelley & Fals-Stewart, 2004). In the study of Kelley and Fals-Stewart (2004), children in drug abusing homes compared to children in the other groups were more than twice as likely to exhibit clinical levels of behavioural symptoms and had greater risk of lifetime psychiatric diagnosis (i.e., 53% versus 25% in alcohol abusing homes and 10% in non-substance-abusing homes). Substance abusing fathers who are absent in the lives of their children may have an indirect role in contributing to diminished parenting capacity of the mother through mechanisms such as loss of income and lack of partner social support (Berridge, 2002; Mcmahon et al., 2007). When the father is absent, there may be fewer financial, child caring and emotionally supportive resources available and this may strain the mother's capacity to attend to the needs of the child (Gelles, 1989; Seagull, 1987). Multiple indirect pathways that may elevate the risk of child

maltreatment include parental dyad functioning and partner violence (Guterman & Lee, 2005). Studies report greater prevalence and frequency of intimate partner violence within the co-parenting relationships of substance abusing men. In a study of 252 mothers, 22% reported the father had a history of drug or alcohol problems. A significant relationship was found between father's history of drug and alcohol problem and mother's report of mental and emotional abuse, verbal threats and physical abuse during pregnancy (Frank, Brown, Johnson, & Cabral, 2002). Compromised family functioning has also been associated with paternal drug abuse. In the co-parenting relationships of 106 fathers enrolled in methadone maintenance treatment, compared with 118 community controls, the opioid-dependent fathers reported greater prevalence of intimate partner violence including physical, sexual, and psychological aggression directed at the mother of their youngest biological child (Moore, Easton & Mcmahon, 2008). In a study of family functioning, families with paternal substance dependence functioned worse than normal comparison families in establishing family norms and rules. They also had poorer communication, were less organized in day-to-day family life and had poorer responses to emotional demands on the family (Moss et al., 2002).

Drug abuse compromises responsible fathering as reflected in parenting behaviour, interactions with children and children's behaviours (Mcmahon et al., 2008). When compared with fathers who reported no history of substance abuse, paternal drug abuse has been associated with poorer father-child communication, poorer parent-child relationships and increased parenting stress (Blackson et al., 1999). Fathers' problem drinking has been associated with child internalizing and externalizing problems (El-Sheikh, & Flanagan, 2001). In a study, comparing 106 opioid-dependent fathers receiving treatment to 118 other fathers with no history of drug and alcohol abuse, significant differences were reported in dimensions that included less involvement in positive parenting, poorer appraisal of self and less satisfaction as a father (Mcmahon et al., 2008). In a number of studies by Eiden and

colleagues the relationship between fathers' alcoholism and the quality of parent–infant interactions has been examined (Eiden, Chavez, & Leonard, 1999; Edwards, Eiden, & Leonard, 2004; Eiden, Edwards, & Leonard, 2002; Eiden & Leonard, 2000). A combination of risk factors including parental depression, antisocial behaviour and family conflict have been associated with father's alcoholism and significantly related with parent-infant attachment security (Eiden et al., 2002). Utilising observational methods of parent-child interactions of parents with alcohol problems 223 families with 12-month-old infants were observed in a free play interaction followed by structured play. It was found that fathers with higher alcohol problems were less sensitive during interactions with their infants and this lower sensitivity was indirectly associated with a greater risk for attachment insecurity (Eiden et al., 2002). Fathers' alcoholism has been associated with higher paternal aggravation and decreased sensitivity in interactions with their 12-month-old infant, an effect mediated by fathers' depression (Eiden et al., 1999; Eiden & Leonard, 2000). A recent study reported that fathers' substance abuse severity was a significant predictor for child avoidant behaviour and dyadic tension (Stover & Coates, 2016). Other studies have also examined perceived child–parent attachments or family functioning variables such as cohesion and adaptability as mediators and moderators of risk associated with parental problem drinking. In families with 6- to 12-year old children, father's reports of problem drinking were associated with less family cohesion and less adaptability. Attachments to fathers moderated the associations between problem drinking and children's social and cognitive problems (El-Sheikh & Buckhalt, 2003).

Fathers entering treatment for substance abuse have expressed concerns about their parenting (McMahon, Winkel, Suchman, & Rounsaville, 2007; Smith Stover, McMahon, & Easton, 2011; Stover, Hall, McMahon, & Easton, 2012). These fathers report high levels of parenting stress compared with non-substance abusing fathers and would be interested in

counselling to help them be more effective fathers if offered (McMahon et al., 2007). Since research has identified fathers as playing a significant role in child maltreatment, developing strategies in response to the needs motivations, and help seeking behaviours of fathers is imperative (Guterman & Lee, 2005). The studies by Eiden and colleagues (Edwards et al., 2004; Eiden et al., 2002) also highlight the importance of targeting interventions at improving father and child interactions with substance abusing parents that may serve to decrease risks to these children.

There seems to be substantial evidence that substance abuse in fathers contributes to a wide range of negative outcomes for children and parenting. However, much less is known about the barriers substance-dependent fathers face, which may contribute to difficulties in engaging fathers in parenting and prevention efforts (Lee, Bellarmy & Guterman, 2009). Qualitative research of substance dependent fathers indicate they feel uncertain in their role as fathers and they partially attribute this to their own experiences of being parented (Peled, Gavriel-Fried & Katz, 2012; Soderstrom & Skarderud, 2013). Through their interviews with substance-dependent fathers, Peled et al. (2012) found that fathers went through a process of parental identity formation. In the first stage they experienced a period where they were "missing in action" (p. 898) marked by feeling like a stranger, alienation, hostility, and fatigue. Fathers reflected on their own experiences with an absent father, which they were imitating. In the final stage there is awareness of their absence and failure as fathers, which leads them to accept responsibility and resolve to make change.

Other qualitative studies have highlighted the role that childhood experiences play in parenting difficulties of fathers. A study of 40 substance dependent fathers with co-occurring intimate partner violence reported that most fathers wanted to be more present, available and warm with their children. A large percentage experienced histories of abusive/harsh parenting by both parents and described their fathers as being absent from their lives (Stover & Kahn,

2013). Rubenstein and Stover (2016) found that exposure to parental violence in their own childhood was a common experience for fathers in residential treatment for substance misuse. High exposure to parental violence amongst fathers with drug and alcohol abuse raises concerns about the potential for PTSD in these samples. In a study of 126 substance abusing men seeking treatment, fathers who had higher levels of PTSD symptomology reported greater severity of alcohol and drug abuse when compared with men who were not fathers. In this sample, 54% of men endorsed a history of traumatic life event and PTSD symptoms were significantly associated with hostile-aggressive parenting behaviours. Fathers who reported a higher level of PTSD symptoms were more likely to indicate they wanted help with their parenting. (Stover et al., 2012).

1.4 The link between Trauma, Parental Substance Abuse and Child Maltreatment

When substance abuse is combined with other parental risk factors, the chance of adverse outcomes for children is greatly increased (Conners, Bradley, Whiteside et al., 2004). Substance abusing parents often present with multiple, interrelated and complex vulnerabilities. These other parental risk factors include physical and mental health problems, familial history of abuse (Conners et al., 2004); socio-economic deprivation and unemployment (Velleman & Templeton, 2007), relationship stress, domestic violence and parental involvement with the criminal justice system (Forrester & Harwin, 2006; Jones 2004). In a study of over 2,000 mothers seeking substance abuse treatment, 88% were unemployed; one third had experienced homelessness and 70.6% were receiving public assistance (Conners et al., 2004). Only 4% of the 4,084 children were exposed to fewer than four risk factors, the mean number experienced by children was 6.5. This study speaks to the complexity of problems in most families with parental substance abuse and highlights that simplistic interventions are unlikely to be sufficient to address these problems.

Due to these high rates of co-morbidity, the effects of substance abuse are difficult to separate from compounding psychological problems afflicting substance-abusing parents. Psychological problems in substance abusing parents such as comorbid mental illness have been found to mediate some of the relationship between substance abuse and child maltreatment (Kelleher, Chaffin, Hollenberg, & Fischer, 1994). Risk of adverse outcomes on children is highly variable but reliably higher for parents with another psychiatric disorder such as depression and antisocial personality disorder (Hussong, Flora, Curran, Chassin, & Zucker, 2008; Hussong et al., 2007).

A number of studies have emphasized the high co-occurrence of Post Traumatic Stress Disorder (PTSD) and substance abuse disorders in substance abusing parents (Appleyard, Berlin, Rosanbalm, & Dodge, 2011; Marcenko et al., 2000; Locke & Newcombe, 2004; Peirce et al., 2008; Stover, Hall, et al., 2012). Compared with those with either early trauma or substance dependence alone, adults with a history of both early childhood trauma and co-occurring substance dependence have more severe mental health problems and worse treatment outcomes (Brady & Back, 2012). Studies have shown an association between childhood history of trauma through abuse and risk of becoming abusive as an adult (Appleyard et al., 2011; Banyard, Williams & Siegel, 2003). Psychological trauma symptoms have been found to mediate this association.

In a community-based study of 499 mothers' and their infants, mother’s childhood history of child maltreatment significantly predicted maternal substance use problems, which in turn predicted offspring victimization (Appleyard et al., 2011). The mediated pathway from maternal history of physical abuse to substance use problems to child victimization was significant (standardized mediated path [ab] = .05, 95% CI [.01, .11]; effect size = .19) as was the mediated pathway from maternal history of sexual abuse to substance use problems to

child victimization (standardized mediated path [ab] = .07, 95% CI [.02, .14]; effect size = .26).

A problem associated with the categorical diagnosis of PTSD is its limitation in capturing the posttraumatic sequelae that falls short of a formal diagnosis of PTSD. The term 'Complex PTSD' has been used to describe repetitive, cumulative interpersonal traumas occurring at developmentally vulnerable times in a victim's life (Cortouis, 2004; 2008). Many of the major characteristics of complex trauma resemble the symptom presentation of Borderline Personality Disorder (BPD) such as emotional lability, relational instability, unstable sense of self and tendencies to self-harm. In addition to the post traumatic symptoms (e.g intrusive recollections and re-experiencing of the traumatic event, avoidance and numbing symptoms, and increased hypersensitivity and arousal), several different problem areas have been identified to describe the complexity of symptoms associated with interpersonal traumas (Luxenberg, Spinazzola & van der Kolk, 2001). These problem areas are: 1) alterations in the regulation of affective impulses; 2) alterations in attention and consciousness; 3) alterations in self perception; 4) alterations in relationship to others; 5) somatization and or medical problems; 6) alterations in systems of meaning (Herman, 1992). These problem constellations have been labelled as Disorders of Extreme Stress (DESNOS) or Complex Trauma since such stressors driving these experiences are often extreme due to their nature and timing (Luxenberg, Spinazolla & van der Kolk, 2001). It is important to understand that a child who is very young when the trauma takes place, may have trouble recalling the traumatic event in terms of specific images or narratives compared to the *flashbacks* and literal nightmares required for a diagnosis of PTSD (D'Andrea, Ford, Stolbach, Spinazzola, van der Kolk, 2012). Thus, parents may have experienced several unresolved traumatic experiences starting from a history of childhood maltreatment and yet not meet all the criteria for a PTSD diagnosis. Adults presenting with symptoms of trauma

can be misdiagnosed with a variety of other psychological disorders such as Depression, Generalized Anxiety or Borderline Personality Disorder that may be erroneously conceptualised as co-morbid difficulties rather than recognising them as an important constituent of complex posttraumatic adaptations (Cortouis, 2004). These symptoms of Complex PTSD are discussed below, in order to clarify the link between parent's experience of childhood trauma, parental substance abuse and child maltreatment.

1.4.1 Alterations in the Regulation of Affective Impulses

Parents with severe child maltreatment histories may have impaired affect regulation since this capacity is thought to develop in the early years of life through the experience of a secure attachment relationship (Bowlby, 1989). Under distress, the traumatized parent may continue to use primitive regulatory strategies such as dissociation, distraction or avoidance as a mechanism for coping with or reducing painful internal states (Briere, 2002). One such avoidance strategy might be the use of substances. Research has consistently found positive associations between exposure to trauma and substance problems later in life, with the onset of trauma preceding the onset of substance dependence (Brady & Back, 2012; Meaney, Brake & Gratton, 2002; Sartor et al., 2010). Neurobiological studies have also shown that early stressful life experiences can lead to vulnerability to addiction in later life through the damaging effects on neurotransmitter systems involved in affect regulation. Meaney et al. (2002) demonstrated that repeated periods of maternal separation in the early life of rats affected the development of the mesocorticolimbic dopamine system, decreasing dopamine transporter expression, increasing dopamine responses to stress and maladaptive behavioural responses to stress, cocaine, and amphetamine.

Parents who have insufficiently developed affect regulation will also have difficulty being attuned to their children's emotional states and assisting them in managing uncertainty, stress and modulating their behaviour. These deficits in emotional attunement include poor

mentalization - the ability to imagine the child's internal experience and children's expression of affect (Allen, 2013). Parents' own history of cumulative trauma has been found to be a predictor of punitive parenting, aggression, and physical discipline (Cohen, Hien, & Batchelder; Banyard, Williams, & Siegel, 2003). Parenting practices that involve over reactivity (i.e., harsh, coercive discipline) and laxness (permissive or inconsistent parenting) can lead to an increased risk of children developing internalizing problems such as depression, anxiety or externalizing problems such as oppositional or conduct problems, anger outbursts and impulsivity (Del Vecchio & O'Leary, 2006; Miller-Lewis, Baghurst, et al., 2006; Snyder, Cramer, Frank, & Patterson, 2005). Thus, a parent experiencing emotional dysregulation as a result of their own trauma, can parent in ways that put their children at risk.

1.4.2 Disturbances in Attention or Consciousness

Traumatized individuals experience cognitive and dissociative problems such as alterations in states of consciousness, amnesia, depersonalization and de-realization, impaired memory, difficulties in attention regulation and executive functioning, problems focusing on and completing tasks, learning difficulties, difficulty planning and anticipating, and problems with processing novel information (Braun, 1988; van der Kolk, van der Hart, Marmar, 1996; Ross, 1991). Parents who have been chronically traumatized may be perceived as inattentive, forgetful or appear to *space out* when these behaviours actually represent strategies (adaptive or maladaptive) for coping with painful emotions or reminders of traumatic experiences. As well as interfering with every day parenting competence, cognitive impairments and compromised attention can critically impact on treatment. For example, parents may experience significant difficulties acquiring and learning information about child development and practices.

1.4.3 Somatization

Somatization refers to physical complaints in the absence of organic findings (APA, 2013). Many chronically traumatized individuals experience multiple difficulties in bodily functions such as sleeping, eating and digestion (Berkowitz, 1998; Saxe, Chinman, Berkowitz et al., 1994). These somatic conditions, pain syndromes, medical illnesses may be directly related to the abuse and physical damage caused. These physical problems can compete for parent's attention resulting in compromised care of the child.

1.4.4 Alterations in Self-perception

Altered self-perception describes a negative internal working model of self, encompassing intense feelings of shame and perceived loss of moral goodness, low self-esteem, chronic sense of guilt and responsibility and lack of a continuous and predictable sense of self (Pelcovitz et al., 1997). Shame and guilt occurs when one violates self-imposed moral standards. However, unlike guilt, shame involves a feeling of being exposed and evaluated by others in a disapproving, scrutinising manner and the perceptions of one self as flawed or damaged. (Tangney & Dearing, 2002; Smith, Webster, & Parrot, 2002). Of the symptoms in this cluster, shame is particularly salient since it has been identified as a risk factor for self-destructiveness and aggression towards other (Budden, 2009). Studies have consistently shown a direct relationship between shame-proneness and anger, hostility and propensity to blame others (Bear, Uribe-Zarain, Manning, & Shiomi, 2009; Harper & Arias, 2004; Tangney & Dearing, 2002). Propensity to experience shame has been consistently linked to substance dependence, PTSD, anxiety, depression, low self-esteem and family violence (Ashby et al. 2006; Brewin et al. 2000; Dearing, Stuewig, & Tangney, 2005; Harper & Arias 2004; Leskela et al. 2002; Stuewig & McCloskey 2005). Compared to individuals in community samples without a history of addiction, adults in residential treatment programs

scored significantly higher on the subscale *proneness to shame* (Meehan et al., 1996; O'Connor, Berry, Inaba, Weiss, & Morrison, 1994).

Children's everyday emotional demands can trigger parents' experience of the past along with the affective experiences of shame and guilt associated with past traumas. For example, a parent may experience shame when a child misbehaves since the misdeed can be perceived as a threat to the parents' sense of self and identity (Aron, Aron, Tudor, & Nelson, 1991). Parental shame was found to be a predictor of harsh discipline strategies (slapping, hitting, spanking, yelling, and swearing at a child) almost 123 mothers. Mothers in the study were given a vignette to read, involving their child acting aggressively toward another child. They were then asked to rate their emotional, cognitive, and behavioural reactions to the hypothetical scenario. Maladaptive disciplinary strategies such as removal of warmth ($\beta = .34$, $p < .001$) and the tendency to overreact ($\beta = .22$, $p = .01$) was positively related to parental shame (Scarnier, Schmader & Lickel, 2009).

1.4.5 Alterations in Relationships to Others

Chronic neglectful or abusive behaviour by significant others leads to a distrust and suspiciousness such as uncertainty about the reliability and predictability of others and not being able to trust their motives (Courtois, 2004). According to attachment theory, the quality of early experiences with caregivers influences beliefs about the self and others, which provides an internal working model that guides behaviour (Carlson, Sroufe & Egeland, 2004). The child carries into subsequent relationships in adolescence and adulthood this model of expectations, reflective of their early experiences. Individuals tend to maintain the same attachment style over time in any given relationship including transmitting strategies of attachment from parents to children (Van IJzendoorn, 1995; Van IJzendoorn & Bakermans-Kranenburg, 1997). When caregivers are inconsistent, rejecting or excessively demanding, children develop models of themselves as unlovable and incompetent and, appraise others as

uncaring and untrustworthy (Purnell, 2010). Attachment problems that develop in response to these maladaptive internal models have been linked to other psychological problems such as mood disturbance and personality disorders (Muller, Lemieux, & Sicoli, 2001; Sroufe, Carlson, Levy, & Egeland 1999). In a study of adults, those classified as dismissing or preoccupied in their attachment style were reported to have the highest rates of substance abuse/dependence Caspers, Yucuis, Troutman, & Spinks (2006).

Parents who experience complex trauma and substance abuse are more likely to have a low sense of parental self-efficacy when they have a view of themselves as being helpless, ineffectual and damaged. In a community sample of 76 at risk mothers, a history of childhood maltreatment indirectly predicted lower self-efficacy through the mediating effects of adult attachment anxiety and maternal depression. These findings suggest that mothers who had a history of childhood maltreatment, felt less secure in their relationships and were more depressed were more likely to lack confidence in their abilities to parent (Caldwell, Shaver, & Minzenberg, 2011). A history of parental emotional rejection, lack of nurturance and adult attachment anxiety and avoidance impacts on the capacity of parents to be attuned and sensitive to the child's emotional needs (Leerkes & Siepak, 2006). For example, adults who experienced harsh parenting as a child (controlling and punitive), reported more hostility and negative attitudes/attributions toward their children (Daggett et al., 2000). Parents with a history of emotional rejection have been found to more likely to make negative/internal attributions and feel amused in response to infant fear (Leerkes & Siepak, 2006). Observations of parent-child interactions involving parents with histories of abuse and or substance abuse problems have reported a tendency towards unresponsiveness to children's emotional cues, intrusiveness and poor sensitivity, rigidity and over control in their parenting, limited emotional involvement and less responsivity in their interaction (Burns, Chethik, & Williams, 1991; Burns, Chethik, Burns & Clark, 1997). A child's basic sense of safety

within relationships is compromised when the caregiving relationship is characterised by uncertainty, unpredictability or fear (Hesse & Main, 2006). According to Main and Hesse (1990), disorganization of infant attachment strategies is correlated with parental unresolved trauma. Fear is transmitted to the infant through parental behaviour that appears frightened or that is frightening to the infant. Since children rely on their attachment figures to protect them from harm, fears stemming from their own caregivers places children in an unresolvable paradox (Hesse & Main, 2000b). These attachment figures are at the same time the source of and the solution for the child's fears.

1.4.6 Alterations in Systems of Meaning

Many chronically traumatized individuals adopt a sense of learned helplessness, they despair from being able to recover from their traumas and feel hopeless about finding anyone to understand them or their suffering (Luxenberg, Spinazzola, & van der Kolk, 2001). Engaging in treatment can be extremely challenging for chronically traumatized parents who experience difficulty trusting others, are lacking in healthy templates of interpersonal interactions, and have a fatalistic approach to life. Caspers et al. (2006) examined the associations between attachment representations and treatment participation in individuals with substance abuse problems. Despite high rates of substance abuse/dependence, individuals classified as dismissing in their attachment style reported significantly lower rates of treatment participation. Consistent with theories of attachment, experiences of unsupportive caregiving (i.e. rejection or neglect) typically associated with dismissing attachment can reinforce feelings of self-reliance and a view that others' are unavailable when distressed. Consequently, individuals classified as dismissing in their attachment style may be less likely to turn to others for help. Parents with substance abuse problems avoid seeking treatment early for fear that their children will be removed from them or they will be criminally prosecuted (Niccols & Sword, 2009). Those parents who do attend substance

abuse treatment have poor treatment retention rates. A report estimated that of parents required to receive substance abuse treatment in the child welfare system, 64% complete an intake for services, 50% attend some treatment, and only 13% complete treatment (U.S. General Accounting Office [GAO], 1998).

1.5 Adult Attachment and Stability

Attachment theory (Bowlby, 1969/1982; 1978; 1980) has become a useful framework for understanding the inherent and necessary biological need for children to display survival behaviours that increase the likelihood of a caregiver attending to their needs. Bowlby's (1969) ideas focused on a mother's response to her infant's behaviours (e.g. cues such as the baby crying) designed to keep the child in close proximity to the caregiver (attachment figure). Bowlby proposed this attachment motivational and behavioural system as necessary in increasing the infant's chances of healthy development and that without these bonds, children would likely become maladjusted and may possibly not thrive in adulthood. His work based on evolutionary psychology brought attention to the necessity of stable parental behaviour, importance of sensitive caregivers and mutually responsive interaction between parent and child (Bretherton & Munholland, 2008).

To operationalize Bowlby's theories of attachment, Mary Ainsworth's research developed the *Strange Situation* assessment procedure, a standardized means of measuring and classifying mother-infant attachment (Ainsworth, Blehar, Waters, & Wall, 1978). Ainsworth was able to demonstrate three types of attachment styles a) secure, b) anxious-ambivalent, and c) anxious-avoidant. Secure infants are hypothesised to view themselves as valued and competent and others as emotionally available and supportive (Bretherton & Munholland, 2008). Avoidant infants experience their parents as rejecting and emotionally

unavailable, and thereby hypothesised to be anxious about their attachment figures (Ainsworth et al., 1978). Ambivalent infants display mixed emotions stemming from inconsistent availability of their caregivers (Weinfeld et al., 1999). Main and Solomon (1990) identified a fourth attachment category utilizing the Strange Situation procedure, *Disorganized attachment*. These infants have been observed to appear conflicted or disoriented in their behaviours, experiencing their parents as frightening in their caregiver style (Main & Solomon, 1990). Underlying processes of disorganized attachment are quite different to the ambivalent and avoidant types. It involves the complex interaction between the parent's current experiences with past attachment traumas which contributes to underlying fear, generated by feelings of helplessness and isolation in the caregiving relationship (Solomon & George, 2011).

Bowlby's theories encompassed *the internal working model* of current attachment theory. The internal working model is the internal representation of an attachment relationship made up of beliefs, feelings and expectations of self and others (Bowlby, 1988; Fonagy et al., 2002). Early attachments influence the internal working model, forming the basis for the child's interpretation of later relationships including peer, romantic and parent and child (Padykula & Conklin, 2010; Thompson 2008). During early childhood (infancy through aged 5), attachment patterns become increasingly stable and resistant to change as relationships become internalised. Based on a meta-analysis of longitudinal studies examining attachment stability, the internal working model has been observed to be predominantly stable and resistant to change across the first 19 years of life (Fraley, 2002). However, attachment styles may be amenable to change in response to stressful life experiences, such as the development of a new relationship and loss of an attachment object in childhood that threatens attachment security (Davila, Burge & Hammen, 1997; Waters, Merrick, Treboux, Crowell & Albersheim, 2000). In a longitudinal study of infants observed

twenty years later, 44 percent (8 of 18) of the infants whose mothers reported negative life events changed attachment classifications (moving from secure to insecure or vice versa) from infancy to early adulthood (Waters et al., 2000). Important factors associated with change were negative life events involving significant caregivers such as loss of a parent, parental divorce, life-threatening illness of parent or child, parental psychiatric disorder, and physical or sexual abuse by a family member. A more recent review of longitudinal studies, looking at high-risk samples, concludes that attachment changes as a function of disruptive life events. That is, greater instability and change to insecurity or disorganization (McConnell & Moss, 2011). The researchers reported that the most stable classification was disorganized type observed in children in maltreating families, suggesting that children who experienced abuse retained patterns of disorganization by possibly frightening the child and leaving them unprotected (McConnell & Moss, 2011).

Operating on the theory that internal working models of attachment are generated from early experiences with caregivers and generalize to other relationships to adulthood, self-report measures have been developed to assess attachment style in close relationships (including romantic partners) during adulthood (Bartholomew & Shaver, 1998; Feeney & Noller, 1996; Shaver & Hazaan, 1994). Securely attached adults' are those characterised by positive views of themselves, their partners and their relationships. Anxious and avoidant (fearful and dismissing) attachment styles are considered as insecure attachment styles. Adults with insecure attachment are characterised as having a negative self-model, often appearing to avoid attachment altogether or have mixed feelings about close relationships, both desiring and feeling uncomfortable with emotional closeness (Bartholomew & Horowitz, 1991). During the adulthood developmental period, the few studies examining continuity and discontinuity of attachment in close relationships during this developmental period suggests a great deal of stability. Internal and external factors such as environmental

stress, depression and coping affected the stability of attachment style (McConell & Moss, 2011). For example, in a study of a high- risk sample of 415 older adults (72-78 years), 81.4% of the sample remained stable in their attachment style, while 18.6% changed classification over the six-year period. Increases in fearful avoidance were predicted by increases in both depressed and hostile affect and by increased environmental stress. (Consedine & Magai, 2006). Another study of 370 individuals (15 to 87 years), found an increase in both secure attachment styles predicted by integrative coping (characterized by flexible and reality-oriented ways of interacting with the world) and a better state of well being (Zhang & Labouvie-Vief, 2004). These studies reinforce the importance of coping and well being mechanisms, which are factors that influence stability and change in attachment in adulthood.

Attachment theory recognises the importance of relationships, particularly those formed early in a child's life. When relationship experiences are impaired by maltreatment, it is not surprising that some seek emotional support and regulation through substance abuse. The research literature presents strong evidence of the relationship between adverse childhood (i.e. early attachment) experiences and substance abuse (e.g., Anda et al., 2002; Dube et al., 2003). Furthermore, experiencing a negative life event has an effect on the quality of the parent-child relationship (Weinfeld, Sroufe & Egeland, 2000). These findings highlight the appropriateness of applying attachment theory to interventions supporting substance-abusing parents.

1.6 Attachment Interventions to Address Parenting and Parental Substance Abuse

Given the pervasiveness of parental substance abuse and serious consequences on children, parenting programs have been integrated into substance abuse treatment programs

but these are mainly focused on mothers (Niccols et al., 2012). Since successful substance abuse treatment requires a considerable amount of time, addressing both substance abuse and parenting difficulties enables parents to attend to both needs rather than prioritising one over the other (Neger & Prinz, 2015). A systematic review of 31 studies with parenting data published from 1990 to 2011 was conducted that involved mothers in integrated programs of substance abuse and parenting (Niccols et al., 2012). In the three randomized controlled trials comparing integrated treatment with addiction treatment as usual (N=419), most improvements in parenting skills were observed in integrated programs. However, in effect sizes, the advantage towards integrated programs was small (ds = -0.02 to 0.94). For example in the study comparing standard methadone treatment plus maternal psychotherapy with standard methadone treatment, the effect size of 0.54 was reported following discharge. When examining factors associated with more positive treatment effects, parenting improvements were associated with attachment-based interventions, children residing in the treatment facility, and improvements in maternal mental health. In a systematic review of 38 studies with substance abusing women, enhancing substance abuse treatment programs with prenatal care or therapeutic childcare were associated with higher rates of abstinence and reduced substance use (Ashley, Marsden, & Brady, 2003). In their meta-analyses, Milligan et al. (2010) examined 10 cohort studies with data on maternal substance use at intake and end of treatment. In the two quasi-experimental studies comparing substance abuse outcomes for women participating in integrated programs to no treatment, effect sizes were small and non-significant (0.18 and 1.41). These researchers concluded that lack of significant differences might be partly attributed to methodological limitations such as issues relating to measurements of substance use (e.g. frequency measures do not account for type of substance used).

Attachment based approaches have been developed to address mothers' experience of childhood maltreatment and promote infant attachment security which is typically a focus of early parenting services (Zeanah, Berlin & Boris, 2011). There are few attachment informed interventions that have been trialled, but research with substance abusing mothers has shown promising results in improving mothers' reflective functioning skills, attunement with their children and relational interactions (e.g. Berlin, Shanahan, & Carmody, 2014; Pajulo, Suchman, Kalland, & Mayes, 2006; Suchman et al., 2010; Suchman et al., 2011). Mothers with infants have participated in randomized trials testing the feasibility of supplementing residential substance abuse treatment with an attachment-based program. These interventions involve programs that emphasise improving mother-child interaction, promoting sensitive and emotionally supportive parenting behaviour through direct observation, modelling and explicit parent coaching (Suchman et al., 2004; Berlin et al., 2014). For example Berlin et al., (2014) provided ten-1 hour home based sessions on specific behavioural targets: a) nurturance b) following the child's lead and c) reducing frightening caregiving behaviour. A moderate effect (*d = .67)* of the intervention on sensitive parenting behaviour was reported for the 21 mothers enrolled in the program. Twenty of those mothers reported experiencing at least one form of childhood maltreatment.

In addition to targeting improvements in caregiving behaviour, psychiatric distress and substance abuse, attachment based interventions have also focused on enhancing maternal reflective functioning (Suchman et al., 2010; Suchman et al., 2011). Maternal reflective functioning refers to the capacity to recognise and make accurate inferences about intentions and emotions underlying their children's behaviours. The Mothers and Toddlers Program focused primarily on mothers' mentalizing about their struggle in regulating their own challenging emotional states and their effect on the child. At post treatment, mothers who participated in the Mothers and Toddlers Program demonstrated better reflective

functioning, which corresponded to improvements in caregiving behaviour (Suchman et al., 2010). The next study by the same research team (Suchman et al., 2011) showed that at post-treatment self-focused reflective functioning but not child-focused reflective functioning significantly improved in mothers who took part in the Mothers and Toddlers Program. Even after a 6-week follow-up, the improvement was maintained.

Pajulo et al. (2006) developed a residential program for substance abusing mothers that took place every day for approximately a 6-month period from the third trimester of pregnancy. The intervention also focused on improving the mothers' mentalization about themselves, their child and their relationship with the child. Outcomes from this intervention were increased levels of reflective functioning from pregnancy to the post-natal phase in the majority (63%) of mothers who received the treatment (Pajulo et al., 2012). Mothers who reported more severe post-traumatic experiences showed a lower increase of reflective functioning.

Attachment interventions have not been evaluated on substance abusing fathers in treatment, and so it is not known how these programs might translate for this group. However, researchers are beginning to incorporate into their program theories of attachment and family systems and include direct work with fathers and their children aimed at improving the parent-child relationship. For example, Stover (2013, 2015) developed *Fathers for Change,* an intervention for substance abusing fathers (with children under 10 years) who also have difficulty with intimate partner violence. Typical goals include the father gaining greater understanding of the meaning of his child's behaviour and improved father-child play interactions. The program showed initial feasibility with a small pilot sample of ten fathers who remained non-violent during treatment and reduced their substance use. Eighty percent became abstinent during treatment (Stover, 2013). Their more recent study was a randomized trial of eighteen fathers with co-occurring intimate partner violence

and substance abuse randomly assigned to Fathers for Change or Individual Drug Counselling. They were assessed at baseline, post-intervention and 3 months following the 16-week intervention period. Analyses of videotaped interactions of father–child play revealed that men in the Fathers for Change intervention showed significantly less intrusiveness during free-play interactions. Men's reports of intimate partner violence showed a reduction for the intervention group (Stover, 2015). Both studies were limited by their small sample sizes.

1.7 Parenting Self Efficacy

Parenting Self Efficacy (PSE) refers to parents' appraisal of his or her beliefs about what they can and cannot accomplish in their responsibilities associated with parenting (Ardelt & Eccles, 2001). Research on the PSE construct has been largely based on Bandura's (1977, 1989) social-cognitive theory (Coleman & Karraker, 1998, 2003; de Montigny & Lacharite, 2005). According to Bandura (1997) PSE involves judgments and beliefs about one's self-competence that influence the choice of activities that parents undertake, the motivation to complete them and their persistence in the face of barriers.

Developmental researchers have highlighted the important role that PSE plays in psychosocial child adjustment. PSE has been recognised as an important variable associated with parenting behaviour (Coleman & Karraker, 1998; Seger, Gulay Ogelman, & Onder, 2012), parental stress (Coleman & Karraker, 2003), maternal infant-attachment security (Raikes & Thompson, 2005) positive developmental outcomes for children (Jones & Prinz, 2005) and child behaviour (Seger et al., 2012). For example, in early childhood, PSE has been linked to children's development in terms of their behavioural adjustment. Bor and Sanders (2005) found that lower levels of PSE among mothers of preschool aged children at

high risk for developing conduct problems were associated with higher levels of concurrent children's disruptive behaviours. In a sample of mothers of clinically referred, 2 to 8 year-old children with conduct problems it was found that lower PSE predicted mothers' use of lax discipline and over-reactive discipline styles (Sanders & Woolley, 2005). Parents, who trust their ability to deal with their child, use less harsh discipline, were less hostile, inconsistent and intrusive in their parenting.

When faced with adversity and multiple stressors, parents with low parental self-efficacy are more likely to become overwhelmed. As a result of this emotional overload, parents can be more vulnerable to giving up on engaging in positive parenting practices (Ardelt & Eccles, 2001). Parents who lack a sense of competence tend to withdraw from interactions with their child and give up addressing child problem behaviors altogether (Coleman & Karraker 1998).

Despite the importance of PSE, limited studies have assessed parental self-efficacy of fathers compared with mothers (de Montigny & Lacharite, 2005; Jones & Prinz, 2005; Sevigny & Loutzenhiser, 2010). Studies that compare PSE in mothers versus fathers suggest there are differences in PSE and its relationship to other variables. For example, maternal but not paternal self-report of depression was correlated significantly with PSE, $r(46) = -0.24$, $p = 0.05$ (Gross & Tucker, 1994). Murdock (2012) found that Paternal Self Efficacy was predicted by supportive, engaged parenting behaviours whereas maternal self-efficacy was predicted by hostile or coercive parenting behaviour. In another study, fathers with high self-efficacy were found to be less anxious than fathers with low self-efficacy only when the child had high levels of behavioural problems (Hastings & Brown, 2002). This suggests that PSE may act as a protective factor when fathers are facing parenting of a difficult child.

Since, PSE according to Bandura is a dynamic and emerging process rather than a fixed personality trait, changing tasks, situational demands and individual factors can modify it. As such, parenting interventions have specifically targeted strengthening PSE beliefs to improve

parenting behaviour (Bloomfield & Kendall, 2007, 2012; Hudson, Campbell-Grossman, Jones, & Prinz, 2005; Sanders & Woolley, 2005). Several studies have shown that parenting programs can have positive effects on PSE (Dekovic et al., 2010; Landy & Menna 2006; Leung et al. 2003). In a review of studies examining parent's experience of parenting programs, parents reported that one of the most valuable elements of parenting programs was an increase in their perceived competence to deal with child behaviour problems (Kane, Wood, & Barlow, 2007). Given the research suggesting a positive relationship between PSE and child behaviours and competent parenting behaviours, enhancing parents' PSE is an important therapeutic goal (Bloomfield & Kendall, 2007). Also, since PSE has been understudied in men, it is important to first identify factors that may affect PSE and in particular with fathers experiencing substance abuse problems. The findings stemming from this research may have implications for the design and focus of parenting interventions.

1.8 Limitations of Existing Literature

Studies are beginning to build awareness about the psychosocial adjustment of drug-abusing fathers and compromise of fathering as an adverse consequence of substance abuse. However, there are a number of limitations in the existing literature. First, cited studies may not accurately represent any population of drug-abusing fathers. Some have been obtained from small groups of self-selected samples of men who may not accurately represent the local population of fathers (e.g. McMahon et al 2007; McMahon et al, 2008). In other studies, the courts or child protection services referred fathers, following their arrest for domestic violence, drug related charges or a call for child related investigations because of these issues (e.g. Stover et al., 2012; Stover, 2015). Whether these results translate to the broader population of men applying for substance abuse treatment in a variety of settings is unclear. Second, although it is important to engage the perspective of men and encourage them in

dialogue about parenting issues, data collected from other informants such as treatment providers, mothers or children may provide a different perspective on the parenting of these substance-abusing fathers and contribute to strengthen the validity of the results. Thirdly, data collected on the quality of father-child relationships and parenting behaviour is limited by the measurement tools used in the studies and presently available to researchers. While some studies have utilised comprehensive observational methods of parent and child relationships (e.g. Eiden et al., 1999; Eiden & Leonard, 2000; Eiden et et al., 2002), other studies have relied on self-report methods (e.g. Catalano et al., 1999; Lam, Fals-Stewart & Kelley, 2009).

As other researchers have highlighted there is still a significant gap in our understanding about how to engage fathers in parenting interventions (e.g. Lee, Bellarmy & Guterman, 2009; Soderstrom & Skarderud, 2013). Unfortunately, parenting has historically been targeted as an issue for substance-abusing women (McMahon & Rounsaville, 2002). There are only few programs that incorporate parenting information for fathers with substance abuse disorders (e.g. Mcmahon, 2013; Stover & Kiselica, 2014). Even when substance-abusing fathers have been included, the efficacy of parent interventions has been relatively modest and affected by high attrition rates (e.g., see Catalano, Haggerty, Fleming, Brewer, & Gainey, 2002). Despite the limitations of these studies, they highlight the need for professionals in the drug abuse treatment system to consider better ways to support substance-abusing men interested in clinical interventions to help them be a more effective parent.

The literature also raises important questions about the confounding and transactional effects of substance abuse co-occurring with parenting difficulties, parenting self-efficacy, mental health, and trauma history and attachment style. Undoubtedly, chronic drug use heightens the vulnerability to parenting problems by altering central reward pathways in the brain and increasing sensitivity to drug stimulus that interfere with parent's ability to

experience pleasure from interactions with their children (Robinson & Berridge, 2003, Volkow, Fowler, & Wang, 2003). However, as described throughout this thesis, the effects of complex trauma and related attachment problems that are so prevalent in the background of substance abusing parents also make a large contribution to the difficulties inherent in engaging and retaining these parents in treatment. They may also impede parent's capacity to develop parenting techniques even when they are abstinent. Clinicians can run the risk of applying treatment approaches that are not helpful when the full spectrum of trauma-related problems are minimised to seemingly unrelated comorbid diagnoses (van der Kolk, 2005). A major limitation of the cited studies is that they report cross sectional association between these factors. For example, although the Caldwell (2011) study presented an integrative model on the links between early exposure to maltreatment and later attachment and parenting problems, they used Structural Equation Modelling, which is correlational in nature and cannot be considered proof of causality. The study is based on retrospective self-reports of child abuse experiences that could lead to underreporting biases or distortions in recalling traumatic events. Currently lacking in this area is rigorous longitudinal research and prospective data to clarify issues of directionality and causality. The relationship between early exposure to childhood maltreatment, subsequent traumas and subsequent parenting difficulties (i.e. attachment problems and parental self-efficacy) is complex. There is a need for other studies of high-risk samples to illuminate other variables in the relationship between trauma, substance abuse and parenting difficulties.

1.9 The Present Study

The research reviewed thus far helps establish the rationale for the present study. Firstly, attachment traumas are related to adult attachment insecurity, PTSD, complex trauma outcomes and parenting self-efficacy. The relationship between these variables has been

established with mothers but not with fathers. Secondly, a high proportion of substance abusing parents have been maltreated by their parents and/or exposed to cumulative traumas and this often has serious negative effects on the ability to parent safely and well. Thirdly, given that substance-abusing parents are vulnerable to relapse as a coping mechanism and report wanting help with their parenting, there is a need to explore concurrent treatment of substance abuse and parenting difficulties. However, this treatment should address factors specific to this population, which may prevent them for benefitting fully from currently available parenting programs. With these findings in mind, this present research consists of two separate, but related studies. The first study aimed to explore the relationship between post-traumatic symptoms, adult attachment and parental self-efficacy in a sample of fathers or male caregivers attending rehabilitation program for substance abuse problems. The objective of the second study is to test the feasibility of *The Black Box Parenting Program,* which has been developed based on the findings from Study One. It is a brief, trauma and attachment informed parenting intervention with the following objectives:

1. *Developing caregiver self-efficacy* by helping parents make sense of their own and their child's experience through providing them with basic information about the effects of trauma and attachment disruption on individuals, both in the short term and long term.

2. *Improving caregiver's self-perception* to increase parent's perceived safety in relational interactions by attending to self-stigmatizing thoughts and feelings (e.g., shame and guilt) that can lead to an avoidance of parenting help.

3. *Strengthening parent and child relationship.* Positive engagement between caregiver and child is addressed through play intervention as the foundation for a rewarding dyadic experience.

Chapter 2

Theory and research suggest that the interaction between complex trauma and parental substance abuse undermines caregiving competency and increases the likelihood of abuse and neglect of children. Parents' own history of cumulative trauma can impact on their attentional capacity, exacerbate somatic conditions, reinforce a negative internal working model of self and other, trigger affective experiences of shame and guilt and lead to distrust and suspiciousness of relationships. Both research and clinical interventions focus disproportionately on parenting amongst substance abusing women, whereas the role of substance abusing fathers has been largely ignored. There is a need to explore trauma related symptoms, attachment security and parenting behaviours in fathers entering treatment for substance abuse.

This chapter reports on the first study that aims to identify the nature of the relationships between parental self-efficacy, post-traumatic symptoms, and adult attachment anxiety in a sample of fathers attending rehabilitation program for substance abuse problems. There is little research examining these variables together, despite the importance of understanding this process if we are to intervene with parenting in this population of at-risk fathers. The study utilised a cross sectional survey design and collected data from participants using self-administered questionnaires.

Mediation analyses were performed to clarify the nature of the relationships between key variables that might influence PSE. The model from this first study was used to refine a parenting intervention for fathers in substance abuse treatment programs that might be feasible within the limitations of the residential setting and resources available. Given that the literature reviewed in the previous chapter suggests these fathers are likely to benefit from existing parenting programs, which have been focused on mothers, it is important to

understand what might need to be included in an intervention, tailored specifically for this population. This will allow any tailored program the best chance of being both acceptable to and useful for these caregivers.

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2. Parenting Self-Efficacy, Trauma and Attachment of Fathers in Residential Substance Abuse Treatment.

2.1 Introduction

The role of fatherhood in the context of substance abuse is an area that has been neglected compared to the literature examining the parenting responses of women in substance abuse treatment (Fals-Stewart & Logsdon, 2004; McMahon & Rousanville, 2002). Fathers entering treatment for substance abuse have expressed concerns about their parenting, report high levels of parenting stress and indicate an interest in therapy to help them be more effective fathers (McMahon, Winkel, Suchman, & Rousanville, 2007; Stover et. al., 2012). Substance abusing fathers are likely to be involved in parenting and can have a significant impact on children. The association between parental substance abuse and child maltreatment is well documented, with statistics that indicate that fathers are more likely than mothers to be perpetrators of severe abuse of children when substance abuse is involved (Mcmahon, Winkel, Luthar, & Rounsaville, 2005). Substance abuse by fathers is associated with high rates of child maltreatment, including physical abuse and neglect of children (Guterman & Lee, 2005; Walsh, MacMillan, & Jamieson, 2003). Substance abusing fathers can also indirectly impact the parenting capacity of mothers through mechanisms such as loss of income and lack of partner social support (Berridge, 2002). Other harmful influences on the family system include disruptions to family rituals and causing family conflict (Arria, Mericle, Meyers, & Winters, 2012).

These fathers present with complex and poorly understood vulnerabilities that can exacerbate and maintain substance abuse and contribute to parenting problems. It is now well established that co-morbid psychiatric symptoms often co-occur with substance abuse problems (Peirce, Kindbom, Waesche, Yuscavage, & Brooner, 2008; Stover, Hall, et al., 2012). One such psychiatric condition is Post Traumatic Stress Disorder (PTSD) that has

been found to be associated with greater severity of alcohol and drug use. Stover et al. (2012) explored the relationship between fatherhood and both psychological distress and severity of substance abuse. Of the 126 men entering treatment for substance abuse, 54% reported a history of a traumatic life event. Compared with men who were not fathers, the correlation between PTSD symptom severity and substance abuse severity was exacerbated for fathers. Stover et al., (2012) also explored parental acceptance and rejection in their relationship with their child as one aspect of a parent's approach to caregiving. A significant and positive correlation (r = .34) was found between PTSD symptoms and hostile-aggressive parenting behaviours.

2.1.1 The Relationship between Trauma and Attachment

Factors other than substance misuse may affect the ability of a parent to interact with and support their child, such as parents' own experiences as children who received poor parenting, or were neglected or abused. When trauma results in disruption to the early attachment relationship it is known as *attachment trauma* and this often contributes to the complexity of posttraumatic symptomology (Schore, 2009). Childhood maltreatment can have an adverse impact on affective self-regulatory capacities and associated skills in effective interpersonal behaviours (Shipman, Edwards, Brown, Swisher, & Jennings, 2005). Specifically within parent-child relationships, research has demonstrated an association between adult attachment style and parenting behaviour (Grossmann et al., 2002; McFarland-Piazza, Hazen, Jacobvitz, & Boyd-Soisson, 2012; Pearson, Cohn, Cowan, & Cowan, 1994). In a longitudinal study of 117 fathers, those who were classified as dismissive and unresolved in their attachment style displayed more hostile caregiving behaviour (McFarland-Piazza et al., 2012).

Adult attachment is typically assessed through interview based method using the Adult Attachment Interview (AAI) or self-report measures to capture the individual

differences in internal working models of self and other, based on their interpersonal experiences (Shi, Wampler & Wampler, 2013). The Adult Attachment Interview (AAI) is a developmental approach for measuring attachment that evaluates an individual's retrospective state of mind (current representations) regarding early attachment experiences with their own caregivers (Goldwyn, 1998). Although the preferred measure of states of mind regarding attachment is the AAI, administering and scoring requires extensive training and financial investment and intensive clinical interview time with respondents (Crowell, Fraley & Shaver, 1999). Another commonly used approach of assessing adult relationships from an attachment perspective is self-report measures used by researchers in the social/personality field. Researchers propose that the internal working model generalizes to other relationships (including adult romantic relationships) during adulthood (Feeney & Noller, 1996; Shaver, 1994). Hazan and Shaver (1987) argued that behaviour in adult relationships might be a result of early childhood attachment experiences. Self-report questionnaires have been developed that typically assess *attachment style*, a social-personality dimension that describes attitudes about close relationships, based on the original work by Hazan and Shaver (1987). A two dimensional model of adult attachment styles was developed, conceptualised in terms of anxious and avoidant insecure attachment orientations (Mikulincer & Shaver, 2010). Anxious attachment anxiety is characterised by chronic worries of separation and excessive need for approval, and attachment avoidance comprising discomfort with closeness and fear of dependence. Low scores on these dimensions indicate a secure attachment style (Mikulincer & Shaver, 2010). In the current study we used the Experience in Close Relationships – Revised (Fraley, Waller, & Brennan, 2000), one of the most common self-report measures of adult attachment patterns. Rather than a particular couple relationship, the questionnaire asks fathers to reflect on "close relationships" in general.

Another major attachment style is disorganized attachment, which is characterised by a contradiction in behaviours (e.g. walking towards caregiver with head turned the other way, disorientation upon parent's return) and a lack of clear attachment orientation. Disorganized attachment is most common in samples known to be marked by child maltreatment (Lyons-Ruth, Yellin, Melnick, & Atwood, 2005) and is thought to play a central role in trauma related disorders (Solomon & George, 2011). Disorganized attachment in children is strongly linked to unresolved attachment classifications in parents whose traumatic experiences have not been resolved (Hesse & Main, 2000; Hesse et al., 2003). Solomon and George (2008) have described the subjective experience of mothers of children classified as disorganized in their attachment as *helplessness* in respect to their child, their own emotions and the relationship. Their observations of mother and child dyads have led to usage of the term "disorganized caregiving system" in the context of mothers struggling to maintain control and provide protection, and who may be at risk of lashing out, retreating or seeking comfort from their child (Solomon & George, 2011). Disorganized attachment can be distinguished from other forms of insensitive caregiving including organized, insecure attachment systems (Out, Bakermans-Kranenburg, & van Ijzendoorn, 2009). In addition to commonly assessed attachment styles (avoidance and anxiety), the present study, sought to evaluate the effects of this aspect of attachment insecurity, which we refer to as parental helplessness.

2.1.2 Impact of Attachment Trauma on Parenting Self-Efficacy

Individuals who are securely attached express greater confidence and satisfaction in their relationships (Adamczyk & Pilarska, 2012). Within the context of parenting, the parent's own confidence in their ability to fulfil the responsibilities of parenting has been referred to as Parental Self-Efficacy (PSE; Ardelt & Eccles, 2001). Low levels of PSE have been associated with negative parenting behaviour (Seger, Gulay Ogelman, & Onder, 2012), parental stress (Coleman & Karraker, 2003), low maternal infant-attachment security, (Raikes

& Thompson, 2005) negative developmental outcomes for children (Jones & Prinz, 2005) and child misbehaviour (Seger et al., 2012).

In mothers, traumatic experiences in childhood and adulthood have been linked to lower PSE and more negative perceptions of oneself as a parent (Caldwell, Shaver, Li, & Minzenberg, 2011). An association has been found between a history of childhood maltreatment and a reduced sense of competence regarding parenting. In a sample of 76 women, 45% of which had a history of addiction to alcohol or illicit drugs, adult attachment anxiety and depressive symptoms were found to mediate the relationship between childhood maltreatment and perceived parenting competence (Caldwell et al., 2011). Mother's history of childhood maltreatment particularly, emotional abuse yielded the strongest correlations with anxious attachment, maternal depression, and parental self-efficacy. Both attachment anxiety and avoidance were related to greater depression and lower parental self- efficacy. A history of childhood maltreatment predicted lower parental self-efficacy through the mediating effects of attachment anxiety and maternal depression. This suggests that mothers who had a history of childhood maltreatment were more depressed, felt less competent in their abilities to parent and felt less secure in their relationships. The high incidence of depression in substance abusing populations may be a consequence of childhood trauma and result in low parenting self-efficacy. There are no similar data available for fathers who have substance abuse problems.

2.1. 3 Present Study

There is a need to assess the relationships between complex trauma, attachment and parenting self-efficacy amongst fathers who have substance abuse problems. These factors could interact in a variety of ways to affect parenting. Substance abusing fathers may want to value parenting but symptoms associated with trauma and attachment difficulties may contribute to decreased self-efficacy in their parenting role. This may further aggravate

negative affect, which then has further impacts on future parenting behaviours. The primary aims of this study are to examine a sample of fathers in residential treatment facilities for substance abuse and: (a) describe the types and severity of prior trauma, (b) describe the overall levels of parenting self-efficacy and attachment style (avoidance, anxiety and disorganized/parental helplessness) and, (c) examine whether attachment style mediates the association between childhood trauma and parental self-efficacy. Based on the previous findings by Caldwell et al. (2011), it was predicted that a history of traumatic life events that include childhood maltreatment would be associated with attachment anxiety and avoidance and decreased parental self-efficacy. It was hypothesised that a history of trauma will be associated with greater trauma-related psychological symptoms as previously found in a study of men applying for substance abuse treatment (Stover et al., 2012). Finally it was hypothesised that higher levels of posttraumatic symptomology will predict lower parental self-efficacy through mediating pathways involving attachment orientation. That is, those adults with greater attachment disruption from their history of maltreatment will manifest greater trauma symptomatology at the time of the study. Posttraumatic symptomology will be inversely related to parental self-efficacy.

2.2 Method

2.2.1 Recruitment and Procedure

Participants were recruited from community managed non-government organisations (NGO) residential rehabilitation programs in Sydney and Queensland. The Salvation Army, Odyssey House and The Glen operated these residential rehabilitation programs. All individuals in these services were receiving treatment for alcohol and or substance abuse problems. The Salvation Army and Odyssey house services both men and women. The Glen

is a men only facility. There were six residential sites that participated in the study. Each site was asked to recruit at two different dates, because of significant turnover of clients. At each time, between 10 - 20% (about 10 – 18 men) at Salvation Army residential sites met the study criteria. About 20% (approximately 10 men) from Odyssey House and 75% (about 15 men) of The Glen residents met criteria. In total, there were approximately 149 men who were eligible to participate and 67% (100 men) completed the questionnaires. Although the majority of eligible men expressed an interest to participate, they had either left the service or were off site on the day the surveys were being administered.

The project received ethical review and approval from the University Human Research Ethics Committee. Caseworkers and managers at each service site provided information about the study to potential participants meeting the inclusion criteria. Respondents completed the questionnaires at their respective sites after they provided informed consent. All potential subjects were told in advance that questions on the survey dealt with exposure to past abuse, victimization, parenting and experience in relationships. To provide support in the event that participants experienced distress following completing questionnaires, residential treatment staff were available during the study.

Inclusion criteria for participation were as follows: (1) male clients of substance abuse residential programs and, (2) in the 12 months prior to entering the residential treatment program, participants had been either the biological father or caregiver for one or more children under the age of 18.

2.2.2 Measures

Demographic data was collected including age, ethnicity, and number and ages of biological children and non-biological children they have lived with in the past 12 months, relationship status, employment status, living arrangements. Specific questions regarding

participants' interest in attending a parenting program and their concerns about their child were also included.

The Parenting Sense of Competence Scale -PSOC (Johnston & Mash, 1989) - Father's Form is used to measure parents' satisfaction with parenting and their self-efficacy in their role as parents. The measure comprises 17 items that are rated on a 6-point Likert scale ranging from (1) Strongly Disagree to (6) Strongly Agree. An example item is, "I meet my own expectations for expertise in caring for a child." Three factors have been identified in a factor analytic study: satisfaction with parenting role, parenting efficacy and interest in parenting (Gilmore & Cuskelly, 2009). Compared to other parental self-efficacy measures that address specific skills needed to parent children of particular age groups, the Parental Sense of Competence Scale has been relevant to children of parents in a broad age range (Rogers & Mathew, 2004). It is the most commonly used tool for measuring parental self-efficacy (Jones & Prinz, 2005). In a large Australian sample study of mothers (*n*=586) and fathers (*n*=615), internal consistencies using Cronbach's alpha were calculated for each of the subscales of the PSOC for parent groups separately. Internal consistency for each subscale were satisfactory [Efficacy (Mothers =. 68; Fathers = .74) and Satisfaction (Mothers =. 72; Fathers = .76Gilmore & Cuskelly, 2008)]. Cronbach alpha for fathers in the current study on the parental self-efficacy scale was 0.64.

The Stressful Life Events Screening Questionnaire (Goodman, Corcoran, Turner, Yuan, & Green, 1998) is a self-report measure that assesses exposure to a variety of traumatic life events of an interpersonal nature. The questionnaire consists of 13 items and asks respondents to indicate whether the event occurred *(yes* or *no)*, their age at the time of event and specific items related to the event (e.g. duration). An example item is, "Was physical force or a weapon ever used against you in a robbery or a mugging? How many perpetrators? Did anyone die?" The total number of stressful life events experienced was calculated for the

present study. The measure has adequate psychometric properties including test re-test reliability, convergent validity and concurrent validity (Goodman et al., 1998). Original reliability and validity of the SLESQ were evaluated in a study of 202 male and female college students. The self-report version of the SLESQ was compared with an interview two weeks later with the same person to assess validity. Correlation between the total numbers of events reported in the questionnaire compared to the interview was .77. Item kappas for validity ranged from .26 to .90, with a median kappa of .64 (Green, Goodman, et al., 2000; Green, Krupnick, et al., 2001; Krupnick et al., 2004).

Trauma Symptoms Inventory –Second Edition (Briere et al., 1995) is a self-report measure of symptoms associated with traumatic experiences. The measure consists of 136 items and respondents are asked to rate how often each symptom has happened to them in the past six months ranging from (0) Often to (3) Never. There are clinical scales that assess a variety of symptom domains of trauma: Anxious Arousal, Depression, Anger/Irritability, Intrusive experiences, Defensive avoidance, Dissociation, Sexual concerns, Dysfunctional behaviour, Impaired Self-confidence and Tension reduction behaviour. This version has three additional scales: insecure attachment, somatic pre-occupations and suicidality. The 10 scales of the second edition have strong psychometric properties. Reliability estimates are good (alpha values ranging from .83 to .93) and the measure is commonly used for clinical and research purposes (Runtz, Godbout, Eadie & Briere, 2008). In the present study we were interested in overall posttraumatic symptom severity, and a total score was obtained for items on the posttraumatic scale. Cronbach coefficient alpha estimates were reported to be .91 for the posttraumatic scale in the current study.

The Experience in Close Relationships –Revised (Fraley, Waller, & Brennan, 2000) is a self-report measure of adult attachment in terms of two distinct dimensions: Anxiety (discomfort with closeness and dependency on others) and Avoidance (fear of rejection or

abandonment). ECQ consists of 36 items asking about respondent's typical behaviour and emotional experiences in relationships and rated using a 7-point Likert scale from 1 (disagree strongly) to 7 (agree strongly). An example of an item from the Anxiety Scale is, "I worry about being rejected or abandoned" and from the Avoidance scale, "I don't feel comfortable opening up to others." Higher scores reflect a high prevalence of attachment anxiety or attachment avoidance. Many studies have demonstrated construct, discriminant, reliability, and predictive validity of the two scales (e.g., Crowell, Fraley, & Shaver, 1999; Fairchild & Finney, 2006; Godbout, Dutton, Lussier, & Sabourin, 2009). Cronbach coefficient alpha estimates were reported to be .93 (avoidance) and .91 (anxiety) in the study (Fairchild & Finney, 2006). In the present study, Cronbach coefficient alpha estimates were .92 and .90 respectively.

The Caregiving Helplessness Questionnaire (CHQ, Solomon & George, 2011) is a self-report screening measure developed to understand maternal helplessness and disorganized caregiving for caregivers with a child aged from 3 to 11 years old. Solomon and George (2011) developed this measure of disorganised parent-child attachment to capture frightening, fearful hostile and helpless atypical caregiving behaviour that has been linked to the child's development of disorganized attachment. In this study, the concept of parental helplessness was used as a proxy to capture disorganized attachment representation. Caregivers are asked to think about what it is like when they are with their child and rate the 45 items using a 5-point scale ranging from (1 *not at all characteristic* to (5) *very characteristic*. Examples of items include, "I am frightened of my child," and "Sometimes my child acts as if he/she is afraid of me." A summary score is calculated for each of the three factors: Mother Helpless, Mother and Child Frightened and Child Caregiving. Construct, discriminant and predictive validity of the CHQ were assessed in a sample of mothers (n = 59). Significant positive correlations were found between the two subscales of

the CHQ (mother helplessness and mother-child frightened) and dimensions of risk including maternal depression, caregiving stress and parenting incompetence (Solomon & George, 2011). Internal consistency of each of the three scales using Cronbach alpha coefficients was .64 (child-caregiving scale), .66 (mother-child frightened) and .85 (mother helpless) (Solomon & George, 2011). In the present study, we were interested in the disorganized caregiving, reflected in the parent (in this study, the father) "helpless scale" as a measure of disorganised parent-child attachment. Cronbach alpha for participants in the current study was .77 on the father-helpless subscale.

2.2.3 Data Analytic Strategy

Data were analysed using the Statistical Package for the Social Sciences (version 21.0). First, descriptive statistics for the total sample including trauma experience and parenting was generated and presented in Tables 1 to 3. Listwise deletion was used for correlations and mediation analyses. To check for the effects of missing values, differences between participants who had provided data for all the key variables in the mediation analyses (n = 69) and those who had missed items within the measures ($n = 31$) were investigated using independent samples t-tests. There were no significant differences between the groups (all $p > .05$) for any of the nine variables assessed: age ($t(93) = .47$), months in program ($t(97) = .32$), number of biological children ($t(98) = .51$), total traumatic events ($t(78) = 1.52$), parental self efficacy ($t(93) = .48$), post traumatic symptomology ($t(82) = .50$), Father helplessness ($t(83) = -.05$), anxious attachment ($t(95) = .89$) and avoidant attachment ($t(95) = 1.23$). Visual inspections of the variables' distributions (Tabachnick & Fidell, 2013) showed no normality violations.

Means, standard deviations, and correlations for the study's key variables were calculated and are reported in Table 4. A mediation analysis was conducted using Hayes (2013) method for assessing indirect pathways. Mediation of the association of trauma

symptoms and parental self-efficacy by attachment is demonstrated by significant indirect co-efficients. The indirect effect was reported as significant when the confidence interval around the effect did not include zero (Preacher & Hayes, 2008). Parallel multiple mediation analyses were performed using SPSS macro PROCESS developed by Preacher and Hayes via bootstrapping (2008). A parallel multiple mediator model was tested with trauma symptoms as the independent variable and the three attachment styles entered simultaneously as mediators. Bias-corrected confidence intervals were generated using bootstrapping with 10,000 resamples. The total, direct and indirect effects are shown in Table 5. In Figure 1 a dashed line depicts non-significant pathways and numerical values are non-standardized path coefficients.

2.3 Results

2.3.1 Description of the Sample

A total of one hundred men participated across all sites. Table 1 presents characteristics of the study sample. As noted above, all participants had a history of substance abuse and were receiving treatment in a residential setting. Of the 70% (*n* =70*)* who indicated their ethnicity, the majority were Anglo-Australian (*n* = 45, 45%) and approximately (N = 13, 13%) were Aboriginal. The age range was 19 to 61 years, with a mean age of 38 years (SD = 9). Participants varied in their length of stay in treatment, but the majority had been in treatment for 4 months or less (*n* =80, 80%). Just over half the sample that endorsed their relationship status (*n=99)* indicated they were single (*n* = 55; 56 %). Of the remainder that were not single, fathers who reported on their living arrangements prior to admission indicated that they were living with their partner (*n* = 21; 21%), living with their partner and children (*n* = 5, 5 %) or living with another tenant (*n* = 18, 18 %).

Table 1

Participant Characteristics

Sample Characteristic	N (%)
Ethnicity	
Anglo-Australian	45 (64)
Aboriginal	13 (19)
Australian (other descent)	4 (1)
Other	8 (11)
Marital Status	
Single and living alone	55 (55)
Living with partner	21 (21)
Living with partner and children	5 (5)
Living with another tenant	18 (18)
Education	
Postgraduate	5 (5)
College/TAFE	21 (21)
High school	67 (68)
Primary school	2 (2)
Employment	
Part time	2 (2)
Full time	24 (24)
Casual	7 (7)
Unemployed	64 (64)
Months in residential program	
Less than a month	21 (21)
1-2 months	28 (28)
3-4 months	30 (30)
5-6 months	10 (10)
6-12 months	8 (8)
Over a year	2 (2)

Note: sample sizes for each item varied from 70 to 100 due to missing data for some items and valid percentages are reported.

2.3.2. Trauma Experience

Of the total sample (*N* =100), 78% (*n = 78)* endorsed at least one traumatic life event. The results from the SLESQ are presented in Table 2. Adult physical abuse including assault (54%, *n* = 54) and emotional abuse (51%, *n* = 51) were the most prevalent of traumatic life events.

Table 2

Prevalence of Traumatic Life Events

Type of Stressful event	*N* (% yes)
Robbery/mugging with force or weapon	32 (33)
Threatened with gun or knife	51 (51)
Life-threatening accident	43 (43)
Life-threatening illness	31 (32)
Death of a loved one	47 (48)
Witness to violence/assault	45 (47)
Childhood physical abuse	45 (46)
Adult physical abuse/assault	54 (56)
Seriously injured or life in danger	19 (20)
Other frightening situation	29 (32)
Sex against one's wishes	16 (17)
Inappropriate touching against one's wishes	16 (16)
Emotional abuse	51(52)

Note: sample sizes for each item varied from 91 to 99 due to missing data for some items and valid percentages reported.

2.3.3 Parenting of Fathers

Biological fathers had a mean number of 2.6 children (*n* = 100, SD = 1.4). In the 12 months prior to admission into the residential program, the majority of fathers had daily contact with their children (*n* = 42, 45 %). The remainder were having at minimum weekly *(n = 24,* 26%) or monthly contact (*n* = 14, 15%). There were a minority of fathers that were seeing their children yearly (*n = 11,* 12%). Participants were asked about their childcare responsibilities during the 12 months prior to starting treatment (more than one category could be specified). There were 47% of fathers (*n* = 47) that provided direct care (e.g. bathing, feeding and dressing). A large proportion of fathers reported having concerns about their child (*n* = 59, 60%). The most commonly reported concern was emotional problems (59%) followed by behavioural (53 %) problems of their children. Over half (*n* = 60, 60%) indicated that they would be interested in attending a parenting program. Fathers most

commonly indicated that they wanted to develop their skills in limit setting (87%) and strategies to respond to behavioural difficulties (72%). Table 3 presents the parenting characteristics of fathers.

Table 3

Parenting of Fathers

Variable	*N* (%)
Childcare Responsibilities	
Direct Care	47 (47)
Financial Support	59 (59)
Teaching	55 (55)
Disciplining	62 (62)
Providing affection and comfort	67 (67)
Frequency of Contact with Children	
Every day	42 (45)
Every week	24 (26)
Every month	14 (15)
Every year	11 (12)
Concerns about their Child	
Behavioural problems	31 (53)
Emotional problems	35 (59)
Physical problems	16 (27)
Academic problems	20 (34)
Relationship with peers	16 (27)
Relationship with parents	20 (34)
Interest Attending Parenting Program	
Skills in setting limits	52 (87)
Learning how to play and spend time with their child	30 (50)
Strategies to respond to behavioural difficulties	43 (72)
Relationship with child	38 (63)
Education about child's needs	39 (65)

Note: sample sizes for each item varied from 97 to 100 due to missing data for some items and valid percentages reported.

2.3.4 Bivariate Correlations

As would be expected, a history of traumatic life events was associated with higher levels of posttraumatic symptomatology.

Anxious attachment, avoidant and disorganized attachment were all significantly related to diminished parental self-efficacy (see Table 4). Higher levels of posttraumatic symptomatology were related to decreased parental self-efficacy and higher levels of father helplessness. No significant relationships were found between posttraumatic symptomology and the anxious and avoidant styles of attachment. No significant relationship was found between total traumatic events experienced and each of the attachment styles; anxious; avoidant and disorganized attachment. Bivariate correlations provide support for associations between investigated constructs in the mediation analyses. The correlations between the constructs were generally in the low to moderate range.

Table 4

Means, Standard Deviations, and Bivariate Correlations among Study Variables

	1	2	3	4	5	6
1. Total Traumatic Events	_	.34**	- .02	.22	.01	.11
2. Trauma Symptoms		_	- .36**	.23	.22	.39**
3. Parental Self Efficacy			_	- .40**	- .47**	- .49**
4. Anxious Attachment				_	.46**	.48**
5. Avoidant Attachment					_	.20
6. Disorganized Attachment						_
M	4.55	55.80	36.70	3.42	3.17	15.20

SD	2.53	1.06	6.96	1.12	1.06	5.64

Note: Listwise deletion was used and the sample was 55 due to missing data for some variables. **Correlation is significant at $p< 0.01$

2.3.5 Mediation Analyses

The specific indirect effect of avoidant and disorganized attachment (with all three insecure attachment ratings entered simultaneously) was significant. Figure 1 displays the models with significant and non-significant pathways. Coefficients on each path are non-standardized path coefficients. The total, direct, and indirect effects are shown in Table 5. Anxious attachment was not a significant mediator. Trauma symptoms predicted avoidant attachment ($\beta = .01, p < .05$) and disorganized attachment ($\beta = .07, p < .05$). Avoidant attachment ($\beta = -1.92, p < .05$) and disorganized attachment ($\beta = -.40, p < .05$) predicted parental self-efficacy. Bootstrapping found a significant indirect effect for avoidant attachment ($\beta = .02, 95\%\ CI = [-.06, -.00]$) and disorganized attachment ($\beta = .02, 95\%\ CI = [-.07, -.00]$). When the mediators were entered into the model, the total effect of trauma symptoms (c = -.10, p = .00) on parental self-efficacy decreased and became statistically non-significant (c' = -.05, p = .08) indicating that only avoidant and disorganized attachment fully mediated trauma symptoms and parental self-efficacy.

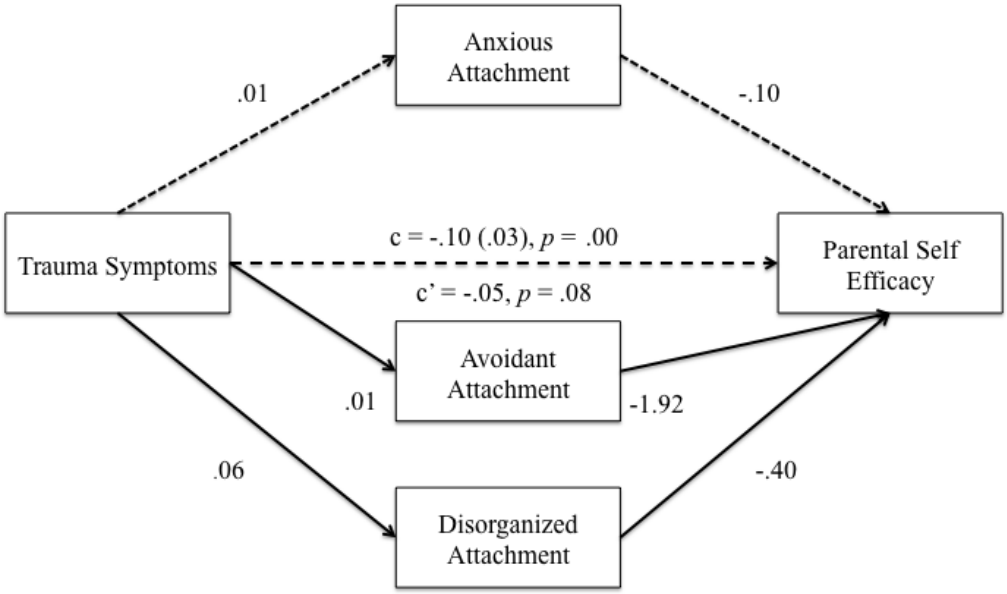

Figure 1 - A model showing direct and indirect pathways

Table 5

Parallel Multiple Mediation Analyses Examining Indirect Effects of Trauma on Self-efficacy via Anxious, Avoidant and Disorganized Attachment

Direct	Unstandardized Parameter Estimate (β)	SE	95% Bias-corrected Confidence Interval (CI)	
			Lower	Upper
Total effect	- 0.10*	0.34	- 0.17	- 0.04
Direct effect	- 0.05	0.03	- 0.12	0.01
Indirect total effect	- 0.05*	0.02	- 0.10	- 0.01
Indirect effect via anxious	- 0.00	0.01	- 0.03	0.02
Indirect effect via avoidant	- 0.02*	0.01	- 0.06	- 0.00

Indirect effect via disorganized attachment	- 0.03*	0.01	- 0.07	- 0.00

*****$p < 0.05$

2.4 Discussion

The purpose of this study was to investigate the relations between substance-abusing fathers' history of traumatic life events, adult attachment, symptoms of trauma, and parental self-efficacy. As anticipated, fathers in this population who report a history of trauma reported higher levels of posttraumatic symptoms. This finding provides support for the growing body of research concerned about the clinical and public health implications of the co-occurrence of posttraumatic stress disorder and substance abuse (Coffey, Read & Norberg, 2008; Dass-Brailford & Myrick, 2010; Haller & Chassin, 2013).

Consistent with our prediction, fathers who experience a higher level of posttraumatic symptoms have a diminished sense of confidence regarding their parenting. Anxious attachment, avoidant and disorganized attachment were related to greater symptoms of trauma and diminished parental self-efficacy. Although the cross-sectional nature of this study precludes conclusions about causality, it could be hypothesised that the effect of traumatic experiences on the attachment system is a critical factor that contributes negatively to parent's emotional well-being and self-efficacy. The results are supported by research showing the wide range consequences of attachment trauma on children's development that can be maintained into adulthood (Briere, 2002; van der Kolk, 2005). A notable discrepancy is that compared with the mean scores obtained by other researchers (e.g. Gilmore & Cuskelly, 2008; Ohan et al., 2000), the fathers in our study scored higher on the self-efficacy

scale. For example, the mean scores on efficacy scale for fathers ranged from (*mean* = 26.0 to 27.0) depending on age of the child compared to (*mean* = 36.7) in our study. The results are surprising given that the parents in the Ohan et al. (2000) study were a non-clinical group of couples that had been parenting together. However, since fathers in this study have limited contact with their children compared with other samples who have direct day-to-day contact, the disparity may be partially attributed to different levels of awareness about the extent of child behaviour problems or parenting challenges. Child behaviour problems and other parenting difficulties have been associated with lower parental self-efficacy (e.g. Markie-Dadds & Sanders, 2006). Thus, it may be useful to include other sources of information of child behaviour (e.g. parent and child observations, mother reports of child behaviour). Despite these difficulties, it is important to note, that similar to previous research on fathers in residential substance abuse treatment (Stover et al., 2012), fathers had concerns about parenting and would be interested in parenting interventions whilst in treatment for substance abuse.

Traumatic events in childhood and adulthood have become increasingly recognised as impacting on caregiver attitudes and behaviours. However, there is no research to date examining how traumatic life events, posttraumatic symptomology, and adult attachment security work together to influence parental self-efficacy in fathers. This study begins to address this gap in the research in relation to fathers who misuse alcohol and other drugs. The multiple mediation model clarifies how, in this sample, posttraumatic symptomology interacts with parental self-efficacy. The data revealed that posttraumatic symptomology was inversely correlated with parental self-efficacy. This finding is consistent with attachment theory that suggests the quality of early experiences influences beliefs about the self and others. When fathers view themselves as being helpless, ineffectual and damaged because of

chronic traumatic experiences, they can bring these beliefs of themselves into their parenting role, leading to low parenting self-efficacy.

What emerged from the multiple mediation model was that only avoidant and disorganized attachment mediated the relationship between posttraumatic symptoms and parental self-efficacy when multiple attachment styles were statistically controlled for. Although the cross-sectional nature of this study precludes conclusions about causality, it could be hypothesised that the effect of traumatic experiences on the attachment system is a critical factor that contributes negatively to parent's emotional well-being and self-efficacy. Results from the current study are consistent with the possibility that symptoms associated with trauma leading to or activating patterns of attachment that involve helplessness and avoidance in close relationships including those of the caregiving kind. These ways of relating could also lead to reduced feelings of efficacy in their parenting role. Disorganized and avoidant attachments both comprise avoidance behaviours. Those with avoidant attachment styles tend to be more predictable in their interaction but those with disorganized helpless styles tend to display unpredictable patterns of opposing approach/avoidance behaviours. In contrast, a person in an anxious attachment relationship is likely to exhibit closeness and clingy behaviours as a response to intense fear of abandonment. It is possible that the closeness that these fathers crave is actually developmentally appropriate for children up until they begin to individuate in adolescence. Therefore, the intense parent-child bond actually supports feelings of parental self-efficacy in some cases. This may not be the case in older children and this mixed presentation may have contributed to the anxious attachment pathway not reaching significance in the present study.

2.4.1 Limitations and Future Directions

The sample size and effect sizes in this study were relatively small, however we believe the results are clinically meaningful and provides useful information about a complex

clinical sample of fathers. Another limitation is the use of self-report measures of attachment, which are subject to self-reporting biases. For example, since self-report measures of attachment style are subjective, anxiously avoidant individuals may be reluctant to answer honestly because it may be viewed as socially undesirable (Mikulincer & Shaver, 2010). Finally, the parenting specific measures (i.e., PSOC, Experience in Close Relationships Questionnaire, Caregiving Questionnaire) have mainly been used on self-referred, non-clinical community samples, comprised predominantly of mothers. Although the PSOC has been trialled on a good number of fathers, researchers have noted that fathers are notoriously difficult sample to recruit (Gilmore & Cuskelly, 2008). More studies are needed to test these measures on fathers in clinical populations such as substance abusing fathers in treatment with concurrent mental health problems as identified in this study. Despite these limitations, the results can inform future research and interventions to help substance abusing fathers. In residential rehabilitation settings where there are limited resources, parenting intervention programs should be tailored to focus on critical attachment components identified as mediators of the trauma-self efficacy relationship. Since attachment is directly related to parenting self-efficacy, then a parenting intervention designed to include a specific focus on improving the parent-child attachment relationship is important. Attachment based interventions that aim to improve relationship interactions are relatively new in the substance abuse treatment field but they are showing promising results (Suchman et. al., 2006).

The results described in this chapter suggest a clear relationship between level of post-traumatic symptomology and parenting outcomes. The importance of attachment style was particularly highlighted. How, then, do we intervene with this population, whose level of both trauma and attachment disruption is so high?

Chapter 3

This chapter is divided into three main sections. The first section presents an overview of the literature on the parenting challenges of fathers in the context of substance abuse treatment systems. The second section sets out how systemic thinking can orient practitioners in responding to the parenting concerns of fathers within such complex systems. In this section, the limitations of adopting traditional Parent Management Training programs within this population of fathers are discussed. This background establishes guidelines for proposing the development of the *Black Box* Parenting treatment program based on systemic principles, which forms the last section of this chapter.

The content of Chapter 3 has been extracted from the published journal article: Torres, M., Sng, R., and Deane, F. P. (2015), Establishing a Parenting Program for Fathers in Substance Abuse Treatment. *Australian and New Zealand Journal of Family Therapy*, 36: 273–288. doi: 10.1002/anzf.1105

3 Establishing a Parenting Program for Fathers in Substance Abuse Treatment.

3.1 Fathers in Substance Abuse Treatment Systems

There is growing appreciation, supported by research, of the contribution of fathers in the lives of families. Fathers can have a positive impact on the developmental outcomes of children in emotional, behavioural and social cognitive ways that are unique to this relationship (Lamb, 2010; Phares, Lopez, Fields, Kamboukos, & Duhig, 2005) and they can be a valuable source of emotional support for partners. In recent decades, an increase in proportion of mothers in paid employment from 55% in 1991 to 65% in 2011 (Australian Institute of Family Studies, 2013) has influenced societal perceptions of the role of fathers. A broader, more inclusive perspective recognises their involvement in different aspects of parenting that is not limited to financial provider, but also includes equally significant roles in developing children's attachment and play experience (Bogels & Phares, 2008).

One complex and underrepresented group in research and interventions are fathers with substance abuse disorders receiving treatment in residential settings. A significant proportion of men in treatment for substance abuse disorders are fathers. In a study of men and women entering drug treatment, 74% of males indicated they had children under 18, although fewer than half indicated they were living with their children (Twomey, 2007). Parental substance misuse represents a significant risk factor for child abuse and neglect (Guterman & Lee, 2005), yet parenting in substance-abusing men is an area that is poorly understood and rarely acknowledged. Fathers entering treatment for substance abuse report high levels of parenting stress and recognise a need to access help with parenting (McMahon, Winkel, Suchman, & Rounsaville, 2007; Stover, Hall, McMahon, & Easton, 2012).

3.2 What Efforts Have Been Made to Help Substance-abusing Fathers?

A number of previous parenting programs have been developed as adjuncts to substance abuse treatment. Studies of parenting programs for parents in substance abuse treatment primarily involve mothers with young children recruited from various outpatient community settings (Suchman, Mayes, Conti, Slade, & Rounsaville, 2004). Very few interventions targeting substance-abusing parents receiving treatment in residential settings have been systematically evaluated, and the few that have been evaluated are based on mothers (Knight, Bartholomew, & Simpson, 2007).

Most interventions involving substance abusing parents adopt cognitive behavioural and psychoeducational approaches with principles informed by Social Learning theory (Kumpfer, Alvarado, & Whiteside, 2003; Webster-Stratton & Taylor, 2001; Suchman, Pajulo, DeCoste, & Mayes, 2006). The role of parents in modelling behaviour and falling into *reinforcement traps*, during which children's negative behaviour is inadvertently reinforced by parents, form the central themes. Based on these philosophies, these parenting programs have reported improvements in parenting skills that are thought to influence children's behavioural adjustment. For example, in one study involving 18 families, fathers were observed to have increased their use of praise and recognition of good behaviour following completion of the program (Orte, Touza, Ballester, & March, 2008). Catalano et al. (1999) found that parents reported more rules had been defined in the household from 6 month follow-up to 12 month follow-up. However, program effects in these substance abusing parent samples are compromised by low retention rates. A study in an outpatient setting, found participants attended on average only 38% of sessions (Huebner, 2002), whilst another study that combined both home visitation and outpatient groups reported 51% of participants in the intervention group attended only half of the sessions (Catalano, 1999). Behaviourally

based approaches implemented in residential programs have had similar problems with small sample sizes and high drop out rates (e.g., Knight et al., 2007).

Meta-analyses have been conducted on behavioural parent training programs in populations evaluated to be at risk for child abuse (e.g. Kaminski, Valle, Filene & Boyle, 2008; Lundahl, Nimer and Parson, 2006). A meta-analysis of 77 parenting programs aimed at children between 0-7 years old found significant effects for program components of, encouraging positive interactions with their child, emotional communication, and practicing with their child (Kaminski et al., 2008). Since these programs were focused on change in child behaviour problems and parenting behavioural skills, the impact on the parent-child relationship was not reported.

Attachment based interventions that aim to improve relationship interactions are relatively new in the substance abuse treatment field. These interventions primarily focus on women with young children, and they are showing promising results. Suchman et al. (2010) reported improved reflective functioning and sensitivity in substance abusing mothers following completion of their program using videotaped play sessions involving mother-child dyads. In contrast to most other studies using behavioural and cognitive approaches, the completion rate was relatively high (72%) and feasability and adaptability to the service was reported as a strength of the program. Such interventions have not been evaluated on fathers, and so it is not known how these programs might translate for this group. However, substance-abusing parents often present with experiences of impoverished attachments (Ford, 2008). There is a significant risk of intergenerational transmission of insecure attachment, so it is important to address these underlying unmet emotional needs in fathers as well as mothers. In their review of attachment-based interventions, Egeland and colleagues (2000) suggest that high risk populations are more likely to show improvements in their parenting

relationships when programs are offered as part of a comprehensive treatment addressing other psychosocial problems (e.g., drug addiction).

Fathers have been included in 'Family-based' parenting outpatient programs that use a combination of parent and family sessions (Dawe & Harnett, 2007; Lam, Fals-Stewart, & Kelley, 2009; Orte, Touza, Ballester, & March, 2008; Templeton, 2014). In order to control research conditions, eligibility criteria in these studies were narrow, limiting their generalizability to clinical populations. In one study, 29% of parents entering outpatient treatment were excluded from participating because they met one or more of the exclusion criteria (Lam et al., 2009). For example, only one parent in the family was permitted to meet diagnoses for alcohol abuse or dependence in order to be eligible. Similarly, parents with a severe drug dependency and existence of "unstable mental symptomology" (p.254) were excluded (Orte et al., 2008). Such exclusion criteria are limiting factors and decrease generalisability since those seeking treatment for substance use disorders typically have high rates of complex mental health issues (McMahon & Rounsaville, 2002; Stover et al., 2012).

One prominent co morbid mental disorder in substance abusing populations is Post-Traumatic Stress Disorder (PTSD). PTSD occurs frequently with substance abuse disorders and is associated with increased severity of other psychiatric problems (Peirce, Kindbom, Waesche, Yuscavage, & Brooner, 2008). In a sample of treatment-seeking men, 48% reported a history of a traumatic life event. Additionally, fathers who reported a higher level of PTSD symptoms were more likely to indicate they wanted help with their parenting, and reported higher rates of parenting difficulties (Stover et al., 2012). Many substance-abusing parents have *Complex Trauma*, described by van der Kolk (2005) as cumulative, chronic, developmentally adverse experiences of trauma in an attachment relationship. In research of mothers with a history of substance abuse problems, a background of childhood maltreatment indirectly predicted lower parental self-efficacy through the mediating effects of attachment

anxiety and maternal depression. Anxious attachment was associated with the mother's own history of childhood maltreatment r (74) = .43 p < .01. Maternal depression was related to parental self-efficacy r (74) = .37 p < .01. Childhood maltreatment was found to be associated with depression r (74) = .48, p < .01(Caldwell, Shaver, Li, & Minzenberg, 2011). This suggests that mothers who felt less competent in their abilities to parent, had a higher risk of having a history of childhood maltreatment and feeling less secure in their relationships and higher risk of feeling more depressed. Despite a growing literature that supports the importance of developing balanced interventions in response to these co-occurring problems (Amaro, Chernoff, Brown, Arvalo, & Gatz, 2007; Stover et al., 2012), many treatment services address substance abuse in isolation from other co-occuring psychological difficulties. This limits the ability of the staff to appreciate the interplay between disorders (Dass-Brailsford & Myrick, 2010).

In summary, traditional parenting programs that focus on improving parenting skills using social learning and behavioural principles dominate interventions in this area and have been predominately tested with substance abusing women with young children. These interventions have had limited success since they are often characterised by low participant retention. High treatment dropout rates have been attributed to the complex nature of the client group with those with co-occurring disorders at greater risk for drop out (Ross, Dermatis, Levounis, & Galanter, 2003). A review of parenting interventions for substance abusing parents, suggested that there might be limited research that systematically evaluates programs in this population because of the "logistical problems of studying a clinical population that often engages in chaotic and unstable lifestyle", (Suchman, Pajulo, DeCoste & Mayes, 2006, p.212). In particular, the evidence suggests that training in behaviour management is effective but there is a need for interventions that also work with the effects of

trauma and attachment problems. The development of a brief, intensive program, which can be delivered in a residential setting, may be less vulnerable to participation difficulties.

3.3 How Can Systemic Thinking Help?

The value of a systemic approach is that it provides a conceptual map, which allows the clinician to focus on any feedback loop, in any part of the system, whether it involves an internal process within the individual or an interaction *between* individuals. The parental subsystem is affected by interactions occurring in different settings and this contributes to the complexity of parenting relationships (Friedman & Neumen, 2010). Patterns of interaction between individual relationships are governed by 'feedback loops' (Bertalanffy, 1972) that generate information guiding parenting behaviour, which are circular rather than linear. Although behavioural and cognitive behavioural principles recognise feedback loops are present and environmental context is important, in practice they tend to emphasise smaller behavioural units of analysis and linear sequences. This emphasis may limit their ability to capture the complex needs of substance abusing parents and the wider system within which they are embedded (Suchman et. al., 2006). An implicit premise of many CBT parent training programs seems to be that parents are the primary influence on the child and by modifying parent's skills desirable changes to the child's functioning will follow. Such a linear view assumes that parenting behaviour has a cause and effect relationship and tends to focus on what parents do *to* their children. Instead, it is important to understand what influences there are on the parents' own behaviours, - WHY do they do what they do? Although behavioural theory has the ability to account for wider historical and environmental influences on the parental relationship, in practice treatments tend to focus much more on immediate or current behaviours and interactions. System thinking seeks to impact on vicious cycles in different domains within individuals, between individuals and between an individual and larger system like the wider treatment system.

3.3.1 Emotional Themes and Issues for Fathers

In considering WHY parents do what they do, it can be helpful to consider emotional themes. Emotional themes are internal processes where a previous experience triggers a specific emotional/behavioural/cognitive response within an individual that can influence parenting responses. These internal processes might be recurring beliefs and affective triggers. As therapists, a useful question to reflect on is: What recurring emotional themes may affect the reactions of fathers attending a group-parenting program? The majority of programs available for this population presently fail to include material aimed at increasing awareness of the complex systemic impacts of trauma and attachment problems on parents and their children, and what factors promote repair in relationships. Given the high proportion of substance abusing fathers that have experienced traumatic events, parenting stress and relationship problems, acknowledging the influence of these factors on parental change is important and potentially plays a powerful role in their parenting responses. As stated previously, attachment difficulties and a lack of safety (both past and present) are also likely to play a large role in influencing the interpersonal patterns played out within the therapeutic group.

Self-efficacy or competence is a central emotional theme that has been linked to overall sense of well-being of Australian fathers (Seymour, Dunning, Cooklin & Giallo, 2014). Parents who report low parental self-efficacy tend to engage in ineffective parenting behaviour (Coleman & Karraker, 2003; Jones & Prinz, 2005). Substance abusing fathers are also likely to be afflicted by guilt and shame that accompany perceptions of being unable to fulfil their parenting role (Mcmahon, Luthar & Rounsaville, 2001). Without understanding the role of these emotional and cognitive processes, interventions may inadvertently reinforce similar unhelpful patterns, rather than assisting in their transformation. Breunlin and Schwartz (1986) suggest clinicians seek to identify the complex network of interconnected

sequences that constitute interactions in order to understand the contextual meaning and emotional experience behind behaviour. By reflecting on parenting behaviour in this way, interventions are likely to get closer to breaking patterns that interfere with change.

3.3.2 Factors for Therapists

The influence of therapeutic factors (e.g. therapist expertise, group processes) on mechanisms of change are less easily captured and tend to be underemphasised in evaluations of group parenting programs despite evidence linking therapist skill to improved client and child behaviour outcome (Scott, Carby, & Rendu, 2008). For example, distrust of the counsellor is commonplace in the course of substance abuse treatment, particularly for clients who have experienced trauma. The therapeutic alliance is also likely to be affected by the treatment ambivalence that is often present in this population (Hagedorn, 2011). Since 'complex trauma' occurs within relationships, there is an increased likelihood that these clients could have emotional reactions triggered by the therapeutic relationship. Thus, attempting to develop parenting skills before a safe therapeutic alliance has been established may be ineffective. Indeed it may even be counterproductive. When parents are unsuccessful in applying the skills they have been taught by 'expert' facilitators there are potential risks of further reinforcing feelings of inadequacy in their parenting role. When negative emotional experiences are triggered, these may result in clients utilising defensive mechanisms, which could contribute to poor treatment engagement. Higher self-criticism in clients' has been found to correlate with greater difficulties in establishing and maintaining a therapeutic alliance (Whelton, Paulson, & Marusiak, 2007). Awareness, attunement to moment-to-moment processes and the application of creative solutions to problems reflect a set of highly developed practitioner skills that can help to shift parents who are struggling with change (Scott & Dadds, 2009). For example, without recognising and addressing recurring beliefs

and underlying emotions that guide behaviour, parents are likely to struggle to apply the knowledge and behaviour management skills they have learned in parent training programs. Tomm (1987) suggested that, "listeners hear and experience only that which they are capable of hearing and experiencing (by virtue of their history, emotional state, presuppositions, preferences and so on)" (p.5). Thus, core components of parent training programs, such as psychoeducation, are only as useful as a client's capacity to receive it and the clinician's sensitivity to this dynamic process.

Adult survivors of complex trauma are particularly vulnerable to the use of avoidance strategies for self-protection and these strategies can be misconstrued as *resistance* to therapy behaviours (Briere, 2002). Resistance can present as missing sessions, a lack of participation or getting stuck in talking about problems. Group alliances and cliques may form in an attempt to shift or share the distress. Briere (2002) notes that, "overly enthusiastic or heavy handed attempts by a therapist to remove such resistance may be seen as potential threats to the client's equilibrium" (p. 10). A task for the therapist is to be able to recognise these protective responses and to respond non-reactively, in a way that validates the client's emotional experience. Group process may need to be prioritised at the expense of moving forward with the session content, to reduce the risk of overwhelming clients with anxiety and further impeding therapeutic progress.

3.3.3 Engaging the Wider System

Theories and research on treatment in mental health care have evolved from assuming that change occurs linearly to considering the impact of social systems and dynamic processes (Gotham, 2004). Contextual factors in a complex system can influence the efficacy of parenting programs, yet adaptability and feasibility concerns of the wider system are rarely

documented in published studies. Organisational policies and barriers, supervisor and clinician practices and competing clinical priorities affect implementation and fidelity of substance abuse treatment approaches (Herbeck, Hser, & Teruya, 2008). Following a study of dissemination barriers, it was reported that clinicians were unlikely to promote interventions involving other family members when they held the belief that substance abuse is an individual problem that should be addressed by the addict (Fals-Stewart & Logsdon, 2004). Social reinforcement from peers and team leaders as well as organisational expectations also play a role in influencing attitudes towards treatment selection. For example, clinician's intentions to engage in Evidence Based Practice in residential substance abuse treatment settings has been found to be influenced by what they perceived others within their organisation approved of and were applying in their practice (Kelly, Deane & Lovett, 2012). These issues highlight the need to consider the feasibility and adaptability of treatment programs against the professional culture, theoretical orientation of clinicians and organisational constraints of the system. Therefore, a parenting program is likely to be more effective if the time and care are taken to include the staff and management of the treatment facility and to ensure they understand the assumptions and values underlying the program.

There is a need to develop parenting programs that suit specific groups rather than adopting a *one size fits all* approach (Scott & Dadds, 2009). In applying systems theory to the assessment of problems, Germain (1991) explains that relationships within systems are transactional "reciprocal exchanges between entities, or between their elements, in which each changes or otherwise influences the other over time" (p.16). Applying a systemic perspective based on family systems models (e.g., Milan Family Therapy) supports the evolution from a narrow understanding of substance abuse as individual pathology to a view of substance use symptoms as a "solution (of sorts)" to a variety of challenges faced by the system (Reiter & Green, 2013).

3.4 Beginnings of a Parenting Program - Laying the Foundation for Fathers

As a first step we have proposed a framework for a parenting program that is currently in development and implementation in substance abuse services. The suggested parenting program is theoretically guided by research reviewed in this article, systemic thinking and experience as family-oriented clinicians in delivering attachment and trauma focused parenting programs.

3.4.1 Create Opportunities for Dialogue with Residential Treatment Staff.

As researchers, how do we avoid the problem of observing the residential system *from the outside* instead of shifting our perspective by recognising our role in the system? Researchers can demonstrate an interest in understanding the needs and concerns of the system by creating opportunities to interact with individuals at multiple levels (e.g. client, counsellor, management, administration). Such seemingly informal channels of exchanging information within the system has been recognised as one of the most effective ways of learning about new practices within substance abuse services (Erikson-Pritchard, 1999). It is important the flow of information works both ways and avoids the sorts of demarcation disputes where each party attempts to be seen as the *expert.* The *special skills and knowledges* (White, 2003) of the staff need to be privileged, just as those of the client are, although not necessarily above those of any other stakeholder. In line with the collaborative traditions, no one person's views are taken as absolute truth, rather how the staff experience the client and how the client experiences the staff are all equally valid stories and given due consideration by the clinician when running the group.

3.4.2 Increasing Safety and Improving Reflection. A Staged Model of Intervention

We propose that a more focused *scaffolding* intervention with fewer sessions over a briefer period of time may improve *goodness of fit* with both the treatment expectations of the service as well as the psychological needs of substance abusing parents. The concept of

scaffolding has become synonymous in the literature with the sociocultural theory of the zone of proximal development (ZPD). Vygotsky (1978, p. 86) defined this as, "the distance between the actual developmental level as determined by independent problem solving and the level of potential development as determined through problem solving under adult guidance, or in collaboration with more capable peers." Scaffolding describes a process of learning that is based on co-construction of knowledge (Wells, 1999). The role of the therapist is as collaborator and co-constructor.

3.4.3 What are the Aims of the Intervention?

The aim of the program is to increase awareness of complex trauma and attachment issues, improve the quality of parent-child relationships, as well as improving parenting self-efficacy which we hypothesise will lead to caregivers feeling more confident in continuing to seek further support with parenting. The metaphor of *scaffolding* is used to capture the nature of supporting and preparing fathers for intensive parenting programs by providing the foundations of parenting. This is provided in a context where the fathers have a background of complex trauma that is likely to have interfered with their ability to develop the attachment relationships that are necessary for healthy parenting. Following completion of this program, it was hypothesised that parents will feel more prepared for intensive behavioural parenting programs, which typically include components that teach parenting skills to improve their abilities to set limits and manage behaviour. Increasing parental self-efficacy is important for substance abusing fathers who have experienced trauma, since traumatic experiences in childhood and adulthood have been linked to low parental self-efficacy and negative perceptions of oneself as a parent (Caldwell et. al, 2011). When faced with multiple stressors, parents with low self-efficacy are more likely to give up on engaging in positive actions because they become emotionally overwhelmed (Ardelt & Eccles, 2001).

A scaffolding parenting program carries potential benefits for several reasons. Firstly, a shorter intervention may be more adaptable within the constraints of residential treatment settings. Maintaining abstinence is the focus of substance abuse residential treatment settings. There are other competing priorities, such as compulsory attendance in recovery groups and medical appointments. Secondly, a scaffolding intervention allows sufficient time to establish emotional safety in the therapeutic relationship, a challenge in this population. This is important because complex trauma can have an adverse impact on affective self-regulatory capacities and associated skills in effective interpersonal behaviours (Shipman, Edwards, Brown, Swisher, & Jennings, 2005; Shipman, Zeman, Penza, & Champion, 2000). Schore and Schore (2008) described this as 'being with' the client during moments that are affectively stressful to help parents to regulate affect and monitor their internal states more effectively. Finally, an intervention that is sensitive to the influence of co-occurring trauma and parenting stress may help increase retention in treatment by addressing symptoms that would otherwise exacerbate other problems.

In the proposed scaffolding intervention, the idea is to focus on reaching the first two goals of The Alternate Care Clinic (ACC) model (Sng, 2009). ACC is a service for children in out-of-home care who experience severe emotional, behavioural and relational difficulties as an outcome of trauma. They provide long-term therapeutic support to foster families. Their principles involve; working systemically, with an attachment focus, and with an interest in "meaning making in the residential care system" (p. 253, Sng, 2009). These principles are synonymous with the intentions of the proposed intervention. The ACC provides a framework for conceptualising three classes of therapeutic goals. It begins with increasing emotional and physical safety as a prerequisite before improving reflection and finally, increasing functioning by building skills. Each goal and its position in the hierarchy are consistent with trauma-focused interventions for adults that emphasise the balance between

safety and containment as well as processing trauma (Courtois, 2008). Briere (2002) proposed that effective psychotherapy occurs in the context of a 'therapeutic window', which highlights the importance of timing interventions to motivate without overwhelming the client or causing them to activate their internal protective systems. The ACC model reinforces the unique course of treatment for each participant. The model allows for back and forth movement between the three stages as treatment progresses and also on a micro-level, for example in a single session.

Given the target group are fathers in residential treatment for substance abuse, the 'Increasing Safety' component of the intervention can be achieved by leveraging the strengths of the residential setting as a supportive environment. Residential treatment settings generally provide an environment of safety in terms of accessibility to medical care, counselling support and assistance with daily living as well an environment where access to substances of abuse is limited and prohibited. There is also a culture of witnessing the recovery of others and reducing isolation and this sense of community is usually strengthened the longer residents remain in treatment. After potentially challenging and emotionally intense parenting group sessions, the structure of the rehabilitation program provides much needed support for clients. The groundwork mentioned previously in including the staff of the facility in the treatment is central to this process. Additionally, the facilitator of the group has a central role in ensuring the level of group arousal remains in the *therapeutic window* for increasing parental reflection about the role of trauma and attachment in parenting.

Increasing Reflection is a crucial step in the development of parenting skills of attunement and sensitivity since reflective functioning is compromised by parent's experiences of invalidating caregiving relationships (Slade, 2005). Increasing caregiver insight into traumatic symptoms and its effects on children and building a strong attachment

foundation must be addressed *before Increasing Functioning* by teaching parents skills (e.g. behaviour management through rewards and limit setting).

3.5 Parenting Program for Fathers – What is Included?

3.5.1 Element One – Black Box Parenting

The first component of this program is a psychotherapeutic group, combining didactic teaching and interactive discussion and exercises, usually with 6-8 participants over three sessions. Group psychotherapy research has demonstrated that group formats encourage a shared learning experience, instils hope, and develops skills through modelling, relief from emotional distress and imparting knowledge (Montgomery, 2002; Yalom & Leszcz, 2005). A non-blaming environment is important, in which a balance is held between encouraging responsibility and acknowledging the limited use of feelings of guilt. To assist with this, the *"Black Box Parenting Program* includes the introduction of Crittenden's concept of *attachment strategies* (Crittenden, 2006) as well as the research on the consequences of trauma (e.g. Perry et al., 1995; van der Kolk, 2005, 2003). It uses the metaphor of a *black box* to explain some of the complex schemata and interpretive biases that parents build up through experiences of trauma and attachment disruption. It focuses not on the contents of the *black box* (that is the experiences per se) but rather the process surrounding it (that is, the effects of the experiences in the here and now). Figure 2 represents an example used to illustrate to the parent the interaction of miscuing and misinterpretation which can lead to many of the difficult interactions with their children. In line with the work of Tomm (1992) it seeks to separate the *intent* of the parent from the *effect* of the parent. In this case, the parent is feeling anxious and *intends* to ask for space from the emotional intensity of the child-parent relationship, however this message is distorted by the parent's *black box* and comes out as

"Go away". The child has their own developing *black box* which in turn interprets this message. The resultant message of rejection and worthlessness is not only heard by the child in the present but contributes to the development of their own *black box* in the future.

The metaphor is simply designed as a tool to discuss the difficulties of parenting in this context without having to re-trigger trauma or feelings of overwhelming grief, loss and guilt. Therefore, it is left up to the parent how much they choose to reveal in the group about the exact contents of their *black box*. Rather, the focus is on the repercussions of the previous experiences on parenting in the present. It is intended to provide a non-blaming picture of the unique challenges of fathers in these situations and seeks to illustrate that each family member is acting in a way that is logical from their own point of view – although it may seem bewildering from the outside if the *black boxes* are not taken into account.

The purpose of the metaphor is to increase the father's capacity to reflect on his own meaning-making process, particularly as it relates to the experiences of trauma and attachment disruption. The metaphor definitely allows for other contributors to the *black box*, for example social constructivist concepts regarding issues such as gender. However, the first introduction speaks only of the contribution of trauma and attachment, for simplicity's sake. It also seeks to encourage the process of mentalization (Fonagy, Gergeley, Jurist & Target, 2002) with regards to their child's experience and the messages they are hearing and to which they are consequently reacting.

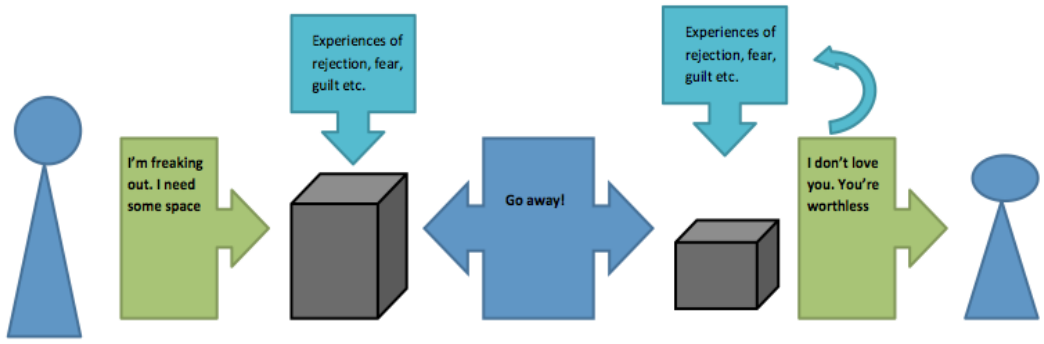

Figure 2 - Black Box Parenting model

3.5.2 Element Two - Father-Child Play Sessions

The second component involves four private parent-child play sessions as an adjunct to the group sessions, involving a clinician, the father and one of their children. Parent and child play sessions can be adapted to suit the needs of the dyad. Consistent with the objectives of intensive attachment-based therapeutic models such as *Mothers and Toddlers Program* (Cohen et. al. 1999) and *Watch, Wait and Wonder* (Suchman et. al, 2006), the aim is to improve the quality of father-child relationship by using play as a technique to bring the child's needs to the parent's attention. To support the father's experience, the father participates in play sessions with the clinician observing and providing feedback about each interaction based on behaviours such as parental responsiveness (e.g. attending to what the child is doing and following their play) and encouragement (e.g. showing enthusiasm, praise). These strategies of observing and *coaching* are drawn from existing evidence-based practices such as Parent Child Interaction Therapy (Callahan, Stevens, & Eyberg, 2010) and Parenting Interactions with Children Checklist Linked to Observations (PICCOLO; Roggman, Cook, Innocenti, Norman, & Christiansen, 2013). These models use 'child led play' to increase a parent's reflective listening, and pro-social verbalizations. Research on fathers have found that paternal displays of warmth, positive affect and sensitivity during play predicts parent-

infant attachment security (Edwards, Eiden, & Leonard, 2004; Eiden, 2002; van IJzendoorn & De Wolf, 1997).

3.6 Conclusion

In this paper we describe the needs of fathers in substance abuse treatment. These fathers are being increasingly recognised as important in lives of families but continue to receive limited parenting help. Systems theory offers a way of enabling us to understand substance-abusing parents' complex interactions in larger social context. This challenges us as researchers and clinicians to be more reflective with our interventions and in particular to consider the impact of our role within the system. Although behavioural parenting programs have demonstrated some success in helping parents implement behaviour management strategies there has been less research showing improvements in the quality of the parent child relationship. Including an attachment and trauma lens adds to our understanding of parenting behaviour within a historical context, specifically addressing factors that can confound fathers' capacity to connect with their children.

In summary, we suggest the following practice considerations for practitioners and organisations working with fathers in substance abuse residential treatment settings.

- Reflect on the expectations and feelings, which underlie the parenting behaviours of fathers. For example recognising the role of grief, guilt and shame. The *Black Box* metaphor might provide a way of communicating this to clients.
- Demonstrate empathy by acknowledging the influence of trauma and attachment on parent's self-efficacy, assumptions and parenting values.
- Develop clinical knowledge to understand the wider picture and patterns occurring in systems

- Develop skills in facilitation to better respond to group processes. For example, recognising opportunities for learning by keeping sessions within the *therapeutic window* of arousal.

Chapter 4

As described in Chapter 3, The *Black Box Parenting Program* has been developed specifically in response to the needs and challenges of substance abusing fathers in residential treatment. It was designed based on the literature review on the effects of complex trauma on parent and child relationships of substance abusing parents and the findings from Study One. Study One linked trauma symptoms and attachment anxiety to parental self efficacy. Finally, the *Black Box Parenting Program* utilises a systemic therapeutic model to address some of the complexities of treatment in this context. The *Black Box Parenting Program* is a brief, trauma and attachment informed parenting intervention with the following objectives: Developing caregiver self-efficacy, improving caregiver's self-perception; strengthening parent and child relationship and to promote readiness to access further help with parenting.

Chapter 4 describes the results of a feasibility study, which endeavours to implement this parenting program for fathers in three substance abuse residential treatment sites run by non-government organizations in NSW. Demand, implementation, integration, preliminary efficacy and acceptability of the program were explored through qualitative interviews with participants, feedback from staff and quantitative measures pre and post intervention.

4 Black Box Parenting Program for Substance Abusing Fathers: A Feasibility Study

4.1 Introduction

Substance abusing fathers report high levels of parenting stress related to concerns about their relationship with their children, poorer appraisal of self as a father and less satisfaction in their parenting role (McMahon, Suchman & Rousanville, 2007; Stover, Hall, McMahon, & Easton, 2012). Without the provision of parenting support, there is increased risk of harm to children as substance abusing men continue to father under difficult circumstances (McMahon & Rounsaville, 2002). Studies have identified father's absence and single motherhood as factors contributing to risk of physical abuse and neglect of children (Berger, 2004; Guterman & Lee, 2005). Even in situations where substance abusing fathers continue to have regular contact with their children, there are serious threats to children's development and health and intergenerational transmission of drug and alcohol abuse (Phares, 1996). Substance abusing fathers can also indirectly impact on the parenting capacity of mothers through mechanisms such as loss of income and lack of partner social support (Berridge, 2002). Other harmful influences on the family system include disruptions to family rituals and family conflict (Arria, Mericle, Meyers, & Winters, 2012).

Most research relating to parental substance abuse focuses on parenting deficits and maladjustment of children rather than protective factors and the positive role that fathers can serve. There is evidence that many fathers make an effort to be present in the lives of their children and understand the importance of their parenting responsibilities. In a study of 116 men receiving methadone maintenance treatment, fathers had on average been seeing their child several times weekly to daily during the period of greatest involvement (McMahon, Winkel, Suchman, & Rounsaville, 2007). Substance abusing fathers want parenting interventions to address issues related to fatherhood (Fals-Stewart & O'Farrell, 2003; Stover et al. 2012). Söderström and Skårderud (2013) found that fathers in residential rehabilitation

treatment programs wanted to be more attentive, supportive and closer to their child. However, they often feel they are a low priority compared to mothers who are predominantly the focus of policy, practice and interventions in the substance abuse area. The authors concluded with a call for interventions that include the fathering role of men (Soderstrom & Skarderud, 2013), this call is consistent with others who have highlighted the important role of these fathers (McMahon, Winkel, Suchman & Rounsaville, 2007; Mcmahon, Winkel, Luthar & Rounsaville, 2005; Mcmahon & Rounsaville, 2002; Stover, Hall, McMahon & Easton, 2012).

There is a need to develop parenting programs that encourage fathers' involvement. A meta-analysis of 26 studies showed parent training that included fathers, compared with those that did not, reported significantly more positive changes in children's behaviour and desirable parenting practices (Lundahl, Tollefson, Risser, & Lovejoy, 2008). However, these studies were not specific to fathers who have alcohol and other drug addictions. Lee, Bellarmy and Gutterman (2009) argue that there is a dearth of knowledge about the challenges to fathering amongst this group and best practices in engaging them in parent interventions.

Research suggests that adverse child outcomes are not associated specifically with parental drug use as a single risk factor but rather the complex interplay between concurrent problems including substance abuse, psychosocial stressors, deficits in parenting skills and knowledge, decreased pleasure from the parenting role and co-morbid mental health problems that compromise their ability to care for their children (Neger & Prinz, 2015). Post Traumatic Stress Disorder (PTSD) has also been identified as a significant contributor to ongoing psychological distress, and increased risk for continued substance abuse in fathers (Dass-Brailford & Myrick, 2010; Haller & Chassin, 2013; Stover et al, 2012). A study of 126 men presenting for substance abuse evaluation at a forensic drug diversion clinic, found

PTSD symptoms were associated with hostile-aggressive and neglectful parenting (Stover et al., 2012). Fathers who have experienced childhood trauma as an outcome of abusive parenting are extremely vulnerable and present with complex posttraumatic symptomology (Schore, 2009). Developmental histories of substance abusing parents are also often characterised by poor attachment relationships (Ford, 2008; Najavitz, 2009). Typically these traumatized fathers are raised in conditions of suboptimal care and likely lacked attentive, nurturing and sensitive role models to support their identity as fathers. Hence interventions should address these complex relational factors that are likely to impact on the experience of fatherhood to promote a safe relationship for their child.

Interventions that work on increasing the awareness of the effects of trauma and attachment problems in the context of substance abusing populations are limited. Neger and Prinz (2015) reviewed 21 outcome studies that treated for both substance abuse and parenting problems. Overall, positive outcomes were reported with respect to reducing parental substance abuse and improving parenting skills. However, 17 of those studies included only mothers. The majority of the programs focused on improving parenting skills using social learning and behavioural principles, increasing psychosocial resources of parents and education about early child development. Attachment based parenting programs have been trialled on substance abusing mothers in outpatient and inpatient settings and are showing promising results in enhancing capacity for reflective functioning (Berlin, Shanahan & Carmody, 2014; Suchman, DeCoste, Mcmahon, Rounsaville, & Mayes, 2011). Reflective functioning is the capacity to mentalize self or the other and captures an individual's ability to understand feelings, thoughts and needs, making sense of one's own and others' actions (Fonagy, Gergely, Jurist & Target, 2002; Slade, 2008). Attachment researchers support the notion that this metacognitive capacity for reflective functioning is an important component

for developing parental sensitivity to children's emotional cues and recognise their needs (Crittenden, Lang, Claussen, & Partridge, 2003; Hautamäki, 2010; Howard, 2010).

Before targeting behaviour management skills, parenting interventions may need to strengthen the parent and child relationship first. This includes increasing parent's understanding about how past experience impacts on the way they experience the relationships. Research has also shown that parents who are able to process their attachment experience coherently and value attachment tend to have children with secure attachment (Van Ijzendoorn, 1995). Neuroimaging studies have found that an attuned attachment relationship allows reparative development in a child's ability to accomplish a range of psychological tasks, such as: regulate emotion, respond flexibly, and feel empathy (Siegel, 2001). It could be suggested that providing an intervention that targets the particular challenges faced by fathers with substance abuse issues may be a means by which to attract and retain these parents in most need of support. This is particularly important for fathers who are often difficult to engage within parenting programs, with drop out rates as high as 40-60% being reported (Baker, Arnold, & Meagher, 2011).

In light of the research reported above, we developed the *Black Box Parenting Program*, a trauma and attachment informed intervention specifically for substance abusing fathers receiving treatment in a residential setting (Torres, Sng, & Deane, 2015). By its use as an adjunct to the treatment that residential services offer, the *Black Box Parenting Program* simultaneously addresses parenting needs in a safe and supportive environment. McCormish et al. (2003) found that compared with non-participants, parents who attended parenting training in addition to the substance abuse treatment had longer mean stays in residential facilities. The *Black Box Parenting Program* is a focused *scaffolding* intervention designed to be adaptable within the constraints of the residential setting and to the psychological needs of substance abusing fathers. The *Black Box Parenting Program* intervention comprises two

major parts. Part A involves three group sessions with fathers. Part B includes three individual play sessions with the father and child dyad. For more detail about the program refer to Torres et al. (2015). One of the key features of the program is that it aims to increase their parental self-efficacy, which in turn is predicted to increase readiness, interest and desire to participate in further parenting training. Parental self-efficacy is defined as the parent's belief in their ability to effectively support and manage the development and success of their child (Ardelt & Eccles, 2001). Since traumatic experiences in childhood and adulthood have been associated with low parental self-efficacy and negative perceptions of oneself as a parent, increasing parental self-efficacy is important for substance abusing parents (Caldwell et al., 2011). A relationship has been found between satisfaction and sense of efficacy in a parent's perceived ability to parent (Coleman and Karraker, 1998). It is difficult for a parent who lacks feeling of competency in his/her parenting role to feel satisfied as a parent and, conversely, it is difficult to work towards competency when a parent lacks satisfaction in their role. It was hypothesised that by increasing awareness of complex trauma and attachment issues and improving the quality of the parent child relationship through this program, there will be improvements in parenting self-efficacy, satisfaction and motivation to access further parenting support.

Feasibility studies are designed to provide data to determine if and how interventions can be implemented and are often used to inform larger randomized controlled trials (Eldridge et al., 2016). Bowen et al. (2009) proposed eight general areas of focus addressed by feasibility studies: Acceptability, demand, implementation, practicality, adaptation, integration, expansion and limited-efficacy testing. In this paper we report on the feasibility trial of a parenting program for fathers in residential substance abuse treatment settings in the community can be shaped to be relevant and sustainable. The elements of feasibility we are assessing include:

1. Demand: Demand for the intervention by gathering data on the proportion of fathers recruited and then retained at multiple residential substance abuse treatment sites.
2. Implementation: The extent to which both parts (A and B) of the parenting program can be implemented by an external group facilitator using the existing facilities on each residential site.
3. Integration: The extent to which the parenting program is perceived as fitting with substance abuse residential service goals and culture
4. Preliminary efficacy: Explore the efficacy of the parenting program by measuring any potential shifts in parenting satisfaction, parenting self-efficacy and closeness in the parent child relationship
5. Acceptability: Perceived acceptability and satisfaction with the parenting program by gathering post group feedback. A mixed method analysis will be used to understand the impact of the intervention on fathers' views of their parenting and motivation to engage in further parenting help as an outcome of participating in the intervention.

4.2 Method

4.2.1 Participants and Recruitment

Participants were fathers (n= 19) in substance abuse residential treatment services. Across NSW, 8 residential substance abuse treatment services from the non-government sector were offered the program to be delivered at their site. Fathers were recruited from three residential treatment facilities all operated by different service providers. Two of the facilities provided secure, apartment style units for men and women. The third facility serviced only men. All fathers enrolled in inpatient substance abuse treatment and caring for at least one child 12 years old and under were invited to participate. Those with a child under 6 years of age could participate in dyadic play sessions. Each group allowed for up to 10 participants.

Eligible fathers were informed about this study during group meetings or in discussions with their caseworker. Fathers were voluntarily enrolled. Ethical approval for the study was gained from The University Human Research Ethics Committee. A mixed method design was employed.

4.2.2 The Black Box Parenting Program Intervention and Treatment Fidelity

Part A of The *Black Box Parenting Program* consists of three modules delivered over sessions of 1.5 hours in duration, combining didactic teaching; interactive discussion and role play exercises on *special play* techniques. A metaphor of a *black box* is used throughout the program to explain some of the complex schemata and interpretive biases that parents build up through experiences of trauma and attachment disruption (see Torres et al., 2015 for more detailed description). One of the complex roles of the group facilitator was to balance encouraging responsibility with acknowledging the limited use of feelings of guilt and shame. Feelings of guilt can motivate an individual to work towards change and reparation (Baumeister, Stillwell, & Heatherton, 1995). Rather than deflecting blame on external situations or other people, guilt prone individuals are inclined to take some responsibility for their actions (Tangney, Wagner, Fletcher, & Gramzow, 1992). However, excessive guilt can be a barrier to action and propensity to experience shame and guilt has been consistently linked to substance dependence, PTSD, anxiety, depression, low self-esteem and family violence (Ashby et al. 2006; Dearing, Harper, & Arias 2004; Stuewig, & Tangney, 2005). To assist with this, session plans were founded on recent advances in theory and research in the area of child development, *attachment strategies* (Crittenden, 2006) and consequences of trauma (e.g. Perry, Pollard, Blackely, & Vigilante, 1995; Courtois, 2008; van der Kolk, 2003, 2005), with each week having the following themes:

Session 1: The Importance of Predictability.

Session 2: Building a Relationship Foundation and Special Play.

Session 3: Relationship Repair and Forgiveness.

A treatment manual was produced for Part A of the program, providing detailed session plans for each week of the group to ensure consistency of delivery across different sites. A fidelity checklist was created to measure therapist adherence to the manual. Due to the time-limited design of the program and with each session drawing on the content from the previous, group participants who missed a week were offered a catch up session prior to attending the next group.

As an adjunct to the group sessions, Part B of the program involves four private parent-child play sessions with the facilitator, father and one of his children. Father's experience of play is supported during role playing as a group during Part A and in individual sessions with the facilitator providing feedback about the father's play interaction with their child. Play sessions are videotaped to maintain treatment fidelity and reliability of scoring outcomes.

4.2.3 Treatment Setting and Resources

The parenting groups were held in a group room at each residential substance abuse treatment facility. Each room differed in size and capacity. For example, the largest space was being used for family visitation days and contained both dining and recreational facilities for families with children. Group therapy sessions, access to medical care and case management were provided at each facility as part of the requirements of the residential program. Parenting services were limited, consisting of referrals to parenting groups such as

Triple P, Positive Parenting Program (Sanders, 2008) run by community providers, at the residential treatment site.

Prior to proceeding with the intervention, each service agreed to provide a caseworker from the service to be available during the program for participant support if they required it. For example, if a participant left the group for any particular reason, the caseworker was required to follow up with the participant. Other than providing a room and caseworker availability, there were no other additional costs to the service. Group facilitators brought their own resources for group activities (e.g. butcher's paper, toys).

4.2.4 Facilitator Characteristics

Group facilitators were all at Doctoral or PhD level. The primary author (MT) facilitated three groups. Two facilitators were subsequently trained by the primary author to facilitate a group. This was implemented to determine the practicality of other facilitators running the program, other than the primary author. Throughout the duration of the group, all facilitators received supervision from the program developer (RS). The program developer and primary author (MT) have child and family therapy and group facilitation experience with similar populations.

4.3 Measures and Procedure

Fathers participated in a pre-intervention (enrolment) interview to obtain informed consent to participate and to complete questionnaires. The enrolment interview included basic demographic questions about the father and his child. Demographic data included age, ethnicity, and number and ages of biological children and non-biological children they have lived with in the past 12 months, relationship status, employment status, living arrangements. The impact of the parenting program was measured through a repeated measures design

where fathers completed questionnaires at baseline and post-intervention. At post treatment, fathers were also given a questionnaire to measure their satisfaction with the treatment process and outcome. Qualitative data was collected from participants at pre-intervention and post-intervention stage by interviewing each participant individually. Treatment outcome measures consist of four main sections detailed below.

4.3.1 Parenting Self-efficacy

The Parenting Sense of Competence Scale (PSOC) -The PSOC Father's Form (Johnston & Mash, 1989) was used to measure; a) parents' satisfaction (such as parental anxieties and frustrations regarding parenting and motivation) and b) self-efficacy (degree of competence and confidence in solving parenting problems and capability in the parenting role). The measure comprises 17 items rated on a 6-point Likert scale ranging from (1) *strongly disagree* to (6) *strongly agree*. Higher scores on each of the sub-scales suggest greater perceived parenting competence. An example item is, "*I would make a fine model for a new father to follow in order to learn what he would need to know in order to be a good parent."* Internal reliability coefficients for three subscales (satisfaction with parenting, parenting efficacy and interest in parenting) range from 0.80 to 0.89. Overall scale reliability has been estimated to be 0.94. External reliability was indicated to range from 0.58 to 0.88 (Kendall & Bloomfield, 2005).

4.3.2 Perceived Closeness in Parent-Child Relationship

Child-Parent Relationship Scale (CPRS) - The CPRS (Pianta, 1998) is a self-report instrument completed by fathers that assesses their perceptions of their relationship with their child. The 15 items are rated on 5-point Likert scales and the ratings can be summed into groups of items corresponding to conflict and closeness subscales. The 8-item conflict subscale measures the degree to which a parent feels that his or her relationship with a particular child is characterized by negativity. The 7-item closeness scale assesses the extent

to which a parent feels that the relationship is characterized by warmth, affection, and open communication. An example item is *"I share an affectionate, warm relationship with my child."* Inter-coder reliability for the composite scores has been reported to exceed .83 at every age from 54 months to first grade (Driscoll & Pianta, 2011).

4.3.3 Engagement and Satisfaction with Treatment

The number of sessions attended by the fathers was used as a measure of parent engagement in treatment. A section of the questionnaire at post treatment required fathers to rate against a number of statements how satisfied they felt about different aspects of the program (e.g. practice play during sessions) and likelihood of engaging in parenting programs outside of the rehabilitation setting. Single item questions were used to measure satisfaction with the intervention (rating scale from anchors 0 – 6). Examples of items included "*I feel that the things we did in the program was useful in improving my relationship with my child," "I felt the group leader cared about me and my challenges with parenting."* Fathers were also asked if they would like to continue meeting as a group after the parenting program and rate this on a scale (anchors 0-6) the likelihood of them attending a parenting program outside of the rehabilitation centre.

4.3.4 Feelings of Guilt in Parenting Role

A single item was also used to measure parental feelings of guilt, at pre and post intervention. Fathers were asked to rate on a scale, (1 – 6 where 1 was *not at all guilty* and 6 was *a lot guilty*). This question aimed to explore feelings of remorse associated with parenting that may contribute as a barrier to change. It is likely to be a barrier for fathers to invest energy in parenting programs when they are burdened with a *learned helplessness*, that regardless of how much time and energy they expend that they entertain little if any hope for change.

4.4 Interviews

In total, 16 participants were interviewed prior to group commencing. Post-group there were 15 participants who completed the interviews. Each semi-structured interview lasted from 10-15 minutes. Group facilitators conducted the interviews following the completion of the program. There were two main parts to the interview post treatment. In the first part, fathers were asked open-ended questions about how their views of parenting have changed since completing the program. Questions were targeted around what they perceived as the components of the program that they found most useful and beneficial. Sample items include, *"Has your view of yourself as a parent changed as a result of this program? How has it changed?"* and *"What was the most useful part of the Black Box parenting program?"*

The second part of the interview aimed to identify perceived changes in understanding their child's behaviours and also to capture any positive shifts in feelings of hope that their desired parenting goals can be reached. For example, fathers were asked open-ended questions such as: "*In what ways do you better understand what's happening in the relationship with your child?"* And *"How hopeful do you feel about your future parenting and relationship with your child?"*

4.5 Data Analysis

Data was analysed by observing the change in outcomes from baseline to post-intervention for each questionnaire and compared using a paired sample *t*-test. Statistical significance was set at $p<0.05$. Spearman's non-parametric correlations were performed in order to determine if there were any relationships between items measuring satisfaction with treatment and key outcome variables (parental self-efficacy, satisfaction with treatment,

closeness and conflict). All analyses of questionnaire data were conducted using SPSS 22.0 for Windows.

Participant responses during the interviews were recorded verbatim since participants did not provide consent for tape recording when asked. Data was then analysed using inductive thematic analysis following Boyatzis (1998). A coding table was developed (see Hruschka, Schwart, John, Picone-decaro, Jenkins & Carey, 2004). Inter coder reliability was established through cross-examination by one of the research team (RS) until a consensus was reached.

4.6 Results

4.6.1 Participant Characteristics at Baseline

Each site recruited up to 8 participants per group, since this seemed to be the average number of men they were currently servicing who met the eligibility criteria. For example, some were fathers but only had children over the age of 12. Prior to session one, there were fathers who dropped out of the program because they had left the rehabilitation facility earlier than planned discharge. Other participants chose not to participate in the program after completing baseline questionnaires, and indicated that they felt discouraged and unmotivated to attend because of circumstances preventing them having visitations with their children. From all the sites combined, 19 fathers completed the program (see Table 6 for number of participants at each site from recruitment to completion of the program and Figure 3 provides a diagram of the recruitment numbers at each stage). At enrolment, fathers ranged in age from 19 - 42 (M = 32.5, SD = 6.9) years. The average age of their children was 7 years (SD 5.3). Table 7 provide descriptive information for participants. Most of the fathers (68%) identified as Anglo-Australian and just over half (58%) had completed high school. About a third were single and living alone (32%), or living with their partner and children (32%).

Almost half (47%) were unemployed, 37% were employed full time prior to being admitted to the residential program. Most fathers (68%) reported being responsible for direct care, disciplining, teaching, providing affection and comfort and supervising their children, prior to their admission into treatment. Forty-four percent had weekly contact with their children.

Table 6

Number of Participants at Each Site

	Recruitment	**Attended Session 1**		**Completed Sessions 1 -3**	
	N	N	%	N	%
Site 1					
Group 1	7	4	57	4	57
Site 2					
Group 2	8	8	100	7	88
Group 3	8	6	75	6	75
Site 3					
Group 4	8	3	34	2	25
Total	31	21	68	19	61

Table 7

Descriptive Statistics

Sample Characteristic	N (%)
Ethnicity	
Anglo-Australian	13 (68)
Aboriginal	3 (16)
Other	3 (16)
Marital Status	
Single and living alone	6 (32)
Living with partner	2 (11)
Living with partner and children	6 (32)
Other	5 (26)
Education	
Postgraduate	1(5)
College/TAFE	7 (37)
High school	11 (58)
Employment	
Part time	1 (5)
Full time	7 (37)
Casual	2 (11)
Unemployed	9 (47)

Months in residential program	
Less than a month	1 (5)
1-2 months	5 (26)
3-4 months	5 (26)
5-6 months	5 (26)
6-12 months	2 (11)
Over a year	1 (5)
Frequency of Contact with Children	
Weekly	8 (44)
Monthly	5 (28)
Yearly	3 (17)
No contact since admission	2 (11)
Parenting Responsibilities	
Direct Care	13 (68)
Financial Support	9 (47)
Disciplining	13 (68)
Teaching	13 (68)
Providing Affection and Comfort	13 (68)
Supervision	13 (68)

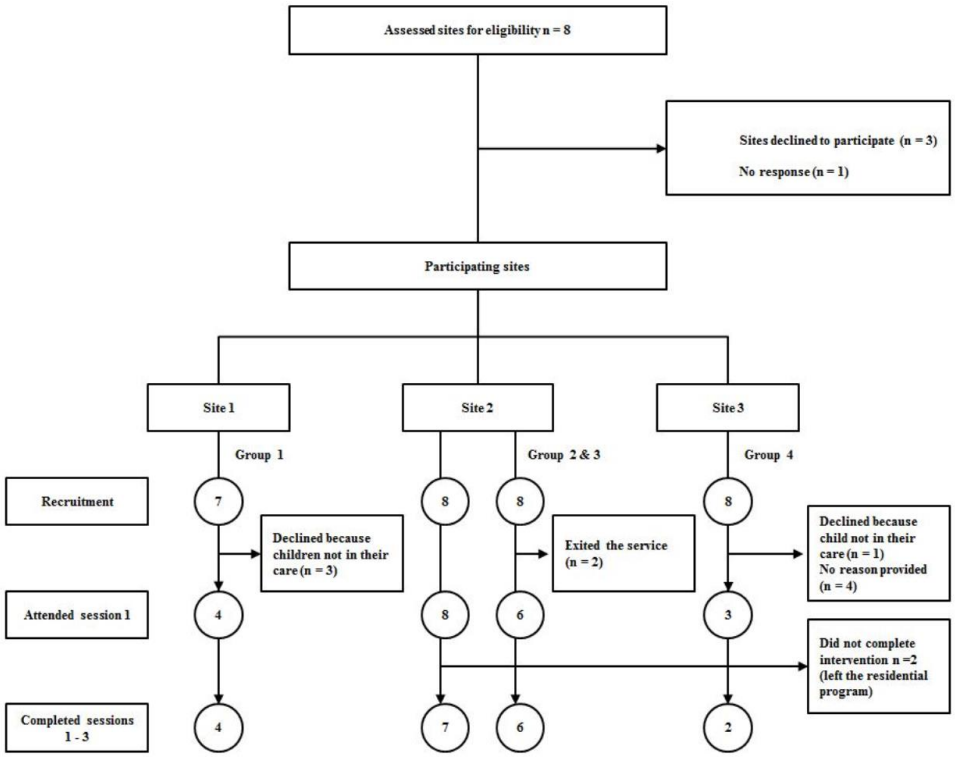

Figure 3 Recruitment consort diagram

4.6.2 Intervention Demand

From the eight residential substance abuse treatment services invited to take part in the program, seven expressed an interest. We did not receive a response from the other service, despite follow up. Two of those services that expressed interest withdrew prior to recruitment based on staffing issues and their inability to provide a caseworker during groups. Another service chose not to proceed due to low client numbers and was unable to foresee recruiting enough participants for a group. A service that accommodated only men withdrew despite having a relatively larger proportion of fathers compared to other sites. Since turnover in clients almost occurred weekly there was doubt that these fathers would be able to commit to attending groups consistently over the three sessions.

4.6.3 Integration to Organization's Goals and Culture

Three services remained committed and were able to successfully recruit fathers. A common factor of these services that may have influenced the success of recruitment process is the fit of the program with the organization's goals and culture and the interest and experience of staff supporting parenting programs delivered by external providers. Caseworkers and managers invested their time in recruiting fathers. For example, talking about the program during their weekly meetings or with individual clients, as appropriate. Two of these services have had past experience with external service providers delivering parenting programs in their service. Since their caseworkers were not trained to provide parenting type interventions, they had made partnerships with community providers to address the need. Caseworkers expressed their interest in being trained as facilitators to be able to run the program themselves in the future and were keen to learn the theory and principles of the program. These services were also proactively involved in encouraging fathers to have contact with their children by being their advocates or offering practical

supports (e.g. child friendly space within the residential site, organising appointments, transport).

4.6.4 Implementation - Treatment Adherence and Barriers to Engagement

Part A of the program could be practically delivered on site since each service was able to provide a group room to be able to run their other group programs. In practice, Part B of the program could not be delivered for the following reasons. Two of the services that participated were unable to support children on site at their facility because of limited space and policies against having children on site. Although the other service created an appropriate space for Part B of the program (father and child play sessions) and offered to assist fathers in arranging for their children to attend the site, fathers were unsuccessful at getting children to attend because they had no contact with their children during their residential treatment stay or were limited in the amount of time they were able to spend with their children. For these reasons, only Part A of the intervention could be delivered for this study.

Although only Part A of the program could be implemented, fathers actively participated in the role-play exercises involving play techniques during the group program. Fathers completed the activity in pairs and each took turns being the parent and the child. The group facilitator provided feedback based on behaviours such as parental responsiveness (e.g., attending to what the child is doing and following their play) and encouragement (e.g., showing enthusiasm, praise). Fathers were encouraged to practice spending one on one time with their child using the play techniques during visits with their child. Most participants *(n* = 8, 57%) expressed feeling more confident in playing with their child since completing the program, attributing the change to learning the special play skills and importance of one on one time with their child.

Absenteeism can disrupt the group process for those regularly participating members. Barriers to engagement were linked to external circumstances of session times clashing with commitments (family visitation times, unexpected family emergencies or service initiated activities). In general, sessions that occurred on Fridays when fathers were preparing for weekend leave, proved to be most disruptive in terms of attendance. Fathers who missed a session attended a catch up session. With the exception of one participant who had left the service prematurely, all other group participants completed three sessions of the program. Consistent and on time attendance at groups was also influenced by the organization's rules and governing structures. The service that was most successful in their attendance rates was strict in supervising their clients and encouraging them to take responsibility to being present at groups. The larger and more flexible the organization in day-to-day routines of residents, the less accountable they were in being available for the voluntary groups they had previously committed to.

4.6.5 Efficacy of the Parenting Program - Preliminary Outcomes

The data was screened for missing values, normality and univariate outliers. See Table 8 for means and standard deviations on all measures.

4.6.6 Parenting Self-efficacy

Paired sample *t*-tests indicated that fathers reported increased parenting self-efficacy on the PSOC questionnaire from pre treatment to post treatment. However, these differences were not significant, t (17) = - 1.25, p = .23). Given the small sample size, an effect size was calculated (http://www.psychometrica.de/effect_size.html) using a method for dependent t-test (Dunlop, Cortina, Vaslow & Burke, 1996). This allows sample estimation for future studies. The effect size was d = .39. With this effect size a sample of n = 43 would have been needed for the paired samples t-test to be significant at $p < .05$ and power at .80. On the

Satisfaction subscale of the PSOC, significant increases were found from pre treatment to post treatment t (17) = -3.8, p = 0.002.

While the quantitative results indicated that the intervention did not have a significant impact on parenting self-efficacy, a majority of qualitative comments suggested that father's view of themselves as a parent improved since completing the program (*n* = 13; 87%). Fathers reported that the program reinforced the strengths they have as a parent that they had not previously acknowledged. Typical responses were:

"In a way that I feel more of a better parent than what I thought I was."

"For myself I've realised I had more skills that I had thought I had. I still want to be more engaged as a parent."

4.6.7 Parent-Child Relationship

On the CPRS questionnaire a paired sample t-tests indicated that fathers' perceived closeness with their child did not improve significantly from pre treatment to post treatment t (17) = -.96, p = .35. Similarly, there was no significant change in the conflict subscale, of the CPRS t (17) = - .52, p = .61. A large number of the qualitative responses (*n* = 8; 53%) suggested an increased awareness in fathers' understanding of the function of the child's behaviours and their feelings. This capacity to make inferences about the emotional states underlying their children's behaviour is a reflective functioning skill, which is important in strengthening emotional bonds between parent and child.

"To understand he (referring to child) has feelings too. He will be emotional and have to learn not to be angry because he's angry."

"…Understanding where they're (referring to children) coming from, understanding why, not being snappy, thinking about how they feel."

Table 8

Means, Standard Deviations and t-test Statistics of Key Outcome Measures at Pre- and Post-intervention

	Pre intervention *M* (SD)	Post intervention *M* (SD)	*t*-value
The Parenting Sense of Competence Scale (PSOC)			
PSOC - Parental self-efficacy	39.6 (5.1)	41.6 (5.5)	-1.25
PSOC – Parental Satisfaction	29.6 (5.3)	33.7 (5.7)	-0.38
Child Parent Relationship Scale (CPRS)			
CPRS - Conflict	26.9 (6.3)	27.7 (4.5)	-0.52
CPRS - Closeness	40.1 (4.9)	41.4 (4.2)	-0.96

n = 18

4.6.8 Feelings of Guilt and Hope

There was a significant decrease pre-to-post intervention on the single item measuring fathers' reported feelings of guilt about their relationship with their child t (12) = 2.3, p = .04. In response to the interview question asking how hopeful they feel about their future parenting and relationship with their child, all respondents were hopeful both prior to the intervention and continued to express hopefulness following the intervention. In terms of hope, fathers expressed hopefulness regarding their relationship with their children both pre-treatment (*n* = 16; 100%) and post treatment (*n* = 15; 100%).

4.6.9 Acceptability of the Parenting Program - Satisfaction with Treatment

In order to explore factors that may determine satisfaction of treatment we ran a series of correlations between post test satisfaction with treatment and changes in parental self efficacy and perceived closeness with their child (pre –post differences). The Spearman's

rho revealed a statistically significant relationship between satisfaction with treatment and changes in parental self-efficacy (r_s [15] = .63 p <. 05). Satisfaction with treatment and changes in perceived closeness with their child was also significantly correlated (r_s [15] = .48 p <. 05). The greater improvements in parental self-efficacy and perceived closeness with their child (pre post differences), the more satisfied fathers were in the parenting program.

The majority of fathers indicated they wanted to continue meeting as a group after completing the parenting program (*n= 13*, 87%). They had a mean of 4.93/6 on the item assessing their motivation to attend a parenting program outside of the rehabilitation centre. Of the 13 fathers who responded to the question about how the program could be improved, 53% *(n = 8)* were positive about the session content (e.g., *"…I really enjoyed everything about it. It was good"*) and provided few additional suggestions about how the program could be improved. Some suggested more sessions and also having the child present during practice play to improve the program. Most participants (n =14, 93%) found The *Black Box* metaphor was helpful. A common response was that the metaphor was useful in reflecting on the feelings that has impacted on their view of the world and on their relationships. For example:

"Stuff isn't pushed aside that's forgotten. There is a storage and that can foster understanding where real concerns come from."

"Realising all of the things I do have that is in the black box. I'm unlikely… I always dismissed them. Writing it out is a way of acknowledging it."

4.7 Discussion

This paper describes the feasibility and preliminary efficacy of The Black Box Parenting Program. Although researchers have determined the need to target and tailor parenting programs for substance abusing fathers, there are very few treatment outcome studies for this population. To our knowledge, this was the first study to assess the feasibility

of an attachment and trauma informed parenting program for fathers in a residential substance abuse treatment setting. We reported on feasibility aspects that included demand, implementation, integration, preliminary efficacy and acceptability of the parenting program.

Demand for the program was lower than expected, given that there were limited parenting programs if any, being offered specifically to fathers at the residential treatment sites. Also, residential substance treatment services that were approached for the study (7 of 8 sites) indicated that the program was acceptable in its fit with the organization's goals of maintaining family connections, appropriate to their clients needs and perceived there to be benefits in implementing the program. However, only 43% of the services that expressed interest went through to implementation. Systemic barriers (e.g. downsizing of staff and budgetary constraints, organization's competing priorities, limited staff availability, low client numbers) were presented as reasons preventing services from proceeding. Each participating site was only able to recruit one group (up to 8 participants) at a given time due to the low proportion of fathers with children under age 12. Some fathers also felt discouraged to attend parenting groups if they had limited, infrequent or no contact with their children. This was despite their desire to be more involved in their lives and efforts to increase visitation and the role they played when they had contact (e.g. financial, nurturing, disciplining). Similar systemic problems as mentioned above were encountered when implementing the entire program (Part A and B) at participating sites. Part B of the program, involving children being on site other than for planned visitations, is not easily integrated into the existing infrastructure and policies of the services. Thus, although the demand and interest initially seemed high, there were low numbers of participants recruited and few services that committed to implementing the program as designed. Clearly there are challenges in reaching those parents who are especially vulnerable and in need of support, particularly fathers (Cortis, Katz & Patulny, 2009; Winkworth, McArthur, Layton, Thomson,

& Wilson, 2010). Moreover, it is well recognised that systemic problems such as those identified in this study affect the implementation and fidelity of many interventions in substance abuse treatment settings (Herbeck, Hser, & Teruya, 2008). There is high need for structural changes within these services that would facilitate procedures to allow for family work onsite. There are significant limitations in working with fathers in isolation from their children.

While the program was able to successfully attract a number of fathers, there were competing priorities that presented as a barrier to consistent attendance. It is likely that a higher risk sample is referred to these inpatient settings to begin with and these fathers along with their other vulnerabilities, struggle with the intense demands of residential treatment. Given the multiple risks within this sample and challenges in engaging fathers, the outcomes are encouraging but indicative of a need to adapt the delivery of certain aspects of the program.

Although limited by a small sample, the finding that 67 - 100% of the sample completed treatment is encouraging. Parent Management Training Programs based on behavioural and social learning theory, are known to have problems with treatment retention (i.e. high attrition), with attrition rates as high as 75% in community mental health settings (e.g. Lavigne et al., 2010; Lyon & Budd, 2010). Moreover, qualitative data indicate that fathers were very satisfied with the *Black Box Parenting Program* as expressed in their motivation to continue meeting as a group and attend parenting groups outside of the rehabilitation centre. The results also indicated that satisfaction with treatment was strongly related to parental self-efficacy. Therefore, the more helpful the group was in encouraging fathers to feel more confident in their parenting, the more the fathers felt satisfied with the program.

Although parental self-efficacy and perceived closeness in the parent child relationship did not significantly improve from pre to post- treatment, this was likely due to the small sample size. Effect size calculations suggested a sample of $n = 43$ would likely reach significance for parental self-efficacy. Suggesting the program may, indeed have utility in increasing parenting confidence.

In line with one of the major aims of the program, there was a significant decrease in feelings of guilt post treatment. Children's everyday emotional demands can trigger parents' experience of the past along with the affective experiences of shame and guilt associated with past traumas (Aron, Aron, Tudor, & Nelson, 1991). The *Black Box Parenting Program* worked on validating father's affective experiences (e.g. helplessness, guilt and shame) as they may be affectively triggered in their interactions with their children. Given that high levels of guilt and shame are correlated with a range of negative outcomes, as mentioned previously, and the barrier they can present to fathers engaging in parenting programs, this ability to reduce excessive shame is a strong positive outcome of the program.

In line with this positive outcome, fathers' satisfaction with parenting was significantly improved by at post treatment, even with this small sample size. Again, this change is likely to improve motivation and reduce barriers to further help-seeking.

4.7.1 Limitations and Future Direction

Study outcomes relied solely on measures of self-report, which are subject to expectancy and socially desirable responding. Original plans to include collateral evidence such as observational assessments particularly when observing father's play skills to increase reliability and validity of data were not able to be implemented due to the inability to conduct Part B of the intervention. Whilst Part A of the program showed some positive results, further research should attempt to include Part B (the dyadic coaching of fathers playing directly

with their children) by addressing some of the logistical issues. This study is obviously representative of a particular geographical area (New South Wales, Australia) and further study would aim to improve the generalisability of the results.

Whilst the results are promising, they are obviously limited by the difficulties in recruiting participants. However, from a feasibility perspective, the results suggest the necessity of highly structured residential programs in order support interventions such as these. Services with a high level of supervision of clients were able to recruit and retain participants well, whereas more flexible programs were not. If a subsequent study were to be planned, it would be advisable to invest time in addressing the barriers preventing services from being able to implement the program. What was clear was the importance of working systemically by being inclusive of staff and management of treatment facilities in ways such as developing their understanding of the assumptions and values underlying programs, considering adaptability against professional culture, theoretical orientation of clinicians and organizational constraints of the system (Torres, Sng, & Deane, 2015).

5.0 General Conclusions

5.1 Limitations

Study One and Two both had several limitations as previously stated. Firstly, both studies were reliant on the use of self-report measures. The validity of self-report measures have been questioned by developmental researchers because beliefs people hold regarding their behaviour in relationships can be inaccurate due to lack of insight into their problems or feelings of defensiveness (Crowell, Fraley, & Shaver, 1999). This may be particularly true in a population marked by substance abuse and maladaptive psychological coping. Anxiously avoidant individuals may be reluctant to answer honestly because it may be viewed as socially undesirable (Mikulincer & Shaver, 2010). These researchers argue that the most reliable and valid form of assessing attachment is through semi-structured interviews coded

by trained observers (Crowell, Treboux, & Waters, 1999; Hesse, 1999; Main & Goldwyn, 1998) or using combined approach of self- reports with coded interviews (Roisman et al., 2007). Also, The Stressful Life Events Screening Questionnaire (SLESQ) and the Trauma Symptom Inventory are self-report measures that assess trauma by asking participants to accurately recall past events retrospectively. Kazdin (2003) expressed a concern that the accuracy of retrospective recalling past events, particularly those that have occurred in childhood, is particularly poor. Another disadvantage of both these trauma measures is that by attempting to capture cumulative trauma experiences (past and present), it was difficult to differentiate between symptoms that develop in response to adverse life events in adulthood versus those specific to childhood. Future studies may benefit from a detailed interview of respondents following initial screening measures to confirm and clarify trauma exposure information. For example, we were not able to estimate premorbid (before substance abuse) trauma exposure, which may be gathered in an interview.

Since PSE and attachment are constructs that are understudied compared to the research on mothers, most instruments have been developed for and validated on samples of mothers. More research is needed on instruments that assess parenting roles and responsibilities that represent a more accurate understanding of men's parenting experience. For example, fathers may identify parenting responsibilities that are not adequately reflected in the existing PSE measure used for this research.

Another limitation is the sample size in the feasibility study was relatively small. Future studies should aim to utilize larger samples for the purpose of obtaining greater statistical power and overall generalizability. The findings of the study must be interpreted in the context of characteristics of the sample. All participants self selected into the program and this was likely because of a strong motivation to be more involved in parenting of their children. Thus, these participants may represent a limited group of substance abusing fathers

with more hope and positive expectations of their future parenting. These factors may have brought them into treatment, commit them to seeking parenting help and to invest in their child. Some fathers were involved with child protection services and all were subject to surveillance and evaluation of the residential treatment program for the purpose of monitoring their progress. These conditions may have influenced fathers to present themselves more favourably. Given the very small sample size that were identified by the service as eligible, it was difficult to implement a comparison group not receiving treatment or group receiving another parenting intervention, which may provide evidence of specificity. The beneficial effects of attending the group program may be partially attributed to fathers receiving more attention and some other program may yield similar results.

Finally, the study did not include any assessment of the drug use severity to be able to examine the interactions between differing levels of substance abuse severity, PTSD symptoms and PSE. This information may provide further support for the need for parenting interventions whilst in substance abuse treatment.

5.2 Strengths

The studies utilized self-report measures that are highly regarded measures in the area. The PSOC scale is the most widely used measure to study both parental competence and parental self-efficacy (e.g., Coleman & Karraker, 2003; Rogers & Matthews, 2004; Sanders &Woolley, 2005). The normative data on the PSOC (Gilmore & Cuskelly, 2009) is based on a large Australian sample.

The ECR-R questionnaire, developed by adult attachment researchers (e.g., Fraley, Waller & Brennan, 2000) is used extensively in research as a self-report measure for adult attachment. While researchers in attachment generally prefer interview methods to self-

reports, personality and social psychologists regard self-report measures as acceptable because they are primarily interested in assessing conscious appraisals and evaluations of relationships rather than unconscious states of mind (Roisman et al., 2007). For this reason, some attachment researchers in the social personality area argue that self-report measures of attachment such as ECR-R should be adequate predictors of the quality of individuals' relationships (Bernier & Dozier, 2002).

Another notable strength is the use of open-ended questions to supplement quantitative results in the feasibility study. Qualitative data provides an alternative way for capturing the inner experience of fatherhood from the perspective of men with substance addiction. Using this multi method approach, we assessed important variables (e.g. father's motivation to improve their parents and group experience) in addition to the impact of the program on parenting (e.g. self efficacy, relationship with their child).

Both studies were conducted in the naturalistic setting within different substance abuse residential treatment services provided by different organisations, which increases the external validity of the findings. We also set out to describe the influence of the setting by reporting on the contextual conditions that facilitated or inhibited processes of implementation of the parenting program. The nature of residential substance abuse treatment systems is complex and under resourced which means implementation has to respond to emerging barriers and opportunities and use of existing resources that can be leveraged or strengthened. For example although Part B of the program (play sessions with the child) could not be implemented, fathers were able to practice play skills during the group sessions with the guidance of the group facilitator. Feedback from the facilitator increases the likelihood of fathers experiencing success in their interactions, which can improve PSE for play skills. Further, more positive beliefs will be reinforced by actual experience gained during group sessions.

Thus, although the sample size in the intervention study was small, it explored a high-risk understudied clinical population receiving treatment in a complex system. In addition, the study used measures (e.g. The SLESQ and Caregiving Helplessness Questionnaire) to capture the complex trauma sequelae experienced by a majority of these men instead of the more narrow and traditional view of PTSD.

5.3 Implications of Findings

In summary, there is theoretical support for the concurrent treatment of substance abuse and parenting difficulties since treating substance abuse without addressing parenting problems can leave parents feeling vulnerable to drug relapse as a coping mechanism (Belt & Punamäki, 2007; Neger & Prinz, 2015; Suchman et al., 2008). A way to address both issues is to incorporate parenting programs into substance abuse treatment services such as residential settings so that men can be supported in becoming more effective fathers or encouraged to consider how substance abuse can impact on their fathering role. Although historically, research and interventions have focused on the parenting responses of substance abusing mothers, there is increasing evidence addressing this gap in knowledge regarding the way substance dependent men experience and understand their roles. The findings stemming from this research emphasize that fathers are important in the development and well-being of their children. They show an interest in the lives of their children, are sensitive to the needs of their children and are active participants in encouraging their cognitive and emotional development.

Results of Study One make several important contributions by providing further evidence that traumatic events in childhood and adulthood are associated with complex trauma outcomes including PTSD symptomatology in adulthood. The first study also showed post-traumatic symptomology was inversely correlated with parental self-efficacy. This finding is consistent with attachment theory, which suggests the quality of early experiences

influences beliefs about self and other. In addition, the results of this study provide evidence supporting theoretical accounts implicating attachment disruptions in the pathway from the experience of trauma to impaired parental self-efficacy. It is possible that the effect of traumatic experiences on the attachment system is a critical factor in a parent's emotional capacity. Overall, results of Study One emphasize the need to consider issues that are specific to the parenting responses of male caregivers with substance abuse problems, particularly the influence of trauma and attachment style on parenting.

The second study takes a program built on the findings of the first study and explores the feasibility of supplementing residential substance abuse treatment for fathers with a brief, trauma and attachment informed group parenting program. There are very few treatment outcome studies for this population. To our knowledge, this was the first study to assess the feasibility of an attachment and trauma informed parenting program intervention for fathers in a residential substance abuse treatment setting. Pre to post intervention assessments revealed significant increases in fathers' satisfaction with parenting, even in this small sample. Fathers also reported feeling motivated to attend further parenting groups. Satisfaction with treatment was related to changes in parenting self-efficacy and closeness with their child. Qualitative comments supported these results suggesting that father's perceptions of themselves as parents improved. Fathers reported that they had increased awareness in understanding of their child and, overall, felt hopeful about their parenting. Importantly, the feasibility study identified a number of systemic problems likely to affect the implementation and fidelity of the intervention. The study demonstrates clearly the importance of a strongly structured substance treatment program with clear supervision as a context for The *Black Box Parenting Program.*

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Appendix 1: Informed Consent

Study One

CONSENT FORM FOR MALE CAREGIVERS

RESEARCH TITLE: Trauma, attachment relationships and parenting self-efficacy in male caregivers receiving substance abuse treatment

RESEARCHER: Marianne Torres

I have been given information about the study *"Trauma, attachment relationships and parenting self-efficacy in male caregivers receiving substance abuse treatment"* and discussed the research project with my caseworker/counsellor from Salvation Army. I am aware that the research is being conducted by Marianne Torres as part of a Doctoral of Clinical Psychology Degree supervised by Dr. Rebecca Sng and Professor Frank Deane in the Faculty of Social Sciences (Psychology) at University of Wollongong.

I have been advised that the study is expected to take approximately 60 minutes of my time to complete the following questionnaires.

1. Demographics Questionnaire
2. Parenting Scale
3. Trauma Symptoms Inventory- 2
4. Stressful Life Events Scale
5. Experience in Close Relationships Questionnaire
6. Caregiving Questionnaire

In the situation that I am emotionally distressed following completing questionnaire items, I have been advised there will be provision for me to meet with an available member of counselling staff at my treatment facility. I have had opportunity to ask Marianne Torres any questions I may have about the research and my participation.

I understand my participation in this research is voluntary; I am free to refuse to participate at any time by not completing the questionnaires. My refusal to participate will not affect my treatment in any way or my relationship with The Salvation Army.

I understand that data collected from my participation will be used primarily for a Doctoral thesis, and used in summary form for journal publication or in presentations at academic conferences, and I consent for it to be used in that manner.

I understand that all identifiable information collected about participants in connection with this study will remain confidential and will be disclosed only with their permission or as required by law. Although the research does not aim to determine whether a child or young person is at risk, if there is sufficient information to suggest a child or young person is at immediate risk of harm, researchers are legally required to report this.

If I have enquiries about the research, I can contact Marianne Torres and or Dr. Rebecca Sng 4221 3747. If I have any concerns or complaints about the research, I can contact the Ethics Officer, Human Research Ethics Committee, Office of Research, University of Wollongong on 4221 3386 or email rso-ethics@uow.edu.au.

By signing below I am indicating my consent to (please tick):

☐ **Participating in the research by completing questionnaires**

Signed ***Date***

..... **... /... /...**

Name (please print)

.....

Study Two

CONSENT FORM FOR MALE CAREGIVERS
(GROUP PARTICIPATION ONLY)

RESEARCH TITLE: Black Box Parenting Program for male caregivers receiving treatment in substance abuse settings

RESEARCHER: Marianne Torres

I have been given information about the study of *"Black Box Parenting Program for male caregivers receiving treatment in substance abuse settings"* and discussed the research project with my caseworker/counsellor from Salvation Army. I am aware that the research is being conducted by Researcher Marianne Torres as part of a Doctoral of Clinical Psychology Degree supervised by Dr. Rebecca Sng and Professor Frank Deane in the Faculty of Social Sciences (Psychology) at the University of Wollongong.

I have been advised that the study will be conducted over a nine-week period, starting a week before the first Black Box parenting program session.

If I agree to participate in this study, I will be asked to complete the following:
1. Attend all 3-group sessions of Black Box Parenting Program (morning and afternoon sessions)
2. Complete up to 4 questionnaires. These questionnaires will ask you about experience as a caregiver and feedback about your experience as a participant in the group.
   - Demographics questionnaire
   - Parenting sense of competence scale
   - Child Parent Relationship Questionnaire
   - Experience about the group Questionnaire

Parts of the questionnaires are administered in a face-to-face interview with the facilitator. The interview will be audio taped with your permission.

3. You will be asked to complete the questionnaires at your pre-group meeting with the facilitator on three occasions; (1) a week prior to the group commencing (2) at the follow up on week 5 after the program and at week 9 which is a month after the program.
4. These questionnaires may take up to an hour to complete.

In the situation that I am emotionally distressed following completing questionnaire items, I have been advised that there will be provision for me to meet with an available member of the counselling staff at my treatment facility. I have had an opportunity to ask Marianne Torres any questions I may have about the research and my participation.

In the situation that I am emotionally distressed following completing questionnaire items or from participation in the *Black Box Parenting Program*, I have been advised there will be provision for me to meet with an available member of counselling staff at my treatment facility. I have had opportunity to ask Marianne Torres any questions I may have about the research and my participation.

I understand that my participation in this research is voluntary; I am free to refuse to participate at any time by not completing the questionnaires, participating in groups or attending parent and child sessions. My refusal to participate will not affect my treatment in any way or my relationship with The Salvation Army.

I understand that the data collected from my participation will be used primarily for a Doctoral thesis, and will also be used in summary form for journal publication or in presentations at academic conferences, and I consent for it to be used in that manner.

I understand that all identifiable information that is collected about participants in connection with this study will remain confidential and will be disclosed only with their permission or as required by law. Although the research does not aim to determine whether a child or young person is at risk, if there is sufficient information to suggest a child or young person is at immediate risk of harm, the researchers are legally required to report this.

If I have any enquiries about the research, I can contact Marianne Torres and or Dr. Rebecca Sng 4221 3747 or if I have any concerns or complaints regarding the way the research is or has been conducted, I can contact the Ethics Officer, Human Research Ethics Committee, Office of Research, University of Wollongong on 4221 3386 or email rso-ethics@uow.edu.au.

Recording of pre and post group interview.

I DO provide permission to be **[audio]** recorded during the pre and post group interview.

I DO NOT provide permission to be **[audio]** recorded during the pre and post group interview.

Signed Date

..../...../.....

Name (please print)

.....

Appendix 2: Demographic Questionnaire

Study One

1. What is your age? _____

2. What is the highest education level you have achieved?
- ☐ Postgraduate
- ☐ College/TAFE
- ☐ High school
- ☐ Primary School
- ☐ Other _____

3. How many months have you been attending the residential treatment program?
- ☐ Less than a month
- ☐ 1 – 2 months
- ☐ 3 – 4 months
- ☐ 5 – 6 months
- ☐ 6 – 12 months
- ☐ Over a year

4. In the 3 months prior to admission into the residential treatment programme, what were your primary living arrangements?

Tick only one
- ☐ Living alone
- ☐ Living with another tenant
- ☐ Living with partner
- ☐ Living with partner and child/ren
- ☐ Living with partner, child/ren and other adults

5. What is your current relationship status?
- ☐ Single
- ☐ Married
- ☐ De facto

6. In the 3 months prior to entering treatment, what was your employment status?
- ☐ Working full time
- ☐ Working part time
- ☐ Casual
- ☐ Unemployed

7. How many biological children do you have? _____

In 12 months prior to entering treatment, how many biological children were you living with?

Number of children_____

Age of each child: _____

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8. In the 12 months prior to entering treatment, how many children were you living with that were **not** your biological children? _____

Age of each child: _____

9. How often did you see or visit the child/ren?

- ☐ Every day (specify the hours) _____
- ☐ Every week (specify approximately how many times a week) _____
- ☐ Every month (specify approximately how often in a month) _____
- ☐ Every year (specify approximately how many times in a year) _____

10. What was your role as caregiver/parent to the child/ren? Tick any that apply

- ☐ Direct care (bathing, feeding, dressing)
- ☐ Financial Support
- ☐ Disciplining and being an authority figure
- ☐ Teaching
- ☐ Providing affection or comfort
- ☐ Supervision (e.g. watching the child, ensuring that they are safe from danger)
- ☐ Other (specify) _____

_____

11. Do you have concerns about your child/ren or the children you have cared for?

- ☐ No
- ☐ Yes

If Yes, tick any concerns that apply

- ☐ Behavioural problems (e.g. aggression, tantrums)
- ☐ Emotional problems (e.g. depressed, anxious)
- ☐ Physical problems (e.g. health, mobility, speech)
- ☐ Academic problems (e.g. school performance)
- ☐ Relationship with peers (e.g. making friends)
- ☐ Relationship with parents (e.g. enjoyment in shared activities)
- ☐ Other concerns (describe): _____

12. Are you interested in attending a parenting program?

- ☐ No
- ☐ Yes

If Yes, what would you like to work on as part of the parenting program (Tick any that apply):

- ☐ Skills in setting limits and boundaries, problem solving and praise
- ☐ Learning how to play and spend time with your child
- ☐ Strategies to respond to child behaviour difficulties
- ☐ Relationship with child
- ☐ Education about your child's needs

Study Two

Demographics Questionnaire – Group Parenting Program

1. What is your age? _____

2. What is the highest education level you have achieved?
- ☐ Postgraduate
- ☐ College/TAFE
- ☐ High school
- ☐ Primary School
- ☐ Other _____

3. How many months have you been attending the residential treatment program?
- ☐ Less than a month
- ☐ 1 – 2 months
- ☐ 3 – 4 months
- ☐ 5 – 6 months
- ☐ 6 – 12 months
- ☐ Over a year

4. In the 3 months prior to admission into the residential treatment programme, what were your primary living arrangements?

Tick only one
- ☐ Living alone
- ☐ Living with another tenant
- ☐ Living with partner
- ☐ Living with partner and child/ren
- ☐ Living with partner, child/ren and other adults
- ☐ Homeless

5. What is your current relationship status?
- ☐ Single
- ☐ Married
- ☐ De facto
- ☐ Divorced
- ☐ Separated

6. In the 3 months prior to entering treatment, what was your employment status?
- ☐ Working full time
- ☐ Working part time
- ☐ Casual
- ☐ Unemployed

7. How many biological children do you have? _____

In 12 months prior to entering treatment, how many biological children were you living with?

Number of children_____

Age of each child: _____

8. In the 12 months prior to entering treatment, how many children were you living with that were **not** your biological children? _____

Age of each child: _____

9. How often did you see or visit the child/ren?
- ☐ Every day (specify the hours) _____
- ☐ Every week (specify approximately how many times a week) _____
- ☐ Every month (specify approximately how often in a month) _____
- ☐ Every year (specify approximately how many times in a year) _____

10. What was your role as caregiver/parent to the child/ren? Tick any that apply
- ☐ Direct care (bathing, feeding, dressing)
- ☐ Financial Support
- ☐ Disciplining and being an authority figure
- ☐ Teaching
- ☐ Providing affection or comfort
- ☐ Supervision (e.g. watching the child, ensuring that they are safe from danger)
- ☐ Other (specify) _____

_____

11. Do you have concerns about your child/ren or the children you have cared for?
- ☐ No
- ☐ Yes

If Yes, tick any concerns that apply
- ☐ Behavioural problems (e.g. aggression, tantrums)
- ☐ Emotional problems (e.g. depressed, anxious)
- ☐ Physical problems (e.g. health, mobility, speech)
- ☐ Academic problems (e.g. school performance)
- ☐ Relationship with peers (e.g. making friends)
- ☐ Relationship with parents (e.g. enjoyment in shared activities)
- ☐ Other concerns (describe): _____

12. Are you interested in attending a parenting program?
- ☐ No
- ☐ Yes

If Yes, what would you like to work on as part of the parenting program (Tick any that apply):
- ☐ Skills in setting limits and boundaries, problem solving and praise
- ☐ Learning how to play and spend time with your child
- ☐ Strategies to respond to child behaviour difficulties
- ☐ Relationship with child
- ☐ Education about your child's needs

13. What is your Ethnicity?
- ☐ Aboriginal
- ☐ Torres Straight Islander

- ☐ Both Aboriginal and Torres Straight Islander
- ☐ Australian - Caucasian
- ☐ Australian – other descent (please specify) _____
- ☐ Asian
- ☐ Arabic
- ☐ African
- ☐ Hispanic
- ☐ Other (please specify) _____

Appendix 3: The Experiences in Close Relationships - Revised (ECR-R) Questionnaire

(Fraley, Waller, & Brennan, 2000)

The statements below concern how you feel in emotionally intimate relationships. We are interested in how you generally experience relationships, not just in what is happening in a current relationship.

Please circle one number for each question	**Strongly Disagree**						**Strongly Agree**
1. I'm afraid that I will lose my partner's love.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
2. I often worry that my partner will not want to stay with me.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
3. I often worry that my partner doesn't really love me.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
4. I worry that romantic partners won't care about me as much as I care about them.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
5. I often wish that my partner's feelings for me were as strong as my feelings for him or her.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
6. I worry a lot about my relationships.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
7. When my partner is out of sight, I worry that he or she might become interested in someone else.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
8. When I show my feelings for romantic partners, I'm afraid they will not feel the same about me.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
9. I rarely worry about my partner leaving me.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
10. My romantic partner makes me doubt myself.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
11. I do not often worry about being abandoned.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
12. I find that my partner(s) don't want to get as close as I would like.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
13. Sometimes romantic partners change their feelings about me for no apparent reason.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
14. My desire to be very close sometimes scares people away.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
15. I'm afraid that once a romantic partner gets to know me, he or she won't like who I really am.	**1**	**2**	**3**	**4**	**5**	**6**	**7**

PLEASE TURN PAGE OVER

Please circle one number for each question	**Strongly Disagree**						**Strongly Agree**
16. It makes me mad that I don't get the affection and support I need from my partner.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
17. I worry that I won't measure up to other people.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
18. My partner only seems to notice me when I'm angry.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
19. I prefer not to show a partner how I feel deep down.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
20. I feel comfortable sharing my private thoughts and feelings with my partner.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
21. I find it difficult to allow myself to depend on romantic partners.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
22. I am very comfortable being close to romantic partners.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
23. I don't feel comfortable opening up to romantic partners.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
24. I prefer not to be too close to romantic partners.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
25. I get uncomfortable when a romantic partner wants to be very close.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
26. I find it relatively easy to get close to my partner.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
27. It's not difficult for me to get close to my partner.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
28. I usually discuss my problems and concerns with my partner.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
29. It helps to turn to my romantic partner in times of need.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
30. I tell my partner just about everything.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
31. I talk things over with my partner.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
32. I am nervous when partners get too close to me.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
33. I feel comfortable depending on romantic partners.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
34. I find it easy to depend on romantic partners.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
35. It's easy for me to be affectionate with my partner.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
36. My partner really understands me and my needs.	**1**	**2**	**3**	**4**	**5**	**6**	**7**

Appendix 4: The Caregiving Helplessness Questionnaire

(Solomon & George, 2011)

When completing this questionnaire, think of **one child** that concerns you the most. Think of how it feels when you and this particular child are together.

Please circle one number for each question	**Not like this child.**				**A lot like this child.**
1. When I am with my/this child, I often feel out of control.	**1**	**2**	**3**	**4**	**5**
2. My/this child is good at tending to and caring for others.	**1**	**2**	**3**	**4**	**5**
3. I am frightened of my/this child.	**1**	**2**	**3**	**4**	**5**
4. My/this child hits, kicks, or bites me.	**1**	**2**	**3**	**4**	**5**
5. I often feel that there is nothing I can do to discipline my/this child.	**1**	**2**	**3**	**4**	**5**
6. My/this child knows how to put other people at ease.	**1**	**2**	**3**	**4**	**5**
7. When I am with my/this child, I often feel that my/this child is out of control.	**1**	**2**	**3**	**4**	**5**
8. I feel that my/this child is a great actor/actress.	**1**	**2**	**3**	**4**	**5**
9. My/this child is very sensitive to the feelings and needs of others.	**1**	**2**	**3**	**4**	**5**
10. I feel that I am a failure as a father/caregiver.	**1**	**2**	**3**	**4**	**5**
11. My/this child likes to be a clown or family comedian.	**1**	**2**	**3**	**4**	**5**
12. I feel that I punish my/this child more harshly than I should.	**1**	**2**	**3**	**4**	**5**
13. My/this child becomes so upset or distressed that he can't be soothed.	**1**	**2**	**3**	**4**	**5**
14. My/this child loses it when he/she is separated from me.	**1**	**2**	**3**	**4**	**5**
15. Sometimes my/this child acts as if he/she is afraid of me.	**1**	**2**	**3**	**4**	**5**
16. I enjoy doing things with my/this child that make him or her happy.	**1**	**2**	**3**	**4**	**5**
17. My/this child is always trying to make others laugh.	**1**	**2**	**3**	**4**	**5**
18. I feel that my situation needs to be changed but am helpless to do anything about it.	**1**	**2**	**3**	**4**	**5**
19. I would describe myself as a reliable person.	**1**	**2**	**3**	**4**	**5**
20. I feel that my life is chaotic and out of control.	**1**	**2**	**3**	**4**	**5**
21. I am rarely bored when I am with my/this child.	**1**	**2**	**3**	**4**	**5**
22. My/this child treats me in a rude or sarcastic way.	**1**	**2**	**3**	**4**	**5**
23. I am happy with myself just the way I am.	**1**	**2**	**3**	**4**	**5**
24. I rarely feel guilty about my actions.	**1**	**2**	**3**	**4**	**5**
25. I can easily express myself to others.	**1**	**2**	**3**	**4**	**5**

26. I frequently talk to others about my/this child.	**1**	**2**	**3**	**4**	**5**

Appendix 5: Stressful Life Events Screening Questionnaire - Revised

(Goodman, Corcoran, Turner, Yuan, & Green, 1998)

The questions below refer to events that may have taken place at any point in your entire life, including childhood.

1. Have you ever had a life-threatening illness?

☐No (*Go to 2*) ☐Yes (At what age __ __

Describe the life-threatening illness _____

How traumatic/distressing was that experience for you? Circle one number:

1 2 3 4 5

Not at all traumatic Extremely traumatic

2. Were you ever in a life threatening accident?

☐No (*Go to 3*) ☐Yes (At what age? _ _

Did anyone die?

☐ No ☐Yes

Who died? _ _ ___ __ __ (Rela io shi to y u)

How traumatic/distressing was that experience for you? Circle one number:

1 2 3 4 5

Not at all traumatic Extremely traumatic

3. Was physical force or a weapon ever used against you in a robbery or mugging?

☐No (*Go to 4*) ☐Yes (A wh t age _____)

Was your lif in dange ?

☐No ☐ Yes

How traumatic/distressing was that experience for you? Circle one number:

1 2 3

Not at all traumatic Extremely ra t c

4. Has an immediate family member, oma ti p rtner o ve y close friend ied because o acciden , h micide, or suicide?

☐No (*Go to 5*) ☐Yes (At what age? _____)

How traumatic/distressing was that experience for you? Circle one num r

4 5

Not at all traumatic Extremely Traumatic

PLEASE TURN PAGE OVER

5. At any time, has anyone (pare t, other family member, roma ic partner, stranger or someone else) ever physically forced you to have intercourse, or to have oral or anal sex against your wishes, or when you were helpless, such as being asleep or intoxicated?

☐No (*Go to 6* ☐Yes At what age? _____)

What relationship did you have with the person? _____(E.g. stranger, parent)

Has anyone else ever done this to you?

☐No ☐Yes

How traumatic/distressing was that experience for you? Circle one number:

1 2 4 5

Not t all traumatic Extremely traumatic

6. Other than experiences mentioned in earlier questions, has anyone ever touched private parts of your body, made you touch their body, or tried to make you to have sex against your wishes?

☐No (*Go to 7*) ☐Y (At what age? _____

What relationship did you have with the person? _____(E.g. stranger, parent)

How old was the person? _____

Has anyone else ever done this to you?

☐No ☐Yes

How traumatic/distressing was the experience for you Circle one number:

1 3

N t at all traumatic Extremely traumatic

---

7. When you were a child, did a parent, caregiver or other person ever slap you repeatedly, beat you, or otherwise attack or harm you?

☐No (*Go to 8*) ☐ Yes (At what age? _ _)

Has anyone else ever done thi to you?

☐No ☐Yes

How traumatic/distressing was that experience for you? Circle one number:

1	2	3	4	5
Not at all traumatic				Extremely traumatic

8. As an adult, have you ever been kicked, beaten, slapped around or otherwise physicall a e y a romantic partner, date, family member, stranger, or someone else?

☐No (*Go to 9*) ☐Yes (At what age? _____)

What relationship did you have with the person? _____(E.g. stranger, parent)

If a sibling, what age was he/she? _____

Ha anyone else ever done this to you?

☐No ☐Yes

How traumatic/distressing was that experience for you? Circle one number:

1	2	3	4	5
Not at all traumatic				Extremely traumatic

9. Has a parent, romantic partner, or family member repeatedly ridiculed you, put you down, ignored you, or told you were no good?

☐No (*Go to 10*) ☐Yes (At what age? _____)

What relationship did you have with the person? _____(E.g. stranger, parent)

If a sibling, what age was he/she? _____

Ha anyone el e ever done this to you?

☐No ☐Yes

How traumatic/distressing was that experience for you? Circle one number:

1	2	3	4	5
Not at all traumatic				Extremely traumatic

10 Other than the experiences already covered, has someone ever threatened you wi h a weapon like a knife or gun?

☐No (*Go to 11*) ☐Yes (At what age? _____)

Has anyone else ever done this to you?

☐No ☐Yes

How traumatic/distressing was that experience for you? Circle one number:

1 2 3 5

Not at all traumatic Extremely traumatic

PLEASE TURN PAGE OVER.

11. Have you ever been present when another person was killed? Seriously injured? Sexually or physically assaulted?

☐No (*Go to 12*) ☐Yes (At what age?) _____

Was your life in a er?

☐No ☐Yes

How traumatic/distressing was that experience for you? Circle one number:

1 2 3 4 5

Not at all traumatic Extremely traumatic

12. Have you ever been in any other situation where you were seriously injured or your life was in da ger (e.g., involved in military combat or living in a war zone)?

☐No (*Go to 13*) ☐Yes (At what age? _____)

How traumatic/distressing was that experience for you? Circle one number:

1 2 3 4 5

Not at all traumatic Extremely traumatic

---

13. Have you ever been in any other situation that was extremely frightening or horrifying, or one in which you felt extremely helpless, that you haven't reported

☐No (*Go to 13*) ☐Yes (At what age? _____)

Describe the situation_____

Appendix 6: The Parenting Sense of Competence Scale

(Johnston & Mash, 1989)

Please circle one number for each question	**Strongly Disagree**					**Strongly Agree**
1. The problems of taking care of a child are easy to solve once you know how your actions affect your child, an understanding I have acquired.	1	2	3	4	5	6
2. Even though being a parent could be rewarding, I am frustrated now while my child is at his / her present age.	1	2	3	4	5	6
3. I go to bed the same way I wake up in the morning, feeling I have not accomplished a whole lot.	1	2	3	4	5	6
4. I do not know why it is, but sometimes when I'm supposed to be in control, I feel more like the one being manipulated.	1	2	3	4	5	6
5. My father was better prepared to be a good father than I am.	1	2	3	4	5	6
6. I would make a fine model for a new father to follow in order to learn what he would need to know in order to be a good parent.	1	2	3	4	5	6
7. Being a parent is manageable, and any problems are easily solved.	1	2	3	4	5	6
8. A difficult problem in being a parent is not knowing whether you're doing a good job or a bad one.	1	2	3	4	5	6
9. Sometimes I feel like I'm not getting anything done.	1	2	3	4	5	6
10. I meet by own personal expectations for expertise in caring for my child.	1	2	3	4	5	6
11. If anyone can find the answer to what is troubling my child, I am the one.	1	2	3	4	5	6
12. My talents and interests are in other areas, not being a parent.	1	2	3	4	5	6
13. Considering how long I've been a father, I feel thoroughly familiar with this role.	1	2	3	4	5	6
14. If being a father of a child were only more interesting, I would be motivated to do a better job as a parent.	1	2	3	4	5	6

15. I honestly believe I have all the skills necessary to be a good father to my child.	1	2	3	4	5	6
16. Being a parent makes me tense and anxious.	1	2	3	4	5	6
17. Being a good father is a reward in itself.	1	2	3	4	5	6

Appendix 7: Caregiving Helplessness Questionnaire

Child-Parent Relationship Scale

(Pianta, 1998)

Definitely does not apply	Not really	Neutral, not sure	Applies somewhat	Definitely applies
1	2	3	4	5

1	I share an affectionate, warm relationship with my child.	1	2	3	4	5
2	My child and I always seem to be struggling with each other.	1	2	3	4	5
3	If upset, my child will seek comfort from me.	1	2	3	4	5
4	My child is uncomfortable with physical affection or touch from me.	1	2	3	4	5
5	My child values his/her relationship with me.	1	2	3	4	5
6	My child appears hurt or embarrassed when I correct him/her.	1	2	3	4	5
7	My child does not want to accept help when he/she needs it.	1	2	3	4	5
8	When I praise my child, he/she beams with pride.	1	2	3	4	5
9	My child reacts strongly to separation from me.	1	2	3	4	5
10	My child spontaneously shares information about himself/herself.	1	2	3	4	5
11	My child is overly dependent on me.	1	2	3	4	5
12	My child easily becomes angry at me.	1	2	3	4	5
13	My child tries to please me.	1	2	3	4	5
14	My child feels that I treat him/her unfairly.	1	2	3	4	5
15	My child asks for my help when he/she really does not need help.	1	2	3	4	5
16	It is easy to be in tune with what my child is feeling.	1	2	3	4	5
17	My child sees me as a source of punishment and criticism.	1	2	3	4	5
18	My child expresses hurt or jealousy when I spend time with other children.	1	2	3	4	5
19	My child remains angry or is resistant after being disciplined.	1	2	3	4	5
20	When my child is misbehaving, he/she responds to my look or tone of voice.	1	2	3	4	5
21	Dealing with my child drains my energy.	1	2	3	4	5
22	I've noticed my child copying my behavior or ways of doing things.	1	2	3	4	5
23	When my child is in a bad mood, I know we're in for a long and difficult day.	1	2	3	4	5
24	My child's feelings toward me can be unpredictable or can change suddenly.	1	2	3	4	5
25	Despite my best efforts, I'm uncomfortable with how my child and I get along.	1	2	3	4	5
26	I often think about my child when at work.	1	2	3	4	5
27	My child whines or cries when he/she wants something from me.	1	2	3	4	5
28	My child is sneaky or manipulative with me.	1	2	3	4	5
29	My child openly shares his/her feelings and experiences with me.	1	2	3	4	5
30	My interactions with my child make me feel effective and confident as a parent.	1	2	3	4	5

Appendix 8: Pre group and Post Group Interview Questions

1. I feel guilty about my past experiences as a parent

0 Not at all Guilty	1	2	3	4	5	6 A lot Guilty

2. I feel confident about playing with my child

0 Not at all Confident	1	2	3	4	5	6 A lot Confident

3. I am likely to attend a parenting program <u>outside</u> of this rehabilitation program

0 Unlikely	1	2	3	4	5	6 Likely

4. Your child is acting up. What do you think can be going on for your child? (Please describe)

5. How hopeful do you feel about your future parenting and relationship with your child? (Please describe).

Interview with Participants – At End of program

1. Has your view of yourself as a parent changed as a result of this program? How has it changed? (Please describe)
2. What was the most useful part of the Black Box Parenting program? (Please describe)
3. What did you see as the main benefits of the Black Box parenting Program? (Please describe)
4. How was the idea of the 'Black Box' metaphor helpful to you? (Please describe)

5. In what ways do you better understand what's happening in the relationship with your child? (Please describe)
6. When your child misbehaves, what are the things you think about now that you hadn't thought about before: (Please describe)
7. What have you noticed that is different in your relationship with your child after completing the program? (Please describe)
8. Has your confidence in playing with your child changed since doing the program? IF YES. What do you think contributed to the change in your confidence? (Please describe)
9. How could the program have been improved? (Please describe)

Appendix 9: Post Group Feedback Questionnaire

Black Box Parenting - Participant Feedback Form

1. My relationship with my child since I took this program has:						
0 Not improved	1	2	3	4	5	6 Improved a lot

2. My confidence in playing with my child has:						
0 Not Improved	1	2	3	4	5	6 Improved a lot

3. I feel that the things we did in the program was useful in improving my relationship with my child:						
0 Not at all useful	1	2	3	4	5	6 A lot Useful

4. I feel less blamed as a parent since I took this program:						
0 I blame myself A Lot	1	2	3	4	5	6 I don’t blame myself

5. What we talked about in group was:						
0 Not at all useful	1	2	3	4	5	6 A lot Useful

6. Use of practice play during group session was

0 Not at all useful	1	2	3	4	5	6 A lot Useful

7. I felt the group leader cared about me and my challenges with parenting						
0 Not at all Satisfied	1	2	3	4	5	6 A lot Satisfied
8. I feel that the group leader in the program was helpful.						
0 Not at all Helpful	1	2	3	4	5	6 A lot Helpful

9. I feel the group was						
0 Unsupportive	1	2	3	4	5	6 Extremely supportive
10. Other group members were interested in me and my child						
0 Interested	1	2	3	4	5	6 Disinterested
11. I would like to keep meeting as a group						
YES				NO		
12. I felt I had enough time to attend The Black Box Parenting Program with my other commitments in the rehabilitation program						
0	1	2	3	4	5	6

Not enough time.						A lot of time.

Appendix 10: Ethics Approval

UNIVERSITY OF WOLLONGONG

In reply please quote: HE13/257

24 October 2013

Ms Marianne Torres
3/70 Hampden Road
SOUTH WENTWORTHVILLE NSW 2145
mtt029@uowmail.edu.au

Dear Ms Torres

Thank you for your response dated 18 October 2013 to the HREC review of the application detailed below. I am pleased to advise that the application has been approved.

Ethics Number:	HE13/257
Project Title:	Trauma, attachment relationships and parenting self-efficacy in male caregivers receiving substance abuse treatment
Researchers:	Ms Marianne Torres, Dr Rebecca Sng, Professor Frank Deane
Approval Date:	24 October 2013
Expiry Date:	23 October 2014

The University of Wollongong/Illawarra Shoalhaven Local Health District Social Sciences HREC is constituted and functions in accordance with the NHMRC *National Statement on Ethical Conduct in Human Research.* The HREC has reviewed the research proposal for compliance with the *National Statement* and approval of this project is conditional upon your continuing compliance with this document.

A condition of approval by the HREC is the submission of a progress report annually and a final report on completion of your project. The progress report template is available at http://www.uow.edu.au/research/rso/ethics/UOW009385.html. This report must be completed, signed by the appropriate Head of School, and returned to the Research Services Office prior to the expiry date.

As evidence of continuing compliance, the Human Research Ethics Committee also requires that researchers immediately report:

- proposed changes to the protocol including changes to investigators involved
- serious or unexpected adverse effects on participants
- unforseen events that might affect continued ethical acceptability of the project.

Please note that approvals are granted for a twelve month period. Further extension will be considered on receipt of a progress report prior to expiry date.

If you have any queries regarding the HREC review process, please contact the Ethics Unit on phone 4221 3386 or email rso-ethics@uow.edu.au.

Yours sincerely

Professor Kathleen Clapham
Chair, Social Sciences
Human Research Ethics Committee

Ethics Unit, Research Services Office
University of Wollongong NSW 2522 Australia
Telephone (02) 4221 3386 Facsimile (02) 4221 4338
Email: rso-ethics@uow.edu.au Web: www.uow.edu.au

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AUSTRALIA

APPROVAL LETTER
In reply please quote: HE15/153

29 May 2015

Ms Marianne Torres
Northfields Clinic
University of Wollongong NSW 2522

Dear Ms Torres

Thank you for your responses of 29 May 2015 to the HREC review of the application detailed below. I am pleased to advise that the application has been approved.

Ethics Number:	HE15/153
Project Title:	Reparative Parenting in Substance Abusing Fathers: A Pilot Parenting Program
Researchers:	Ms Marianne Torres, Dr Rebecca Sng, Professor Frank Deane
Documents Reviewed/ Approved:	Initial Application Demographics Questionnaire Parenting Scale Pre Group and Post Group Interview Questions Black Box Parenting – Participant Feedback Form Interview with Participants – at end of program and follow up Participant Information Sheet for Male Caregivers, V4 Information to Parents About Play Sessions, V4 Consent Form for Male Caregivers (Group and Play Sessions), V2 Consent Form for Male Caregivers (Group participation only), V2 Parenta/Guardian Permission for Children Participant in Research, V4 Session layout Recruitment process Script for telephone call to parent PICCOLO Letter of Support on behalf of Salvation Army, 17 Feb 2015 Black Box Parenting Program Process Confirmation of insurance coverage, 25 March 2015 V2: Guide for Caseworkers V1: Consent Form for Caseworkers
Approval Date:	29 May 2015
Expiry Date:	28 May 2016

The University of Wollongong/Illawarra Shoalhaven Local Health District Social Sciences HREC is constituted and functions in accordance with the NHMRC *National Statement on Ethical Conduct in Human Research.* The HREC has reviewed the research proposal for compliance with the *National Statement* and approval of this project is conditional upon your continuing compliance with this document.

Ethics Unit, Research Services Office
University of Wollongong NSW 2522 Australia
Telephone (02) 4221 3386 Facsimile (02) 4221 4338
Email: rso-ethics@uow.edu.au Web: www.uow.edu.au

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AUSTRALIA

AMENDMENT APPROVAL LETTER
In reply please quote: HE15/153

18 June 2015

Ms Marianne Torres
Northfields Clinic
University of Wollongong NSW 2522

Dear Ms Torres,

I am pleased to advise that the amendment dated 10/06/15 to the following Human Research Ethics application has been approved.

Ethics Number:	HE15/153
Project Title:	Reparative Parenting in Substance Abusing Fathers: A Pilot Parenting Program
Researchers:	Ms Marianne Torres, Dr Rebecca Sng, Professor Frank Deane
Amendment:	Additional Sites – Odyssey House and Northfields Clinic
Amendment Approval Date:	18 June 2015
Expiry Date:	28 May 2016

Please remember that in addition to reporting proposed changes to your research protocol the HREC requires that researchers: immediately report:

- Report serious or unexpected adverse effects on participants immediately
- Report unforeseen events that might affect continued ethical acceptability of the project.
- Submit a progress report annually and on completion of your project. The progress report template is available at http://www.uow.edu.au/research/ethics/UOW009385.html. This report must be completed, signed by the researchers and appropriate Head of Unit and returned to the Research Services Office prior to the expiry date.

If you have any queries regarding the HREC review process, please contact the Ethics Unit on phone 4221 3386 or email rso-ethics@uow.edu.au.

Yours sincerely,

Associate Professor Melanie Randle
Chair, UOW Social Sciences
Human Research Ethics Committee

The University of Wollongong/ Illawarra and Shoalhaven Local Health Network District (ISLHD) Social Science HREC is constituted and functions in accordance with the NHMRC National Statement on Ethical Conduct in Human Research.

Ethics Unit, Research Services Office
University of Wollongong NSW 2522 Australia
Telephone (02) 4221 3386 Facsimile (02) 4221 4338
Email: rso-ethics@uow.edu.au Web: www.uow.edu.au

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AMENDMENT APPROVAL LETTER
In reply please quote: HE15/153

26 June 2015

Ms Marianne Torres
Northfields Clinic
B22
University of Wollongong NSW 2522

Dear Ms Torres,

I am pleased to advise that the amendment dated 24 June 2015 to the following Human Research Ethics application has been approved.

Ethics Number:	HE15/153
Project Title:	Reparative Parenting in Substance Abusing Fathers: A Pilot Parenting Program
Researchers:	Ms Marianne Torres, Dr Rebecca Sng, Professor Frank Deane
Amendment:	Additonal Group Facilitator – Briony Osborne
Amendment Approval Date:	25 June 2015
Expiry Date:	28 May 2016

Please remember that in addition to reporting proposed changes to your research protocol the HREC requires that researchers: immediately report:

- Report serious or unexpected adverse effects on participants immediately
- Report unforeseen events that might affect continued ethical acceptability of the project.
- Submit a progress report annually and on completion of your project. The progress report template is available at http://www.uow.edu.au/research/ethics/UOW009385.html. This report must be completed, signed by the researchers and appropriate Head of Unit and returned to the Research Services Office prior to the expiry date.

If you have any queries regarding the HREC review process, please contact the Ethics Unit on phone 4221 3386 or email rso-ethics@uow.edu.au.

Ethics Unit, Research Services Office
University of Wollongong NSW 2522 Australia
Telephone (02) 4221 3386 Facsimile (02) 4221 4338
Email: rso-ethics@uow.edu.au Web: www.uow.edu.au

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AUSTRALIA

AMENDMENT APPROVAL LETTER
In reply please quote: HE15/153

7 August 2015

Ms Marianne Torres,
Northfields Clinic
B22
University of Wollongong NSW 2522

Dear Ms Torres,

I am pleased to advise that the amendment dated 5 August 2015 to the following Human Research Ethics application has been approved.

Ethics Number:	HE15/153
Project Title:	Reparative Parenting in Substance Abusing Fathers: A Pilot Parenting Program
Researchers:	Ms Marianne Torres, Dr Rebecca Sng, Professor Frank Deane
Amendment:	Additional site for recruiting participants
Amended Documents:	Letter of Support from One80TC
	Consent Form for Caseworkers V1.1
	Consent Form for Male Caregivers V2.1
	Guide for Caseworkers V2.1
	Participant Information Sheet for Male Caregivers V4.1
Amendment Approval Date:	6 August 2015
Expiry Date:	28 May 2016

Please remember that in addition to reporting proposed changes to your research protocol the HREC requires that researchers: immediately report:

- Report serious or unexpected adverse effects on participants immediately
- Report unforeseen events that might affect continued ethical acceptability of the project.
- Submit a progress report annually and on completion of your project. The progress report template is available at http://www.uow.edu.au/research/ethics/UOW009385.html. This report must be completed, signed by the researchers and appropriate Head of Unit and returned to the Research Services Office prior to the expiry date.

Ethics Unit, Research Services Office
University of Wollongong NSW 2522 Australia
Telephone (02) 4221 3386 Facsimile (02) 4221 4338
Email: rso-ethics@uow.edu.au Web: www.uow.edu.au

UNIVERSITY OF WOLLONGONG

AMENDMENT APPROVAL
In reply please quote: HE15/153
Further Enquiries Phone: 4221 3386

16 October 2015

Ms Marianne Torres
Northfields Clinic
B22
University of Wollongong NSW 2522

Dear Ms Torres

I am pleased to advise that the amendment requested to the following Human Research Ethics application has been approved.

Ethics Number:	HE15/153
Project Title:	Reparative Parenting in Substance Abusing Fathers: A Pilot Parenting Program
Researchers:	Ms Marianne Torres, Dr Rebecca Sng, Professor Frank Deane
Amendments:	
	Additional Site: Mission Australia, 19 Denham St, Surry Hills NSW 2010
	Letter of support from service site
	Participant Information Sheet for Male Caregivers V4.1
	consent for Male Caregivers (group only) V2.1
	Consent form for Caseworkers V1.1
	Guide for Caseworkers V2.1
Amendment Approval Date:	16 October 2015
Application Expiry Date:	**28 May 2016**

Please remember that in addition to reporting proposed changes to your research protocol the HREC requires that researchers immediately report:

- serious or unexpected adverse effects on participants
- unforseen events that might affect continued ethical acceptability of the project.

The University of Wollongong/ Illawarra and Shoalhaven Local Health Network District (ISLHD) Social Science HREC is constituted and functions in accordance with the NHMRC National Statement on Ethical Conduct in Human Research.

A condition of approval by the HREC is the submission of a progress report annually and a final report on completion of your project. The progress report template is available at http://www.uow.edu.au/research/rso/ethics/UOW009385.html. This report must be completed, signed by the appropriate Head of School and returned to the Research Services Office prior to the expiry date.

Ethics Unit, Research Services Office
University of Wollongong NSW 2522 Australia
Telephone (02) 4221 3386 Facsimile (02) 4221 4338
Email: rso-ethics@uow.edu.au Web: www.uow.edu.au

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