

BEN- GURION UNIVERSITY OF THE NEGEV
THE FACULTY OF HUMINITIES AND SOCIAL
SCIENCES
DEPARTMENT OF SOCIAL WORK

**Substance Abusing Mothers:
Toward an Understanding of Parenting and Risk
Behavior**

THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR THE MASTER OF ARTS DEGREE (M.A.)

MOR YEHUDAI

UNDER THE SUPERVISION OF: PROF. ORLY SARID

MAY 2015

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MAY 2015

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Abstract

Background: The use of harmful substances is a worldwide problem that has a major impact on public health. While the levels, patterns and context of substance use may vary from country to country, there is general agreement that substance abuse is incompatible with appropriate parenting. Parenting by substance abusers can be chaotic, inconsistent, and unpredictable. Maternal substance abuse in particular, is a major health and social problem.

The purpose of this study is to identify the impact of personal characteristics of substance abusing mothers, patterns of substance use on parenting skills and risk behavior.

Method: A total of 41 life time female substance users with children were surveyed at a methadone maintenance clinic in the southern region of Israel– the Negev. The sampling procedure was geared to collecting psychosocial data from mothers in order to estimate their parenting skills. Personal interviews of the study participants were conducted by drug treatment center personnel in 2014. Multiple data collection instruments were used, including the *Alcohol Use Disorders Identification Test (AUDIT)*- a screening instrument for hazardous and harmful alcohol consumption; *Substance Use Survey Instrument (SUSI)*- an instrument testing personal background characteristics, substance use patterns, and risk taking behavior; *Parenting Stress Index - short form (PSI-SF)*, assesses stressors originating from parent, child, and parent-child interaction, including parental distress, parent-child dysfunctional interaction, and difficult child behavior; *Parent Child Relationship Inventory (PCRI)* - assesses parents' perception of their relationships with their children; *Generalized Anxiety Disorder Scale (GAD-7)*– screens

for Generalized Anxiety Disorder (GAD) and assesses its severity; *Health-Related Anxiety Questions*- assesses recent health-related anxiety. This scale taps four domains that can be significantly affected by anxiety: sleep, appetite, social contact, and concentration at school or work; *The Suicidal Behaviors Questionnaire- Revised (SBQ-R)* – instrument measuring four different dimensions of suicidality. Data were coded and analyzed at the Regional Alcohol and Drug Abuse Research Center (RADAR), Spitzer Department of Social Work, Ben Gurion University. Statistical analysis, using SPSS - version 19, included the Mann–Whitney U test.

Results: Problem behavior such as loss of appetite; trouble sleeping; difficulties maintaining social lives, and trouble concentrating at work/ school were affected by the type of drug(s) used by the mothers. Mothers using alcohol and cannabis tended to have higher stress levels and parenting problems than those who did not use these substances. Mothers using prescription drugs and with older children, had higher levels of anxiety. Additionally, mothers of children over the age of 18 had more difficulties gaining the child’s cooperation and/or managing the child’s behavior. Higher levels of anxiety were found among mothers who served time in jail/prison compared to mothers that did not. Surprisingly, mothers using opiates reported lower levels of Total Stress compared to mothers that do not.

Another study issue was suicidal behavior. Mothers with higher levels of suicidal thoughts or attempts reported higher levels of anxiety, problem behaviors and stress regarding their parental role. Mothers who reported higher levels of suicidal thoughts or attempts showed increased parental disappointment about the child; feeling rejected or alienated by the child, and/or the feeling that parent-child interactions are not satisfying.

Furthermore, mothers with higher levels of suicidal thoughts had a hard time gaining the child's cooperation and/or managing the child's behavior.

Conclusion: This exploratory study assessed and evaluated parenting skills among substance abusing mothers using an evidence-based approach. Substance abusing women are at high risk of experiencing multiple problems that may undermine their ability to care for their children. Yet, to date, no study in Israel has researched parenting skills among substance abusing mothers receiving methadone maintenance treatment (MMT). Treatment agencies such as MMT programs should have greater awareness of the connection between substance abuse, problem behavior and parenting skills. Clearly, the opportunity to access a high risk population of substance abusing women with children has generated significant findings that provide "usable knowledge" for prevention and treatment purposes in Israel and elsewhere. Nevertheless, there is a need for further research of such high risk mothers (and fathers) and effective means to promote parenting skills.

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Introduction

The harmful use of substances is a worldwide problem that has a major impact on public health. The use of psychoactive substances causes significant health and social problems for the people who use them, family members and society. For example, about 6% of the world's population ages 15-64 use psychoactive substances including cannabis, amphetamines, cocaine, opioids, and non-prescribed psychoactive prescription medication and more than 3.3 million people or 5.9% of all global deaths every year are attributed to alcohol use alone (World Health Organization [WHO], 2014). In Israel, national survey results show 64.3% of the adult population drink alcohol; 11.4% use an illegal substance, 37.6% smoke cigarettes, and 3.4% use medications without a doctor's prescription (IADA, 2009). While the levels, patterns and context of substance use may vary from country to country, there is general agreement that harmful substance behavior may be attributed to one or a combination factors including those of a psychological, legal, medical, social, and cultural nature (Choi & Ryan, 2007).

Literature Review

Overtime, many substance use terms have changed due to shifting behavior patterns; research; clinical interventions; and laws. The following definition of select terms provides understanding of the present research of parenting skills among substance using mothers in treatment.

1. What is a Drug?

A drug is as any substance other than food, which by its chemical nature, affects the structure and function of the living organism. What makes a substance a drug is not its

chemical properties but how it is used by people. From a positive perspective, a drug is used to maintain health, fight infection, reverse a disease process, and/or relieve symptoms of illness. In a neutral context, it is any substance that causes or creates significant psychological and/or physiological changes in the body. And from a negative perspective, it is often an illegal drug that causes addiction, habituation, or a marked change in psychological functioning (Isralowitz & Myers, 2011).

2. Substance Abuse Disorders

According to the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (DSM)-V, substance related disorders encompass ten separate classes of drugs: alcohol; caffeine; cannabis; hallucinogens, inhalants; opioids; sedatives; stimulants; tobacco; and other (or unknown) substances (American Psychiatric Association, 2013). A substance use disorder is a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems. An important characteristic of substance use disorders is an underlying change in brain function that may persist beyond detoxification, particularly in individuals with severe disorders. Overall, the diagnosis of a substance use disorder is based on a pathological pattern of behaviors related to use of the substance.

Substance use disorders can range from mild to severe based on the number of symptom criteria involved. For example, a *mild* disorder includes the presence of two to three symptoms, *moderate*- four to five symptoms, and *severe*- six or more symptoms. Among the diagnostic criteria are:

Impaired control over substance use (Criteria 1-4)

- 1) The individual may take the substance in larger amounts or over a longer period than was originally intended.
- 2) The individual may express a persistent desire to cut down or regulate substance use and may report multiple unsuccessful efforts to decrease or discontinue use
- 3) The individual may spend a great deal of time obtaining the substance, using the substance, or recovering from its effects.
- 4) In some instances of more severe substance use disorders, virtually all of the individual's daily activities revolve around the substance.

Social impairment (Criteria 5-7)

- 5) Recurrent substance use may result in a failure to fulfill obligations at work, school, or home.
- 6) The individual may continue substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.
- 7) Important social, occupational, or recreational activities may be given up or reduced because of substance use; and, the individual may withdraw from family activities and hobbies in order to use the substance.

Risky use of the substance (Criteria 8-9)

- 8) This may take the form of recurrent substance use in situations that are physically hazardous.
- 9) The individual may continue substance use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to be caused by the substance.

Pharmacological criteria (Criteria 10 and 11)

- 10) Tolerance is signaled by requiring an increase of the substance to achieve the desired effect or a reduced effect when the usual dose is consumed. Tolerance varies from one person to another and the type of substance used.
- 11) Withdrawal is a syndrome that occurs when blood or tissue concentrations of a substance decline in an individual who had maintained prolonged heavy use of the substance. After developing withdrawal symptoms, the individual is likely to relapse and consume the substance to relieve the symptoms (American Psychiatric Association, 2013).

Alcohol and opioid use disorders are most common disorders, especially among mothers receiving substance abuse treatment.

2.1 Alcohol use disorder is a problematic pattern of use leading to clinically significant impairment or distress manifested by at least two of the symptoms listed above occurring within a 12-month period. The disorder includes behavioral and physical symptoms of withdrawal, tolerance, and craving. Once a repetitive and intense pattern of use develops, individuals may devote much time to obtaining and consuming alcoholic

beverages. Craving for alcohol is indicated by a strong desire to drink that makes it difficult to think of anything else. School and job performance may also suffer; child care or household responsibilities may be neglected; and, alcohol-related absences may occur. The individual may use alcohol in physically hazardous circumstances (e.g., driving an automobile, swimming, or operating machinery). Individuals with an alcohol use disorder may continue to consume alcohol despite knowledge that its use contributes to significant physical (e.g., blackouts and liver disease), psychological (e.g., depression), social, or interpersonal problems (e.g., violent arguments with spouse while intoxicated and child abuse). About 40%-60% of alcohol use disorder may be explained by genetics passed on from one family member to another (American Psychiatric Association, 2013).

2.2 Opioid use disorder is the problematic use of the substance (e.g., heroin) leading to significant impairment or distress manifested by at least two of the symptoms listed above occurring within a 12-month period. This disorder tends to include compulsive, prolonged self-administration of opioid substances that are used for no legitimate medical purpose. If it is used for a medical condition, the amount consumed is in excess of the amount prescribed. Individuals with opioid use disorder tend to develop regular patterns of compulsive drug use that involves much time obtaining and administering the substance. Opioids are usually purchased on the illegal market; obtained from physicians falsifying or exaggerating medical problems; or by receiving prescriptions from multiple physicians. Most individuals with opioid use disorder have significant levels of tolerance and experience withdrawal when the substance is discontinued (American Psychiatric Association, 2013).

The risk for opiate use disorder can be related to individual, family, peer, social environment and genetic factors. Opioid use disorder are commonly first observed in when a person is in late teens or early 20s and it is often associated with the use of other substances including tobacco, alcohol, cannabis, stimulants, and benzodiazepines. Individuals with opioid use disorder are at risk for the development of depression and antisocial behavior. Posttraumatic stress disorder often resulting from physical and/or sexual abuse is a common factor among (American Psychiatric Association, 2013).

3. Theoretical Considerations and Risk Factors

Much progress has been made over the past few decades in understanding basic factors and developmental processes associated with substance use, its prevention and treatment. The initiation of substance use is a necessary precursor to abuse and dependence. It develops during the adolescent years; and the behavior is often preceded by biological, psychological, social, and environmental factors that originate as early as the prenatal period. The misuse and illicit use of harmful substances can interfere with the normal healthy functioning of persons across the lifespan –extending well beyond adolescence into adulthood (NIH 2008).

The life course developmental perspective suggests that individual and environmental factors interact to increase or reduce vulnerability to substance use, abuse and dependence. Vulnerability can occur at many points along the life course but especially at critical transition periods including those of a biological (e.g., puberty); normative (e.g., relocation and moving from school to school); social (e.g., interaction with peers and dating); and trauma (e.g., coping with crisis events including the death of

a parent and loved one) nature. In addition, vulnerability to substance abuse involves dynamic intrapersonal (e.g., temperament), interpersonal (e.g., family and peer interactions) and environmental (e.g., school environment and neighborhood) factors that affect the interactions between individuals and social systems. Also, substance use, abuse, and dependence often co-occur with delinquency and criminal behavior, interpersonal violence, mental health problems, HIV, sexually transmitted infections, and reproductive health problems (Ibid).

Underlying this explanation are a host of biomedical, psychological and/or sociological considerations such as: 1) the history of substance abuse patterns and the changing population of users; 2) recognition that specific substance abuse patterns are culturally determined – that cultures (and subcultures) differ in the availability of drugs and the extent of abuse; 3) awareness that demographic (and epidemiological) characteristics of abusers depend upon the time period, nation, and locale selected for study; 4) the need to delineate the specific drug (or drugs) of abuse, route of administration, and length of dependence; 5) the etiology of social context in which drug abuse begins; 6) the influence of major institutions (e.g., family, community, peer group, schools, and media) upon the onset and continuation of drug dependency; 7) why substance abuse is more prevalent in certain populations than others; and, 8) determination of institutional supports that promote successful treatment and rehabilitation, including consideration of how persistent behavior in subcultures can be changed (Goode 1989).

Over time major factors associated with substance use have included:

3.1 Social Order - people are often referred to as deviant when they do not share the values or adhere to the social norms regarding conduct and personal attributes prescribed by society (Merton 1957; Merton 1969).

3.2 Deviance – reflecting the belief that social groups create deviance by making the rules whose violations constitute deviance, and by applying those rules to particular people and labeling them as outsiders. Studies in the drug field shifted the emphasis from asking why people used harmful substances to asking how became involved in substance use and how they remained involved (Feldman & Aldrich 1990).

3.3 Social Forces: Physical Environment, Values and Morals - from research conducted as early as the 1920s in the United States, it has been shown that the environment where a person lives can be an influential factor in the use and abuse of harmful substances. An environment that is deteriorating and poverty-stricken serves as a breeding ground for problem behavior such as use. In order to exist, norms and values different from those prescribed through explicit and implicit social policies, laws and methods of enforcement are adopted by these people, enabling them to achieve goals that are readily attainable and less abstract. While issues such as lower-class values and morals and the disproportionate amount of crime and drug problems found among the poor have been widely covered by sociological research and literature, there are studies which show that such problem behavior is also indigenous to the middle and upper classes. Facts and statistics reveal that substance use and abuse is a problem found among all social classes. However, it is a problem that tends to be more easily rooted among poor people in conditions of poverty and social degradation, and the “social reality” defined by politicians, law enforcement officials, police, and other decision-makers.

3.4 Family - The role of the family is a major causal factor in shaping the personality and behavior of children. The family serves as a reference group on personal and normative levels. Parents train their children to conform or not to conform to particular moral standards through the examples they provide by their own behavior. Investigators of families with a drug-abusing member have identified some consistent patterns related to adolescent drug use, including the role of mother and/or father to their child. Research shows family relations, parent roles, divorce, parent and sibling alcohol and drug use, death or absence of a parent, emotional, physical and/or sexual abuse, mental health, low aspirations, and other factors linked to drug use (Isralowitz & Myers, 2011).

3.5 Peers - Peer relations is often linked to substance use. Such behavior may be learned through association and interaction with others who are already involved with drugs. The relationship a person has with peers may serve as a means of providing the individual with an escape from other interpersonal dealings such as family, school or work. Peers tend to have a consistent influence on health risk behavior and may be better predictors of such behavior than parental influences among young adolescents (Kandel, 1980).

3.6 Education - The school has a major role in the socialization process of people. Many studies have shown the relationship between a negative school experience and drug use to be strong. Long term studies have shown school performance strongly associated to early drop out, cigarette use, alcohol and illicit drugs, sexual activity, pregnancy, delinquency, suicide thoughts, and weapons use.

3.7 Media - The media has an influence on the socialization process and in turn, substance use and related problem behavior. Children and adolescents spend much time with a variety of media including television, videos, video games, and the Internet. Behavior such as substance use in the media can have a lasting effect on children and youth if the themes presented are repeated often enough; and, the information imparted by the media is not clearly contradicted by significant others such as parents, peers, or teachers (Atkin 1990; Strasburger & Donnerstein, 2000).

3.8 Labeling-Criminalization Process - The labeling process is a method that determines the fate of a person. It tends to reinforce problem behavior rather than ameliorate it. Essentially, labeling theories are less interested in the problem behavior of a person and his characteristics than in the criminalization process – apprehending and punishing law violators leaving them with a negative status. In terms of substance use, a consistent pattern of events tends to take place resulting in a feedback cycle involving more deviations, more penalties, and still more deviations. Hostilities and resentment are built up culminating in official reactions that label and stigmatize the substance user, thereby justifying even greater penalties and restricting opportunities for the person to change problem behavior violations. Based on the labeling/criminalization process, therefore, the treatment of drug offenders may serve as a self-fulfilling prophecy. It forecloses non-criminal options and coerces users into a permanent state of drug use and other violations (Gray, 1998).

3.9 Biological and Psychological Characteristics - Research has shown that genetic factors are estimated to contribute 40%-60% of a person's vulnerability to addiction, but this includes the contribution of combined genetic-environmental interactions. Drug

addiction is a brain disease, although initial drug use might be voluntary; once this addiction develops this control is markedly disrupted. It has been found that genetic influences are stronger for abuse of some drugs than for others and that abusing one category of drugs such as sedatives, stimulants, opiates, or heroin is associated with a marked increase in the probability of abusing every other category of drugs. Heroin is the drug with the greatest influence for abuse (Tsuang et al. 1998; Volkow, 2005). Other studies suggest that genetic factors from drug abuse are stronger in males than females (Zikler, 1999). Another theory postulates metabolic imbalance as a possible cause of drug abuse – specifically, narcotic addiction. Whether drug users and abusers are at higher risk of suffering some metabolic imbalance is not widely known; however, there are some related factors (Isralowitz & Myers, 2011).

Psychological theories associated with substance use may be categorized into two groups: those that emphasize the mechanism of reinforcement and those that stress personality differences between people who use and are dependent on drugs and those who abstain. Research shows that drugs have addicting reinforcement properties independent of personality factors – it can be positive and negative. Positive reinforcement occurs when the individual receives a pleasurable sensation and, because of this, is motivated to repeat what caused it. Negative reinforcement occurs when an individual does something to seek relief or to avoid pain (Goode 1989). Personality pathology, defect, or inadequacy is another theoretical approach. The inadequate personality approach points to problems of an emotional or psychological nature of certain individuals leading them to drug use. Drugs are used to escape reality and avoid problems. This personality type lacks responsibility, independence, and the ability to

defer pleasurable gratification for the sake of achieving long range goals. Other personal characteristics include low self-esteem and feelings of self-derogation brought about by peer rejection, parental neglect, school failure, impaired sex-role identity, ego deficiencies, low coping abilities, coping mechanisms that are socially devalued and/or are otherwise self-defeating (Petraitis et al. 1998). Other characteristics include being less religious, less attached to parents and family, less achievement-oriented, less cautious, and having a higher level of sexual activity.

4. Substance Abusing Women

Substance abuse has been widely viewed as a problem that mostly affects males. However, by the mid-1990s the pattern of use of harmful substance based on gender status changed (Kumpfer & Fowler, 2007); and, the gap between the two have been diminishing since (Isralowitz & Reznik, 2012). Over time, males and females have used harmful substances for different reasons. For example, stressful events are often cited as a trigger for female use of harmful substances. Also, women tend to be more vulnerable to abuse and addiction than males (Isralowitz & Myers, 2011); and, they are at greater risk for adverse health outcomes including physical illnesses, cognitive motor impairment, and cancer caused by hazardous substance abuse (Nolen-Hoeksema, 2004).

Women tend to begin abusing drugs later in life than men and they are more likely to have a coexisting psychiatric problem such as depression; a greater history of suicide attempts; and, tend to be more hostile. Many women report that their substance-using male sex partners initiated them into drug abuse. In addition, drug-dependent women have great difficulty abstaining from harmful substances when the lifestyle of their male partner is one that supports such use (Isralowitz & Myers, 2011).

5. Parenting

The family has a major role in shaping the personality and behavior of children as noted above. Factors such as parental divorce, arrest, a lack of closeness between parents and children, parent and sibling drug use, family disorganization, mental illness, low educational aspirations for the children, lack of parental involvement in the child's activities, weak parental control and discipline, death or absence of a parent, and emotional, physical, and/or sexual abuse are factors that have been found to be linked to drug use (Isralowitz & Myers, 2011).

Parenting by substance abusers can be chaotic, inconsistent, and unpredictable. The substance abusing parents are less likely to provide appropriate feeding and bedtime routines that infants need. Also, they are less likely to cope with infants' nighttime awakenings and to provide correct nutrition. As children of substance abusers enter school, there is less likelihood that they will receive adequate help with or monitoring of homework, or that their parents will attend parent-teacher conferences (Myers & Isralowitz, 2011). Parental substance abuse is associated with a more than twofold increase in the risk of exposure to childhood physical and sexual abuse (Walsh, MacMillan & Jamieson, 2003).

According to Hussong et al., (2008), children of substance abusers tend to experience negative life events more chronically or repetitively than their peers. Thus, they appear to differ from their peers in terms of the types of events they experience, in the severity of those stressors and, to some extent, in the chronicity of their exposure. Therefore, these children and their families need skills to cope not only with a high

stress load that includes common stressors, but also severe events. On top of that, children of substance abusers may be prone to experience similar life events as more severe than do other children given a relative lack of parental support, positive family functioning, and personal coping resources. In other words, the chaotic and conflict-ridden family environment may simply magnify life events so that they are experienced as more severe by those children (Hussong et al., 2008).

In comparison with children raised by parents who do not use harmful substances, children who live with an alcoholic and other substance abusing parent exhibit elevated symptom levels for both internalizing (e.g., sadness and worrying) and externalizing (e.g., aggression) syndromes (Fals-Stewart et al., 2004). Moreover, studies show that if a child observes a parent drinking or drug use, he/ she may exhibit high usage patterns and have greater tolerance for the associated problems as a result of their presence in his or her family of origin (Locke & Necomb, 2004). Many mothers with substance use disorders are at greater risk for maladaptive parenting than mothers who do not have substance use problems (Suchman, McMahon, DeCoste, Castiglioni & Luthar, 2008). As mentioned above, child abuse is a common problem experienced by children of parents who are substance users. Parents affect the use of substances by their children through the modeling of specific behaviors and through their parenting styles. The importance of such modeling tends to differ by type of substance abused. For example, mother's drinking has predicted both daughters' and sons' alcohol use in the future (Raskin- White, Johnson & Buyske, 2000).

Maternal substance abuse is a major health and social problem. Research has indicated that substance abuse is incompatible with appropriate parenting (Kelley,

1998). According to Velez et al. (2004), mothers entering drug abuse treatment have limited parenting knowledge and hold misconceptions about basic parenting practices. Lack of knowledge in parenting domains is likely to negatively affect mother-infant interaction, especially during the crucial postpartum period, and thus may affect the development of the child, thereby producing increased feelings of guilt and inadequacy among substance-abusing women. This, in turn, may lead to poor mother-infant communication, developmental delay, child abuse and/or neglect, and relapse to drug use after the baby is born (Velez et al., 2004).

Many drug-using women do not seek treatment because they fear not being able to take care of or keep their children, reprisal from their spouses or boyfriends, and punishment from authorities in the community (Isralowitz & Myers, 2011). In addition, substance abuse has been understood as an effort to compensate for deficits in emotional regulation. From this understanding, it is possible that as the capacity of the mother to contain and regulate the painful emotions of her child increases, her desire to return to substance use as a source of emotional comfort may also diminish.

5.1 Mothers with Infectious Diseases

Substance abusing mothers often suffer from problems and difficulties regarding both their parenting and their health. For example, Hepatitis B virus (HBV) and Hepatitis C virus (HCV) infections are highly prevalent among injection drug users (Kelley, 1992). Infected mothers, including those receiving treatment for addiction, put their children living with them at risk of infection. These children experience more psychological distress compared to children whose mother is not infected. Also, the level of

depression, anxiety, and aggression among these children is higher when their mothers have poorer physical functioning or physical illness symptoms (Murphy, Greenwell, Mouttapa, Brecht & Schuster, 2006).

Parent illness has been associated with negative outcomes for children; and, parenting skills appear to be one mechanism operating in that association (Murphy, Marelich, Armistead, Herbeck & Payne, 2010). Mothers suffering from infectious diseases may have difficulty maintaining routines in their household because they are challenged with physical and mental distress due to their disease (Murphy et. al., 2006). Research shows mothers with HIV report compromised parenting skills across a variety of parenting domains. Mothers who were more anxious about their own health and functioning, and more stressed in their parental role, were more likely to exhibit poorer parenting skills. Parents experiencing high levels of stress are likely to pay more attention to negative behavior and attribute them to the child rather than make situational attributions (Murphy et. al., 2010).

5.2 Parenting Stress

The term 'parenting stress' encompasses the difficulties in adjusting to the parenting role (Leigh & Milgrom, 2008). Parenting stress is associated with negative parenting practices that have been linked to increased health risk behaviors (Taylor, Rodriguez, Seaton & Dominguez, 2004). Socioeconomic status is an important determinant of parenting stress. Families in poverty are subjected to chronic levels of stress because of financial strain that diminishes the resources they have to deal with the stresses of daily life. This chronic stress can diminish the psychological well-being of a parent. Those most at risk include parents with low education levels, single parents, parents in poor

health, youth with existing internalizing and externalizing problem behaviors, and families with high levels of conflict (Taylor et. al., 2004).

Research shows parenting stressors related to social and financial factors and child health care are commonly reported by mothers with young children, especially low-income mothers and those who are members of racial/ethnic minority groups. Social and financial parenting stressors increase the risk of poor maternal mental health, and mothers who report multiple stressors are at particularly high risk (Mistry, Stevens, Sareen, De Vogil & Halfon, 2007). Maternal characteristics, especially substance dependency, have been found to be closely associated with parenting stress and child maltreatment. As expected, mothers who used harmful substances during pregnancy reported the greatest amount of total parenting stress, child-related stress, and parent-related stress. Mothers who used substances reported problems in attachment to their children, sense of competence as a parent, social isolation, depression, concerns regarding their own health, and perceived their children as very demanding (Kelley, 1992).

According to Kelley (1998), substance-abusing mothers experience high levels of stress and resort to maladaptive coping behaviors, such as abusive and neglectful behavior. Due to the additional stress associated with caring for a child, stress levels will most likely increase further, possibly leading to an escalation in drug use and increased risk of child abuse and neglect (Kelley, 1998). The high levels of parenting stress found in previous studies, suggest that substance-abusing mothers lack resources and effective coping mechanisms to deal appropriately with stressors related to the parenting role. Many substance-abusing mothers have inadequate internal resources because of what is

termed “co-morbidity.” That is, in addition to substance-abuse disorders, many are affected by depression, anxiety, and posttraumatic stress disorder. Other resources, typically the family’s financial resources, are diverted to support the mother’s addiction (Kelley, 1998).

6. Substance Abuse and Suicide

Information about substance abuse, suicide ideation and parenting is very limited. Substance abuse and suicide have been recognized as major self-destructive behaviors with strong co-morbidity linked to similar risk and protective factors (Forman & Kalafat, 1998; Borges et al, 2000). For example, substance abuse has been linked to suicide attempts including repetitiveness, serious intent, and lethality among youth. The exact nature of the relationship between substance abuse and suicide is unclear, but possible mechanisms are that substance abuse (a) exacerbates the effects of depression and anxiety; (b) increases the isolation from supportive peers, family, and other adults; and/or (c) attenuates cognitive appraisal and the inhibitions against risk behaviors. Forman & Kalafat (1998), found comorbid depression and substance abuse were the most frequent individual diagnosis in suicide attempters. In a study of substance abusers in treatment, women were found to be more likely than men to attempt suicide. Those who attempted suicide were more likely to have additional psychiatric diagnoses such as major depression and a higher level of addiction including the abuse of multiple substances especially alcohol and sedatives, than those who were non attempters (O’Boyle & Brandon, 1998).

Suicidal ideation, defined as thoughts about death in general, the wish to die, or suicidal thoughts, is a risk factor for suicide attempts and suicide. Suicidal ideation is also a predictor of suicide especially among drug users. It has been found correlated with an absence of family support, the severity of the psychosocial dysfunctioning, multi-drug abuse, and requests for treatment (Mino, Bousquet & Broers, 1999). Substance users with suicidal ideation have an elevated risk of first suicide attempts even in the absence of a plan (Borges & Kessler, 2000). The incidence of suicide is higher among drug users than in the general population. With regard to the protective effect of treatment, only methadone maintenance treatment for opiate abusers seems to reduce the risk of depression, suicide, and overdose (Mino et. al., 1999).

7. Treatment

For decades, treatment for addiction to harmful substances such as alcohol and heroin was largely separated from broader concerns of physical and mental wellbeing. Addiction was conceptualized and treated as a distinct illness to which many other problems were secondary and would probably resolve once the primary disorder had been addressed. More than three-quarters of people with addiction-related problems never enter treatment. Of those who do, many more leave treatment soon after their initial contact (Miller & Miller, 2009).

Drug-addiction treatment can include behavioral therapy, medications, or their combination. Behavioral therapies offer people strategies for coping with their drug cravings, teach them ways to avoid drugs and prevent relapse, and help them deal with relapse if it occurs. The best programs provide a combination of therapies and other

services to meet the needs of the individual patient. And, because drug addiction is typically a chronic disorder characterized by occasional relapses, a short-term one-time treatment often is not sufficient. For many, treatment is a long-term process that involves multiple interventions and attempts at abstinence. Treatment outcomes are better when treatment efforts are individualized, promote client motivation, and extend the amount of time the client is involved in the program (Isralowitz, 2004; Isralowitz & Myers, 2011). Most people treated for dependency of opiates such as heroin are enrolled in programs that offer drug substitution therapies known as “opioid substitution therapies,” which include methadone maintenance programs (Isralowitz & Myers, 2011).

Methadone hydrochloride, a synthetic narcotic, works to block opiate molecules at the specialized sites in the central nervous system. Methadone is described as a harm-reduction strategy that allows the patient to attain a legal and productive lifestyle (Isralowitz & Myers, 2011). The drug is usually administered orally in a liquid, once a day usually under the supervision of a clinic staff member. Once a maintenance level dose is reached, it almost completely blocks the effects of heroin, and, thus, controls craving (O’Brien & McLellan, 1996). MMT (Methadone Maintenance Treatment) programs are generally similar worldwide. Nevertheless, the characteristics of the patients, the levels of drug abuse and the rates of Hepatitis C and HIV infection, are reported to be higher in the US compared with the Israeli patient population. In Israel, MMT has been available with various restrictions for opiate-dependent patients since 1973 (Peles, Schreiber & Adelson, 2006). According to Peles, Schreiber & Adelson (2006), long-time retention in MMT, is associated with three parameters: high

methadone dose, the cessation of street-opiate abuse, and the fact that a patient is a parent. In Israel, about 80% of injection drug using women are infected with HBV and/or HCV (Isralowitz & Reznik, 2012).

Female substance users may belong to a special disadvantaged group that needs further attention and resources (Mistry et. al., 2007). Health and family problems are factors that motivate women to enter treatment. Among those who seek treatment, many are likely to have an alcoholic or addicted male partner or to be divorced or separated (Isralowitz & Bar- Hamburger, 2002; Isralowitz & Reznik, 2012; Isralowitz & Reznik, 2014). Children of women entering treatment often had been exposed to domestic violence, frequent child welfare involvement, and residential instability (VanDeMark et. al., 2005). With respect to the relationship between being a parent and using treatment repeatedly, this pattern may be due to either the motivation of the parent to get care for their addiction or referrals from child welfare systems aimed at improving child well-being by referring parents to substance abuse treatment (Chassler, Lundgren & Lonsdale, 2006).

Objective of the current Study

The purpose of this study is to identify the possible connection between personal characteristics of substance abusing mothers, patterns of substance use and their impact on parenting and risk behavior.

Research hypotheses

1. Substance use patterns are related to parenting problem behavior. Mothers that abuses substances will show more difficulties in her parenting behaviors. Statistically
2. The second hypothesis: substance abuse patterns including the type substance being used are linked with levels of parenting stress among substance abusing mothers. A mother who uses more substances will show higher stress level.
3. Personal background factors including marital status, age, country of origin, education, socio-economic status, religion/religiosity and/or number of children differed between mothers who differed in drug use patterns.
4. Mothers with higher GAD levels will experience more difficulties communicating with her child.

Method

1. Sample

A total of 41 life time female heroin users, with children were surveyed at the methadone maintenance clinic in Be'er- Sheva, the major population center of the southern region of Israel – the Negev. The Negev, with a population of about 700,000 is often referred to as the country's "barn" for illegal substances (Isralowitz, 2015).

The sampling procedure was primarily one of convenience and geared to collecting psychosocial data from a sample of substance using mothers in order to estimate their parenting skills. The site used for the interview, i.e., the methadone treatment clinic, is representative of similar treatment facilities throughout the country. The main inclusion criterion for the substance using clients interviewed was being a mother. Mothers were interviewed about their substance use patterns and their parenting skills. Table 1. provides details about the study group's background characteristics, including country of origin, education, religion and marital status (see table 1).

2. Sample characteristics

The study total sample consists of 41 women, out of whom 22 women were born in Israel (53.7%), 16 women who immigrated to Israel from the Former Soviet Union (39%), and 3 women of other origin. Marital status among the participants is: 35% single; 20% married; 45% separated or divorced. Regarding educational background, 30.8% of the participants are elementary school graduates and 69.2% finished high-school or higher education. In terms of religious orientation, 82.9% are Jewish; 9.8% Christian; 2.4% Muslim and 4.9% other religious orientation.

3. Instruments and Measures

All interviews were conducted in Hebrew by social work students at the methadone treatment clinic, working with the clients. The instruments used, recommended by UCLA-Integrated Substance Abuse Treatment Programs Resident Research Professor-Debra Murphy, an international expert addressing parenting skills among substance abusing mothers, were translated from English to Hebrew and back translated. Permission to conduct this study was secured in writing from the methadone treatment program director, and the Director of the substance abuse treatment - Israel Ministry of Health.

Prior to data collection, a meeting was held with the methadone treatment center director about the target study population. Initially, the study group was expected to number 60 women. However, some women did not meet the inclusion criteria and others were reluctant to participate. All study participants signed an agreement understanding their rights and safe guards. Information collected from participants was confidential and complied with BGU-IRB guidelines (See appendix for the client consent letter agreement).

During the month of May 2014, personal interviews of the study participants were conducted by drug treatment center personnel to promote interaction and minimize stress that may arise from someone unfamiliar with the study participant.

Instruments

Valid and reliable instruments were used in this study, these instruments are:

Alcohol Use Disorders Identification Test (AUDIT) - developed from a six country WHO collaborative project as a screening instrument for hazardous and harmful alcohol consumption. It is a 10 item questionnaire that covers the domains of alcohol consumption, drinking behavior, and alcohol-related problems. Responses to each item are scored on a Likert scale from 0 to 4 (0= never, to 4= daily or almost daily), giving a maximum score of 40. AUDIT provides a simple method of early detection of hazardous and harmful alcohol use in primary health care settings, and is the first instrument of its type to be derived on the basis of a cross- national study (Saunders et. al., 1993). The AUDIT has been validated in several countries, showing good levels of sensitivity and specificity for the detection of the harmful use of alcohol (Magnabosco, Formigoni, & Ronzani, 2007).

Parenting Stress Index (PSI) - a screening and diagnostic assessment technique designed to yield a measure of the relative level of stress in the parent-child setting. Two major source domains of stressors in the parent-child relationship are measured by the PSI: (a) child characteristics and (b) parent characteristics. the degree of adaptability of the child, the child's reinforcing qualities, degree of demanding, the child's activity level, and the parent's subjective feeling of being trapped by parenting responsibilities, social isolation, attachment to child, and, spousal and social system support.

In the current study, **the parenting stress index - short form (PSI- SF)** was used. It is a 36 item self-report questionnaire that assesses stressors originating from parent, child, and parent-child interaction, including parental distress, parent-child dysfunctional interaction, and difficult child behavior (Putnick et al., 2008). Each item can be assessed on a Likert scale from 1 to 5 (1= strongly disagree, to 5= strongly agree).

Among the items are: Since having a child, I feel that I am almost never able to do things that I like to do; I feel trapped by my responsibilities as a parent; My child smiles at me much less than I expected (Cronbach alpha= 0.922).

Parent Child Relationship Inventory (PCRI) - This self-report instrument assesses parents' perception of their relationships with their children. The PCRI assess dimensions identified as important aspects of the parent-child relationship (Steinberg & Silk, 2002). The instrument includes scales of *Satisfaction with Parenting* - the degree of gratification derived from being a parent; *Involvement* - the level of engagement and familiarity with the child; *Communication* - how capably a parent communicates with the child; *Limit Setting* - a parent's perception of the effectiveness of discipline practices utilized; and, *Autonomy* - the parent's capacity to facilitate the child's independence (Coffman, Guerin & Gottfried, 2006). In the current study, only the *Communication Subscale* was used. This subscale consists of 9 items, Responses to each item are scored on a Likert scale from 1 to 4 (1= strongly disagree, to 4= strongly agree), Among items are: I can tell by my child's face how he or she is feeling; My child would say that I am a good listener; I generally feel good about myself as a parent (Cronbach alpha= 0.678).

Generalized Anxiety Disorder Scale (GAD-7) – The GAD-7 screens for Generalized Anxiety Disorder (GAD) and assesses its severity in clinical practice and research (Spitzer, Kroenke, Williams & Löwe, 2006). This questionnaire was initially developed to diagnose generalized anxiety disorder and to measure the severity of symptoms following DSM criteria. It is a 7 item measure that can be self-administrated or administrated by an interviewer. With the GAD-7 items, participants are asked how often over the past two weeks they have been bothered by each of the seven core

symptoms of generalized anxiety disorder (Daig, Herschbach, Lehmann, Knoll & Decker, 2009). Each item can be assessed on a Likert scale from 1 to 4 (1= not at all, to 4= nearly every day). Among the items are: worrying too much about different things; feeling afraid as if something awful might happen; and, not being able to stop or control worrying. The validity of the scale was established in many studies (Delgadillo et al., 2012). (Cronbach alpha=0.798).

Health-Related Anxiety Questions- A short, four-item scale assessing health-related anxiety over the past week. This scale taps four domains that can be significantly affected by anxiety: sleep, appetite, social contact, and concentration at school or work. Each item can be assessed on a Likert scale from 1 to 5 (1= not at all, to 5= always) (Murphy et al., 2001). Cronbach's alpha for the scale for this sample is 0.781.

The Suicidal Behaviors Questionnaire- Revised (SBQ-R) - four items scale. Each item measures a different dimension of suicidality. SBQ- R item 1 taps into lifetime suicide ideation and suicide attempt; item 2 assesses the frequency of suicidal ideation over the past twelve months; item 3 taps into the threat of suicidal behavior; and, item 4 evaluates self- reported likelihood of suicidal behavior. The use of SBQ-R has several advantages due to the wording of the four SBQ items. A broad range of information is obtained from this brief data collection instrument. Not only can responses be used to identify at-risk individuals, but specific risk behaviors are reported instead of the level of risk that must be inferred from other self- report instruments (Osman et. al., 2001).

Substance Use Survey Instrument (SUSI) - developed by the Regional Alcohol and Drug Abuse Research Center, Spitzer Department of Social Work, Ben Gurion University. SUSI consists of 31 questions about personal background characteristics,

substance use patterns, and risk taking behavior. Among the questions used are: where was your mother born? (e.g., Israel, Former Soviet Union, Ethiopia, etc.); during the last month have you used alcohol or an illicit substance; and, during the last month have you had 5 or more alcohol drinks in one drinking occasion? Also, SUSI includes questions on religious preference and level of religiosity (Isralowitz & Reznik, 2007) (Cronbach alpha=0.798).

4. Data collection

Data were collected by interviewing the study participants. As noted above, informed consent was acquired from the study subjects and all data were anonymous. The participants were interviewed by treatment program personnel familiar with the mothers. This pattern of interviewing was chosen in order to create a non-threatening, non-stressful experience for the participant aiming to achieve honest responses to the questions.

5. Data analysis

Data were coded and analyzed at the Regional Alcohol and Drug Abuse Research Center (RADAR), Spitzer Department of Social Work, Ben Gurion University. Statistical analysis was performed using SPSS, version 19. The Mann–Whitney U test was used for analysis of all four hypotheses. This is a nonparametric test used to determine if a particular population has larger values of a certain criteria than the other. In the current study includes ($p < 0.1$) was set as a level of significance due to the exploratory nature of this study.

Results

The first hypothesis: substance use patterns are related to parenting problem behavior. Mothers that abuse substances will show more difficulties in their parenting behaviors. Statistically significant differences in GAD 8-12 were found between mothers that use amphetamines, prescription drugs and LSD compared to mothers who do not use these substances (see table 2. GAD 8-12, $U=128.0$; $p=0.09$; GAD 8-12, $U=117.0$; $p=0.033$; GAD 8-12, $U=47.5$; $p=0.087$). No additional statistically significant differences were detected among the participating mothers. Thus, the first hypothesis is partly supported.

The second hypothesis: substance abuse patterns including the type substance being used are linked with levels of parenting stress among substance abusing mothers. Mothers who use more substances will show higher stress level. Table 2. presents substance use and parenting stress. Statistically significant differences in the Total Stress subscale were found between mothers using alcohol and mothers that did not use alcohol ($U=124.0$; $p=.055$). Statistically significant differences in the Total Stress subscale were found between mothers using cannabis and mothers that did not ($U=104.0$; $p=0.008$). Statistically significant differences in Parental Distress (PD) were found between mothers who use and do not use alcohol ($U=125.0$; $p=0.058$), cannabis ($U=101.5$; $p=0.007$) and LSD ($U=48.0$; $p=0.094$). Statistically significant differences in Defensive Responding (DR) were found between mothers who use and do not use alcohol ($U=118.5$; $p=0.037$) and cannabis ($U=91.0$; $p=0.003$). Surprisingly, mothers using opiates reported lower levels of Total Stress compared to mothers that do not use opiates ($U= 96.0$; $p= 0.042$). The second hypothesis is partly supported.

The third hypothesize: personal background factors including marital status, age, country of origin, education, socio-economic status, religion/religiosity and/or number of children, varied according to mothers' drug use patterns. No statistical significant differences were found (see tables 3-4). Therefore, the third hypothesis was not supported.

The fourth hypothesis: Mothers with higher GAD levels will experience more difficulties communicating with their children. Findings show that mothers using prescription drugs compared with mothers who did not had higher levels of anxiety (Table 2. GAD 7, $U=125.5$; $p=0.059$). Mothers of children under the age of 18 had lower levels of anxiety than those with children over 18 (Table 4., GAD 7, $U=133.5$; $p=0.053$). Additionally, mothers of children over the age of 18 had more difficulties gaining the child's cooperation and/or managing the child's behavior compared to mothers with children under the age of 18 (DR, $U=143.5$; $p=0.095$). Higher levels of anxiety were found among mothers who served time in jail/prison compared to mothers that did not (Table 4., GAD 7, $U=141.5$; $p=0.098$). Hypothesis four is partially supported. .

Further analysis was conducted with respect to last month drug use, parenting skills and suicide

Suicide related issues were not considered for this study. However, due to its exploratory nature, it was decided to examine substance abuse patterns and suicidal behavior. The SBQ-R instrument, measuring four different dimensions of suicidality, yielded significant findings.

Table 5. shows significant differences in anxiety levels among mothers who reported high and low levels of suicidal thoughts and attempts. Mothers with higher levels of suicidal thoughts or attempts showed higher levels of anxiety (thoughts: GAD 7, $U=127.0$; $p=0.030$, attempts: GAD 7, $U=92.0$; $p=0.011$). Also, significant differences were found among mothers who reported high vs. low levels of suicidal thoughts or attempts in terms of problem behavior such as loss of appetite; trouble sleeping; difficulties maintaining social lives, and trouble concentrating at work/school. Mothers who showed higher levels of suicidal thoughts or attempts had higher levels of problem behavior (thoughts, GAD 8-12, $U=99.54$; $p=0.004$, attempts, GAD 8-12, $U=100.5$; $p=0.021$). Also, significant differences were found regarding stress about parental role. Mothers who reported high levels of suicidal thoughts or attempts had higher levels of stress regarding their parental role (thoughts, PD, $U=113.5$; $p=0.012$, attempts, PD, $U=83.0$; $p=0.005$). Significant differences were found between mothers who reported higher vs. lower levels of suicidal thoughts or attempts in terms of parent- child dysfunctional interaction. Mothers who reported higher levels of suicidal thoughts or attempts showed increased parental disappointment about the child; feeling rejected or alienated by the child, and/or the feeling that parent-child interactions are not satisfying (P-CDI, $U=114.5$; $p=0.058$).

Differences were found in terms of parental stress among mothers who reported high vs. low levels of suicidal thoughts or attempts. Mothers with higher levels of suicidal thoughts or attempts reported higher levels of parental stress (thoughts, Total Stress, $U=100.0$; $p=0.004$, attempts, Total Stress, $U=71.0$; $p=0.001$), and higher levels of Defensive Responding towards their children (thoughts, DR, $U=118.0$; $p=0.016$,

attempts, DR, $U=98.5$; $p=0.019$). Significant differences were found among mothers who reported high vs. low levels of suicidal thoughts and suicide attempts in terms of how "difficult" they perceive their child to be. Mothers with higher levels of suicidal thoughts or attempts had a hard time gaining the child's cooperation and/or managing the child's behavior (thoughts, DC, $U=132.5$; $p=0.041$, attempts, DC, $U=82.0$; $p=0.004$). It is interesting to note that levels of suicide thoughts or attempts did not differ in terms of levels of religiosity.

Tables

Table 1. Sample Characteristics

Numbers (percentages)

	Country of Origin (N=41)			Religion (N=41)			
	Israel	FSU	Other	Jewish	Christian	Muslim	Other
n (%)	22 (53.7)	16 (39)	3 (7.3)	34 (82.9)	4 (9.8)	1 (2.4)	2 (4.9)

	Marital Status (N=41)			Education (N=41)		
	Single	Married	Separated\ Divorced	Elementary School	High School	Academic Degree\ Other
n (%)	14 (35)	8 (20)	18 (45)	12 (30.8)	23 (59)	4 (10.2)

Table 2. Life Time Substance Use and Parenting Skills

The Mann–Whitney U test

	Alcohol		Amphetamines		Cannabis		Opiates		LSD		Sedatives		Prescription Drugs	
	Yes (n=26)	No (n=15)	Yes (n=14)	No (n=27)	Yes (n=24)	No (n=17)	Yes (n=11)	No (n=30)	Yes (n=5)	No (n=36)	Yes (n=21)	No (n=19)	Yes (n=26)	No (n=15)
GAD 7, Mean (SD)	11.3 (5.7)	9.6 (5.6)	12.2 (5.3)	9.8 (5.8)	11.6 (5.9)	9.3 (5.1)	12.1 (5.8)	10.1 (5.6)	10.8 (3.6)	10.6 (5.9)	11.9 (5.4) [†]	9.2 (5.7) [†]	11.7 (5.6) [†]	8.8 (5.5) [†]
GAD 8-12, Mean (SD)	9.4 (4.8)	8.6 (3.4)	10.9 (5.1) [†]	8.1 (3.6) [†]	9.8 (4.4)	8.0 (4.2)	9.8 (5.1)	8.8 (5.0)	13.4 (5.8) [†]	8.5 (3.8) [†]	9.5 (3.8)	8.6 (4.9)	10.0 (4.3)*	7.5 (4.1)*
DR, Mean (SD)	32.8 (6.9)*	30.0 (5.4)*	32.5 (5.6)	31.4 (6.9)	34.3 (5.3)**	28.2 (6.3)**	27.8 (8.3)	33.2 (5.0)	37.6 (5.8)*	31.0 (6.2)*	31.5 (7.7)	32.0 (4.8)	32.1 (7.4)	31.2 (4.5)
PD, Mean (SD)	35.9 (7.6) [†]	32.8 (6.3) [†]	35.4 (6.6)	34.4 (7.7)	37.5 (6.1)**	30.9 (7.2)**	30.1 (9.0) [†]	36.5 (5.8) [†]	41.0 (7.3) [†]	33.9 (6.9) [†]	34.6 (8.7)	34.9 (5.5)	35.1 (8.3)	34.1 (5.1)
P-CDI, Mean (SD)	30.3 (7.8)	28.0 (4.3)	29.0 (7.8)	29.4 (6.2)	31.2 (7.4)	27.0 (4.8)	26.8 (6.0)*	30.5 (6.8)*	34.2 (9.2)	28.8 (6.2)	28.7 (7.4)	30.4 (5.9)	28.8 (7.3)	30.7 (5.6)
DC, Mean (SD)	33.7 (7.1)	29.5 (8.0)	30.4 (7.4)	33.1 (7.7)	33.5 (7.5)	30.2 (7.5)	28.7 (6.8)	33.4 (7.6)	35.7 (11.5)	31.7 (7.0)	31.5 (8.7)	32.9 (6.3)	31.7 (8.1)	33.0 (6.8)
Total stress, Mean (SD)	99.9 (18.9) [†]	90.3 (16.5) [†]	94.9 (18.9)	97.2 (18.5)	102.2 (18.3)**	88.2 (15.6)**	85.6 (18.9) [†]	100.4 (16.9) [†]	110.9 (24.9)	94.4 (16.8)	94.8 (21.9)	98.3 (13.8)	95.6 (21.0)	97.7 (13.5)
PCRI Com, Mean (SD)	26.3 (2.1)*	29.4 (3.9)*	26.8 (3.4)	27.6 (3.2)	26.7 (2.9)	28.5 (3.6)	28.2 (4.4)	27.1 (2.8)	26.2 (2.0)	27.6 (3.4)	27.8 (3.6)	26.8 (2.8)	27.5 (3.5)	27.2 (2.9)

[†] p<0.1; * p<0.05; ** p<0.01; (Mann-Whitney test)

- * GAD- 7= Generalized Anxiety Disorder Scale
- * GAD- 8-12= Health Related Anxiety Questions
- * DR= Defensive Responding
- * PD= Parental Distress

- * PCRI Com= Parent Child Relationship Inventory- Communication Scale
- * P- CDI= Parent Child Dysfunctional Interaction
- * DC= Difficult Child

Table 3. Last Month Substance Use, Parenting Skills and Demographic Factors

The Mann–Whitney U test

	Last month prescription drugs use		HCV		Children		Custody	
	Yes (n=19)	No (n=22)	Yes (n=26)	No (n=15)	One (n=22)	More (n=19)	Yes (n=24)	No (n=17)
GAD 7, Mean (SD)	12.5 (4.9) [†]	9.1 (5.9) [†]	11.3 (5.5)	9.5 (5.9)	10.6 (5.0)	10.6 (6.5)	10.1 (5.4)	11.5 (6.0)
GAD 8-12, Mean (SD)	9.9 (4.2)	8.3 (4.4)	9.8 (4.7)	7.9 (3.3)	9.6 (4.8)	8.5 (3.8)	8.5 (3.9)	9.9 (4.9)
DR, Mean (SD)	33.2 (6.3)	30.6 (6.5)	31.8 (7.2)	31.7 (5.2)	31.8 (7.8)	31.6 (4.6)	31.4 (7.8)	32.3 (4.1)
PD, Mean (SD)	36.3 (7.1)	33.4 (7.3)	34.9 (8.0)	34.4 (5.9)	34.7 (8.8)	34.8 (5.3)	34.3 (8.9)	35.4 (4.2)
P-CDI, Mean (SD)	29.7 (7.3)	29.3 (6.4)	29.6 (7.8)	29.2 (4.4)	29.1 (7.6)	29.9 (5.8)	30.1 (7.9)	28.6 (4.8)
DC, Mean (SD)	33.3 (9.4)	31.1 (5.6)	33.4 (7.4) [†]	30.0 (7.6) [†]	31.9 (8.0)	32.4 (7.3)	31.4 (9.4)	33.3 (4.0)
Total stress, Mean (SD)	99.4 (22.0)	93.9 (14.7)	98.0 (19.7)	93.7 (16.1)	95.8 (20.5)	97.2 (16.2)	95.8 (23.1)	97.2 (9.0)
PCRI Com, Mean (SD)	27.4 (3.3)	27.5 (3.3)	27.0 (3.1)	28.3 (3.5)	27.5 (2.8)	27.4 (3.8)	27.7 (3.9)	27.1 (2.1)

[†] p<0.1 (Mann-Whitney test)

Table 4. Last Month Substance Use, Parenting Skills and Demographic Factors

The Mann–Whitney U test

	Origin		Children younger 18		Jail/Prison		Education	
	Israel (n=25)	FSU (n=16)	Yes (n=18)	No (n=23)	Yes (n=24)	No (n=17)	Elementary School (n=12)	High School/more (n=29)
GAD 7, Mean (SD)	11.5 (5.6)	9.3 (5.7)	8.5 (5.9)*	12.3 (4.9)*	11.7 (5.8) [†]	9.2 (5.4) [†]	10.3 (6.2)	10.8 (5.5)
GAD 8-12, Mean (SD)	9.5 (4.4)	8.4 (4.3)	9.0 (4.4)	9.1 (4.4)	10.0 (4.5)	7.8 (3.8)	9.3 (4.6)	9.0 (4.3)
DR, Mean (SD)	32.7 (5.1)	30.3 (8.1)	30.6 (6.3) [†]	32.7 (6.6) [†]	32.4 (5.8)	30.8 (7.3)	31.9 (3.1)	31.7 (7.4)
PD, Mean (SD)	35.6 (5.8)	33.5 (9.2)	33.5 (7.1)	35.7 (7.4)	35.4 (6.5)	33.8 (8.4)	34.8 (3.2)	34.7 (8.4)
P-CDI, Mean (SD)	29.5 (5.8)	29.4 (8.2)	28.2 (8.3)	30.5 (5.2)	28.5 (6.7)	30.8 (6.7)	28.6 (2.3)	29.9 (7.9)
DC, Mean (SD)	31.1 (7.2)	33.8 (8.1)	30.5 (9.9)	33.4 (5.1)	32.5 (8.7)	31.7 (6.0)	32.4 (5.7)	32.1 (8.4)
Total stress, Mean (SD)	96.2 (15.4)	96.8 (22.9)	92.2 (23.2)	99.7 (13.3)	96.5 (19.9)	96.3 (16.7)	95.7 (8.9)	96.7 (21.3)
PCRI Com, Mean (SD)	27.8 (3.6)	26.9 (2.7)	28.2 (3.5)	26.8 (3.0)	28.2 (3.4) [†]	26.4 (2.9) [†]	28.5 (3.1)	27.0 (3.3)

[†] p<0.1; * p<0.05 (Mann-Whitney test)

Table 5. Last Month Substance Use, Parenting Skills and Suicide

The Mann–Whitney U test

	Suicide Thoughts		Suicide Attempt		Level of religiosity	
	Yes (n=21)	No (n=20)	May be/ yes (n=13)	No (n=28)	Secular (n=26)	Somewhat (n=15)
GAD 7, Mean (SD)	12.6 (4.3)*	8.6 (6.2)*	13.6 (5.4)*	9.3 (5.3)*	10.7 (5.9)	10.6 (5.6)
GAD 8-12, Mean (SD)	11.0 (4.8)**	7.1 (2.7)**	10.9 (4.4)*	8.2 (4.1)*	7.6 (2.6)	10.0 (4.8)
DR, Mean (SD)	33.9 (5.5)*	29.5 (6.7)*	34.6 (3.3)*	30.5 (7.2)*	31.4 (5.7)	32.0 (6.9)
PD, Mean (SD)	37.3 (6.3)*	32.1 (7.4)*	38.3 (3.3)**	33.1 (8.0)**	34.4 (6.4)	35.0 (7.2)
P-CDI, Mean (SD)	31.6 (7.0)	27.3 (5.9)	31.2 (4.0) [†]	28.7 (7.6) [†]	29.0 (6.1)	29.8 (7.2)
DC, Mean (SD)	34.1 (8.7)*	30.1 (5.8)*	32.7 (9.1)**	32.0 (7.3)**	33.0 (8.7)	31.7 (7.0)
Total stress, Mean (SD)	103.0 (19.1)**	89.5 (15.1)**	98.2 (19.3)**	96.0 (18.5)**	96.3 (18.4)	96.4 (18.8)
PCRI Com, Mean (SD)	27.4 (3.4)	27.5 (3.2)	27.8 (4.4)	27.3 (3.0)	28.1 (3.7)	27.0 (3.0)

[†] p<0.1; * p<0.05; ** p<0.01; *** p<0.001 (Mann-Whitney test)

Discussion

This exploratory study assessed and evaluated parenting skills among substance abusing mothers using an evidence-based approach. The approach taken was done building on evidenced-based research conducted by Health Risk Reduction Projects, Integrated Substance Abuse Programs, Department of Psychiatry, UCLA. Substance abusing women are at high risk of experiencing multiple problems that may undermine their ability to care for their children (Nair, Schuler, Black, Kettinger & Harrington, 2003). Yet, to date, no study in Israel has researched parenting skills among substance abusing mothers receiving methadone maintenance treatment (MMT).

Most research of substance-abusing women and their children have compared the parenting environment and child development to non-substance abusing women and children. Although such research can be useful in identifying differences related to substance use, it does not provide information on diverse substance use patterns and the links between parenting behavior and child development. The relationship between psychosocial risk and parenting attitudes illustrates the variability that occurs among substance abusing women and the importance of helping them reduce their risk (Nair, et. al., 2003).

Previous studies show alcohol use is common among MMT patients (Maremmani et al., 2007; Nyamathi et al., 2009; Wurst et al., 2008). Alcohol use among MMT patients tends to be a means of achieving the ‘high’ that is no longer attainable due to opiate tolerance and the narcotic block resulting from methadone use (Maremmani et al., 2007). Alcohol intoxication is a risk factor for death among opioid

users. Thus, an accurate understanding of drinking patterns among MMT patients is important to shape treatment intervention and promote positive outcomes that include the absence of the psychosocial complications associated with such abuse (Maremmani et al., 2007; Wurst et al., 2008). The current study shows mothers using alcohol have more stress about their role as a parent. This finding is consistent with other research that shows maternal characteristics, especially substance dependence, closely associated with parenting stress and child maltreatment including abuse and neglect (Kelley, 1992, 1998). Substance-abusing mothers experience high levels of stress and resort to maladaptive coping behaviors. In contrast, the current study found opiate use reduced parental stress. Moreover, opiate use tends to minimize mothers' feelings of disappointment about their children, feelings of rejection or alienation by the child, and/or perceiving parent-child interactions as not satisfying.

The relationship between substance abuse and suicidal behavior has been explored by a number of researchers (Bukstein et al., 1993; Dhossche, Meloukheia & Chakravorty, 2000; Felts, Chernier & Barnes, 1992). Findings from previous studies support an association between substance abuse and suicidal behavior (Bukstein et al., 1993; Dhossche et al., 2000). For example, substance abuse may cause disruption in key relationships that may in turn increase the risk of suicide. Second, substance abuse through its effects may impair judgment and make suicide more likely to occur. And third, substance abuse may have acute and chronic mood altering effects that may make suicidal behavior more common (Bukstein et al., 1993).

Suicide is a major risk for heroin (and other opium-based substance) users and a major problem for drug treatment agencies that deal with this population. Overall,

heroin users are 14 times more likely than peers to die from suicide (Darke & Ross, 2002). Major risk factors (i.e., gender, psychopathology, family dysfunction and social isolation) for suicide thoughts and attempts in the general population apply to heroin users as well. What is different with heroin users is the greater exposure to these causal factors and their substance use. For example, polydrug use is linked to an increased risk of suicide and heroin users are overwhelmingly polydrug users (Darke & Ross, 2002). Attempted suicide occurs at a rate well in excess of that found for general population as does suicidal ideation (Darke & Ross, 2002).

Female heroin users including those in MMT are at particular risk for suicidal behavior; more so than males (Darke, Ross, Lynskey & Teesson, 2004). According to previous studies, suicide thoughts and attempts among females are related to long-standing problems such as physical and sexual abuse (Darke & Ross, 2001; Isralowitz & Myers, 2011). Methadone clinics are not only dealing with a population in which a history of attempted suicide is common, but with a group that has high levels of current suicidal ideation and depression (Darke & Ross, 2001).

In the current study, suicidal thoughts and attempts were found linked to high levels of anxiety and related problem behavior (i.e., loss of appetite; trouble sleeping; difficulties maintaining social lives; and, trouble concentrating at work/school) among substance abusing mothers. Also, suicidal thoughts and attempts were significantly associated with increased parental stress and increased stress in the mothers' role as a parent; and, feelings of disappointment of their children, feelings of rejection or alienation by the child, and/or perceiving parent-child interactions as not satisfying.

Generalizations of the above findings are difficult because of the limited study cohort, from one location and one point of time. However, the study results are consistent with other research about substance abuse and suicidal thoughts and behavior. Recognition of this relationship and its' effect on parenting is important for professionals involved in substance use prevention and treatment programs particularly for mothers.

Suicidal behavior is a global public health problem and a complex phenomenon influenced by a number of biological, psychological, social and cultural factors. In most known religions of the world, suicide is condemned; especially in the three monotheistic religions of Judaism, Christianity and Islam (Sisask et al., 2010). According to previous studies, religion has been found to have an impact on suicidality. One's degree of religiosity can potentially serve as a protective factor against suicidal behavior, with greater religiosity predicting decreased risk of suicidal behavior. Several mechanisms have been attributed to the protective role of religion, including a decrease of aggression and hostility and an increase in reasons for living (Gearing & Lizardi, 2009). In contrast to these findings, findings from this study did not show suicidal thought and attempts differed based on religiosity levels.

Several studies assessed the issue of mothers serving time in jail/prison. The typical incarcerated mother is described as having a significant amount of stress and multiple concerns about her children. Such mothers are likely to have elevated emotional and behavioral distress as well as feelings of inadequacy and loss as a parent (Houk & Booker- Loper, 2002). These results are consistent with current study findings that show time in jail/prison linked to higher levels of anxiety among substance abusing mothers.

1. Policy Considerations

The current study addressed the issue of parenting skills among substance abusing mothers receiving methadone treatment. There is a lack of literature about female-specific prevention approaches. Consequently, treatment for women must address the many unique issues of females thereby decreasing the negative repercussions of substance use for them and their children (Isralowitz, Reznik & Straussner, 2011; Isralowitz & Reznik, 2013). Substance abusing women in treatment are more likely than men to have primary responsibility for their children (Henderson, 1998). Also, they tend to be at the highest risk of poverty, mental health problems and having their child placed in out-of-home care (Holmila, Raitasalo & Kosola, 2013). Children who do live in homes in which a parent abuses substances are at elevated risk for developing emotional, social, and behavioral problems (Fals- Stewart, Fincham & Kelley, 2004). Therefore, treatment agencies such as MMT programs should have greater awareness of the connection between substance abuse, problem behavior and parenting skills.

Previous studies have found that women entering substance abuse treatment, in contrast to men, are more likely to report the effects of their substance use on their children and family and seek help that includes family services (Straussner & Zelvin, 1997). Such findings suggest treating substance-abusing parents, either with couple's therapy or a combination of couples therapy with parenting skills training, can lead to significant improvements in child functioning (Fals- Stewart, Fincham & Kelley, 2004).

As mentioned above, having children often serves as a motivation for mothers to attend treatment. Social and health care professionals have a potentially important role

in providing support to these mothers by providing them with the opportunity to improve their parenting skills through female-specific treatment approaches and interventions. Female substance abusers need gender-specific services that are designed with knowledge and expertise to address their parenting roles (United Nations, 2013; Isralowitz and Reznik, 2013). Prison and jails are opportune places to provide specialized attention in treatment programming for incarcerated substance-abusing mothers.

2. Limitations of the Study

The present study is typical of many studies of drug using women in terms of the difficulty to access a large enough study cohort to justify generalization of findings. This factor limited the nature and scope of the study analysis. Furthermore, since the data collected for this study were obtained through interviews, participants may not have felt comfortable divulging information about sensitive topics such as parenting stress, anxiety and suicide face-to-face with an interviewer. As with most studies on substance use, information obtained through interviews may be subjected to influences such as social desirability and memory bias.

3. Conclusion

Clearly, the opportunity to access a high risk population of substance abusing women with children has generated significant findings that provide “usable knowledge” for prevention and treatment purposes in Israel and elsewhere. Nevertheless, there is a need for further research of such high risk mothers (and fathers) and effective means to promote parenting skills especially through brief intervention methods that can be

effective and cost efficient. Mothers and fathers with chronic illness other than substance use (e.g., diabetes, heart disease, obesity, respiratory disease, etc.), living with difficult conditions and limited resources is another important area of research to consider.

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Appendices

כתב הסכמה מדעת

הנך מוזמן/ת להשתתף במחקר שנערך על ידי פרופ' ריצ'רד ישראלוביץ' מהמחלקה לעבודה סוציאלית באוניברסיטת בן גוריון בנגב. במידה ואתה מעוניין/ת לקחת חלק במחקר, אנא חתום והשב את הטופס המצורף למכתב זה.

המחקר יעסוק בנושאים הקשורים לבריאות, הרגלי השימוש בסמים כמו גם כישורי ההורות שלך. מטרת המחקר הינה לבסס גוף ידע אשר יאפשר בהמשך לפתח שיטות התערבות חדשות, שמטרתן לשפר את כישורי ההורות בקרב אנשים הזקוקים לסיוע בתחום זה.

ההשתתפות במחקר הזו היא בהתנדבות. זכותך לבחור שלא להשתתף במחקר, ואתה יכול לבחור להפסיק לענות על השאלון בכל רגע נתון ללא שיהיו לכך כל השלכות לגביך. כמו כן, זכותך לבחור שלא לענות על אחת מהשאלות אם היא מעוררת בך תחושת אי נוחות.

המחקר הינו אנונימי ואין כל דרך לקשר בין זהותך לבין התשובות שענית בראיון. לא תשאל/י לגבי פרטים מזהים כגון: שםך, מספר תעודת הזהות שלך או מספר הטלפון שלך.

הסטודנטיות המעבירות את הראיונות וצוות המחקר במחלקה לעבודה סוציאלית באוניברסיטת בן גוריון בנגב יהיו היחידים שתהיה להם גישה לנתוני המחקר. אם המחקר יוצג בכנסים מקצועיים יימסר רק מידע לגבי קבוצת המחקר כולה, ולא לגבי יחידים.

אם יש לך שאלות לגבי המחקר, את/ה יכולים ליצור קשר עם צוות המחקר:

מרכז "ראדאר": 08-6472316,

פרופ' ריצ'רד ישראלוביץ': 08-6472316

מור יהודאי: moryehu@post.bgu.ac.il

חתום/י בתחתית הדף אם הנך מסכים/ה להשתתף במחקר זה:

שם: _____ תאריך: _____

מיומנויות הוריות

תודה שהסכמת לקחת חלק במחקר החשוב הזה, אשר נוגע להורים ולילדיהם. אני רוצה להזכיר לך שהתשובות שלך הן חסויות, שמך לא יוזכר במידע. חשוב שתענה על השאלות באופן כנה כיוון שתשובותיך יעזרו לנו להבין כיצד לתת מענה לצרכים הייחודיים של הורים המתמודדים עם בעיית שימוש בסמים.

בחלק מהשאלות הבאות אני אראה לך כרטיס שיציג את התשובות האפשריות לשאלה (לדוגמא: "בכלל לא", "מעט", "הרבה"). בכל פעם אקריא לך את הכרטיס ולאחר שאציג את השאלה אבקש שתאמר לי איזו תשובה מהכרטיס אתה בוחר.

שאלון דמוגרפי

1. מין: זכר / נקבה
2. גיל: _____
3. השכלה: א. יסודית ב. תיכונית ג. אקדמאית ד. אחר:
4. ארץ לידה: _____
5. שנת עלייה: _____
6. דת: א. יהודי ב. נוצרי ג. מוסלמי ד. אחר:
7. את/ה: א. חילונית ב. מסורתית ג. דתית ד. אחר:
8. מצב משפחתי: א. רווק/ה ב. נשוי/אה ג. פרוד/ה ד. גרושה ה. אלמ/ה
9. האם יש לך ילדים? א. כן ב. לא
10. האם ילדיך נמצאים בחזקתך? א. כן ב. לא
11. מספר ילדים: _____
12. גילאי הילדים: ילד 1 _____ ילד 2 _____ ילד 3 _____ ילד 4 _____
13. מצב סוציו-אקונומי: א. 0-5000 ₪ ב. 5001-10000 ₪ ג. 10001-15000 ₪ ד. 15001 ₪ ומעלה

שאלון א': קשר הורה- ילד

Parent-Child Relationship Inventory (PCRI-Communication)
(Gerard, 1994) *Communication Subscale*

השאלות הבאות נוגעות לקשר שלך עם ילדך. בנוגע לכל טענה אבקש שתאמר לי האם אתה :
"מסכים בהחלט", "מסכים", "לא מסכים" או "מאוד לא מסכים".

מס' שאלה	שאלה	מאוד לא מסכים	לא מסכים	מסכים	מסכים בהחלט	לא מעוניין לענות	לא יודע
1א	הילד שלי בדרך כלל לא משתף אותי כשמשוהו מפריע לו	1	2	3	4	8	9
2א	אם אני צריך לומר "לא" לילד שלי, אני אנסה להסביר לו מדוע	1	2	3	4	8	9
3א	אני יכול לראות על הפנים של הילד שלי איך הוא מרגיש	1	2	3	4	8	9
4א	הילד שלי מספר לי הכול על החברים שלו	1	2	3	4	8	9
5א	אני מרגיש שאני יכול לדבר עם הילד שלי ברמה שלו	1	2	3	4	8	9
6א	באופן כללי אני מרגיש טוב בנוגע להורות שלי	1	2	3	4	8	9
7א	הילד שלי יעיד עליי שאני יודע להקשיב	1	2	3	4	8	9
8א	כשהילד שלי נתקל בבעיה, בדרך כלל הוא יפנה אליי בכדי לעבד את הדברים	1	2	3	4	8	9
9א	עדיף להסביר לילדים באופן הגיוני מאשר פשוט לומר להם מה לעשות	1	2	3	4	8	9

שאלון ב':

GAD-7 (Generalized Anxiety Disorder) & Health-Related Anxiety Questions
(GAD-7: Spitzer, Kroenke, Williams, & Löwe, 2006) *Complete*

במהלך השבועיים האחרונים, באיזו תדירות היית מוטרד מהבעיות הבאות:

לא יודע	לא מעוניין לענות	כמעט כל יום	יותר מחצי מהימים	מספר ימים	כלל לא	שאלה	מס' שאלה
9	8	4	3	2	1	הרגשת עצבנות או חרדה	ב1
9	8	4	3	2	1	חוסר יכולת להפסיק, או לשלוט בדאגה	ב2
9	8	4	3	2	1	דאגה יתרה בנוגע לדברים שונים	ב3
9	8	4	3	2	1	קושי להירגע	ב4
9	8	4	3	2	1	חוסר מנוחה, קושי לשבת במקום	ב5
9	8	4	3	2	1	מתעצבן, מוטרד בקלות	ב6
9	8	4	3	2	1	תחושת פחד שמשהו נורא עלול לקרות	ב7

(מראיין: אם המרואיין ענה: 2,3, או 4, לאחת מפריטים 1-7, שאל את שאלה 8, במידה ולא עבור לסדרת השאלות הבאות)

ב8. באיזו מידה הקשו עליך הבעיות הללו לבצע את עבודתך, לדאוג לדברים בבית או להסתדר עם אנשים אחרים בסביבתך?

- 1 לא הקשו כלל
- 2 הקשו מעט
- 3 הקשו מאוד
- 4 הקשו בצורה בלתי רגילה
- 8 לא מעוניינת לענות
- 9 לא יודעת

Health-Related Anxiety Questions (Murphy, Durako, Moscicki, Vermund, Ma, Schwarz, & Muenz, 2001) *Complete*

לעיתים דאגה לבריאות שלך עלולה להשפיע על תחומים אחרים בחייך. לדוגמא: אם אתה מאוד מודאג בנוגע לבריאותך, זה עלול להוביל לקושי להירדם, או התעוררות במהלך הלילה. השאלות הבאות יעזרו לנו לגלות אילו תחומים בחייך הושפעו מהדאגה שלך במהלך השבוע החולף.

9. במהלך השבוע האחרון, חשבת על בעיית השימוש בסמים שלך ובעקבות זאת היו לך קשיים בשינה (קושי להירדם או שינה לא רצופה)

- | | |
|---|------------------|
| 1 | כלל לא |
| 2 | כמעט ולא |
| 3 | לפעמים |
| 4 | לעיתים קרובות |
| 5 | כל הזמן |
| 8 | לא מעוניין לענות |
| 9 | לא יודע |

10. במהלך השבוע האחרון, חשבת על בעיית השימוש בסמים שלך ובעקבות זאת לא היה לך תיאבון, או שאכלת מעט מאוד

- | | |
|---|------------------|
| 1 | כלל לא |
| 2 | כמעט ולא |
| 3 | לפעמים |
| 4 | לעיתים קרובות |
| 5 | כל הזמן |
| 8 | לא מעוניין לענות |
| 9 | לא יודע |

11. במהלך השבוע האחרון, חשבת על בעיית השימוש בסמים שלך ובעקבות זאת לא היה לך חשק לצאת או לנהל חיי חברה

- | | |
|---|----------|
| 1 | כלל לא |
| 2 | כמעט ולא |
| 3 | לפעמים |

4	לעיתים קרובות
5	כל הזמן
8	לא מעוניין לענות
9	לא יודע

ב12. במהלך השבוע האחרון, חשבת על בעיית השימוש בסמים שלך ובעקבות הדאגות הרבות התקשית להתרכז בעבודה או לימודים

1	כלל לא
2	כמעט ולא
3	לפעמים
4	לעיתים קרובות
5	כל הזמן
8	לא מעוניין לענות
9	לא יודע

שאלון ג':

AUDIT

השאלות הבאות נוגעות למריחואנה ואלכוהול. אלכוהול כולל משקאות כגון: בירה, יין, רום, וודקה וויסקי ולמעשה כל משקה אשר מכיל אלכוהול.

ג1. באיזו תכיפות אתה שותה משקה אשר מכיל אלכוהול?

0	אף פעם
1	פעם בחודש או פחות
2	2-4 פעמים בחודש
3	2-3 פעמים בשבוע
4	4 או יותר פעמים בשבוע
8	לא מעוניין לענות
9	לא יודע

ג2. ביום טיפוסי בו אתה שותה, כמה משקאות אלכוהוליים אתה נוהג לשתות?

0	אחד או שניים
---	--------------

1	שלושה או ארבעה
2	חמישה או שישה
3	שבעה עד תשעה
4	עשרה או יותר
8	לא מעוניין לענות
9	לא יודע

ג3. באיזו תדירות אתה שותה ארבעה משקאות אלכוהוליים או יותר באותה ההזדמנות?

0	אף פעם
1	פחות מפעם בחודש
2	פעם בחודש
3	פעם בשבוע
4	כל יום או כמעט כל יום
8	לא מעוניין לענות
9	לא יודע

ג4. במהלך השנה האחרונה, באיזו תדירות מצאת את עצמך לא מסוגל להפסיק ברגע שהתחלת לשתות?

0	אף פעם
1	פחות מפעם בחודש
2	פעם בחודש
3	פעם בשבוע
4	כל יום או כמעט כל יום
8	לא מעוניין לענות
9	לא יודע

ג5. באיזו תדירות במהלך השנה האחרונה לא הצלחת לעמוד בהתחייבויות שלך בעקבות שתיית אלכוהול?

0	אף פעם
1	פחות מפעם בחודש
2	פעם בחודש
3	פעם בשבוע
4	כל יום או כמעט כל יום

8 לא מעוניין לענות

9 לא יודע

ג6. במהלך השנה האחרונה, באיזו תדירות היית זקוק למשקה בבוקר כדי להתחיל את היום לאחר לילה של שתייה מרובה?

0 אף פעם

1 פחות מפעם בחודש

2 פעם בחודש

3 פעם בשבוע

4 כל יום או כמעט כל יום

8 לא מעוניין לענות

9 לא יודע

ג7. במהלך השנה האחרונה, באיזו תדירות חשת תחושת אשמה או חרטה לאחר ששתית אלכוהול?

0 אף פעם

1 פחות מפעם בחודש

2 פעם בחודש

3 פעם בשבוע

4 כל יום או כמעט כל יום

8 לא מעוניין לענות

9 לא יודע

ג8. במהלך השנה האחרונה, באיזו תכיפות לא היית מסוגל לזכור מה קרה במהלך הלילה הקודם בעקבות שתיית אלכוהול?

0 אף פעם

1 פחות מפעם בחודש

2 פעם בחודש

3 פעם בשבוע

4 כל יום או כמעט כל יום

8 לא מעוניין לענות

9 לא יודע

9ג. האם קרה שאתה או אדם אחר נפצעתם בעקבות הרגלי השתייה שלך?

- 0 לא
- 2 כן, אך לא במהלך השנה האחרונה
- 4 כן, במהלך השנה האחרונה
- 8 לא מעוניין לענות
- 9 לא יודע

10ג. האם קרוב משפחה, חבר, רופא או מטפל אחר, הביעו דאגה בנוגע להרגלי השתייה שלך או הציעו שתפחית בכמויות?

- 0 לא
- 2 כן, אך לא במהלך השנה האחרונה
- 4 כן, במהלך השנה האחרונה
- 8 לא מעוניין לענות
- 9 לא יודע

שאלון ד':

Parenting Stress Index (PSI Short Form)
(Abidin, 1990) Full Scale

כעת אציג בפנייך 36 משפטים, בנוגע לכל אחד מהם אבקש שתתייחס (לילד) ותאמר לי האם אתה : מסכים בהחלט, מסכים, לא מסכים, מאוד לא מסכים או לא בטוח. ייתכן שלא תהיה תשובה אשר מתארת את הרגשתך במדויק, במקרה כזה אבקש שתציין את התשובה הקרובה ביותר לתאר את הרגשתך.

מס' שאלה	שאלה	מאוד לא מסכים	לא מסכים	בטוח לא	מסכים	מסכים בהחלט	לא מעוניין לענות	לא יודע
1ד	לעיתים קרובות אני מרגיש שאני לא מצליח להתמודד עם דברים בצורה טובה	1	2	3	4	5	8	9
2ד	אני מוצא את עצמי מוותר על חלק גדול יותר בחיי בכדי לענות	1	2	3	4	5	8	9

							על צרכי הילדים שלי.	
9	8	5	4	3	2	1	אני מרגישה כלוא על ידי המחויבות והאחריות שלי כהורה	3ד
9	8	5	4	3	2	1	מאז שהילד שלי נולד, לא הייתה לי אפשרות לעשות דברים חדשים ושונים	4ד
9	8	5	4	3	2	1	מאז שהילד שלי נולד, אני מרגיש שאני כמעט ולא יכול לעשות דברים שאני אוהב	5ד
9	8	5	4	3	2	1	אני לא מרוצה מקניית הבגדים האחרונה שלי	6ד
9	8	5	4	3	2	1	ישנם לא מעט דברים שמטרידים אותי בנוגע לחיי	7ד
9	8	5	4	3	2	1	הבאת ילד לעולם גרמה ליותר בעיות ממה שציפיתי, בקשר שלי עם בן/ בת הזוג שלי	8ד
9	8	5	4	3	2	1	אני מרגיש לבד וללא חברים	9ד
9	8	5	4	3	2	1	כשאני יוצא למסיבה, לרוב אני לא מצפה ליהנות	10ד
9	8	5	4	3	2	1	אני לא מתעניין באנשים כפי שהתעניינתי בעבר	11ד
9	8	5	4	3	2	1	אני לא נהנה מדברים במידה שנהניתי בעבר	12ד
9	8	5	4	3	2	1	הילד שלי פעמים	13ד

							נדירות עושה למעני דברים שגורמים לי להרגיש טוב	
9	8	5	4	3	2	1	לפעמים אני מרגיש שהילד שלי לא מחבב אותי ולא מעוניין להיות קרוב אליי	14ד
9	8	5	4	3	2	1	הילד שלי מחייך אלי הרבה פחות ממה שציפיתי	15ד
9	8	5	4	3	2	1	כשאני עושה משהו למען הילד שלי, יש לי הרגשה שהוא לא מעריך את המאמצים שלי	16ד
9	8	5	4	3	2	1	בזמן משחק, הילד שלי לא מרבה לצחוק	17ד
9	8	5	4	3	2	1	נראה שהילד שלי לא לומד באותה המהירות בה לומדים רוב הילדים	18ד
9	8	5	4	3	2	1	נראה שהילד שלי מחייך פחות משאר הילדים	19ד
9	8	5	4	3	2	1	הילד שלי לא מסוגל לעשות דברים במידה שציפיתי	20ד
9	8	5	4	3	2	1	לילד שלי דרוש זמן ומאמץ רב בכדי להתרגל לדברים חדשים	21ד

22ד. אני מרגיש שאני :

- 5 לא כל כך טובה בלהיות הורה
- 4 אדם עם מעט קשיים בהורות
- 3 הורה ממוצע
- 2 הורה טוב יותר מהממוצע
- 1 הורה טוב מאוד
- 8 לא מעוניין לענות
- 9 לא יודע

מס' שאלה	שאלה	מאוד לא מסכים	לא מסכים	לא בטוח	מסכים	בהחלט מסכים	לא מעוניין לענות	לא יודע
23ד	ציפיתי שיהיה לי רגש חם וקרוב יותר לילד שלי וזה מטריד אותי	1	2	3	4	5	8	9
24ד	לפעמים הילד שלי מפריע לי רק מתוך רשעות	1	2	3	4	5	8	9
25ד	הילד שלי נוטה לבכות בתדירות גבוהה יותר משאר הילדים	1	2	3	4	5	8	9
26ד	הילד שלי בדרך כלל מתעורר במצב רוח רע	1	2	3	4	5	8	9
27ד	אני מרגיש שהילד שלי נוטה למצבי רוח ומתרגז בקלות	1	2	3	4	5	8	9
28ד	הילד שלי עושה כמה דברים שמטרידים אותי מאוד	1	2	3	4	5	8	9
29ד	הילד שלי מגיב בחומרה רבה כאשר קורה משהו שהוא לא אוהב	1	2	3	4	5	8	9
30ד	הילד שלי מתרגז בקלות, מהדבר הכי	1	2	3	4	5	8	9

							קטן	
9	8	5	4	3	2	1	יצירת שגרה של ארוחות ושינה עבור הילד שלי, הייתה הרבה יותר קשה ממה שציפיתי	31ד

32ד. גיליתי שלגרום לילד שלי לעשות משהו, או להפסיק לעשות משהו:

- 5 זה הרבה יותר קשה ממה שציפיתי
- 4 זה מעט יותר קשה ממה שציפיתי
- 3 זה קשה בערך במידה שציפיתי
- 2 זה מעט יותר קל ממה שציפיתי
- 1 זה הרבה יותר קל ממה שציפיתי
- 8 לא מעוניין לענות
- 9 לא יודע

33ד. אנא מנה את מספר הדברים שהילד שלך עושה שמפריעים לך או מטרידים אותך לדוגמא: מתבטל, מסרב להקשיב, רב, מיילל, מפריע, חסר מנוחה, בוכה וכו'.

- 5 +10
- 4 8-9
- 3 6-7
- 2 4-5
- 1 1-3
- 8 לא מעוניין לענות
- 9 לא יודע

מס' שאלה	שאלה	מאוד לא מסכים	לא מסכים	לא בטוח	מסכים	מסכים בהחלט	מעוניין לענות	לא יודע
34ד	ישנם דברים שהילד שלי עושה שמטרידים אותי מאוד	1	2	3	4	5	8	9

9	8	5	4	3	2	1	הילד שלי התברר כבעיה גדולה יותר ממה שציפיתי	35ד
9	8	5	4	3	2	1	הילד שלי דורש ממני יותר מרוב הילדים	36ד

שאלון ה' - שאלון למחקר על שימוש בסמים

Substance Use Survey Instrument (SUSI)

מטרתו של שאלון זה הנה לאסוף מידע שימושי על הרגלים והתנהגויות הקשורות לשימוש באלכוהול, סיגריות וסמים. אנו מקווים שתשתף/פי עמנו פעולה באיסוף הידע.

אנא, הקף/הקיפי, או מלא/י את התשובות הנכונות ביותר.

1. האם את/ה

זכר _____

נקבה _____

2. מהו גילך? _____ שנים

3. עיר וארץ הלידה: _____

4. שנת ההגירה לישראל: _____

5. האם הגעת לישראל לבד? _____

() כן (אם כן, אנא ענה/י על שאלה 7)

() לא (אם לא, אנא עבור/עברי לשאלה 6)

6. בחר/י אחת או יותר מהתשובות המתאימות ביותר למצבך בעת ההגירה:

() עם בן/בת זוג, בלי ילדים

() עם בן/בת זוג, עם ילדים

() עם אחד מהוריקך, או שניהם

() עם אחים, או אחות/יות

() אחר (אנא ציין/י) _____

7. האם שרתת בצבא? _____

() כן (אם כן, אנא ענה/י על שאלה 8)

() לא (אם לא, אנא עבור/עברי לשאלה 9)

8. איפה שרתת?

- () ברית המועצות לשעבר (בריה"מ)
- () ישראל
- () ישראל ובריה"מ

9. מצב משפחתי

- () נשוי/אה חיה עם בן/בת זוג
- () נשוי/ אה בשנית
- () אלמן/ה
- () פרוד/ה
- () גרוש/ה
- () רווק/ה

10. האם יש לך ילדים מתחת לגיל 18?

- () כן (אם כן, אנא ענה/י על לשאלה 11)
- () לא (אם לא, אנא ענה/י על לשאלה 12)

11. כמה ילדים מתחת לגיל 18 יש לך? _____

12. האם את/ה יהודי/ה?

- () כן
- () לא

13. האם בן/בת הזוג שלך יהודי/ה?

- () כן
- () לא

14. האם ההגירה לישראל השפיעה על היחסים במשפחה שלך?

- () לטובה (או ללא שינוי)
- () לרעה

15. האם שהית אי פעם בכלא/במעצר?

- () כן (אם כן, אנא ענה/י על שאלות 16,17,18,19)
- () לא (אם לא, אנא עבור/עברי לשאלה 20)

16. איפה?

() ברית המועצות לשעבר (בריה"מ)

() ישראל

() ישראל ובריה"מ

17. כמה פעמים? _____

18. כמה זמן סך הכל (בחודשים)? _____

19. למה? (סיבות) _____

20. האם יש לך קעקוע?

() כן (אם כן, אנא ענה/י על שאלות 21,22,23)

() לא (אם לא, אנא עבור/עברי לשאלה 24)

21. הקעקוע נעשה בכלא

() כן

() לא

22. הקעקוע נעשה ללא ציוד סטרילי

() כן

() לא

23. האם את/ה רוצה להסיר את אחד הקעקועים או את כולם?

() כן

() לא

24. האם יש לך צהבת (הפטיטיס C)?

() כן

() לא

25. האם אתה נשא HIV (איידס)?

() כן

() לא

26. האם יש/היה לך שחפת?

() כן

() לא

27. האם שהית אי פעם בבית חולים לחולי נפש?

() כן (אם כן, אנא ענה/י על שאלות 28,29,30,31)

() לא (אם לא, אנא עבור/עברי לשאלה 32)

28. איפה?

() ברית המועצות לשעבר (בריה"מ)

() ישראל

() ישראל ובריה"מ

29. כמה פעמים? _____

30. כמה זמן סך הכל (בחודשים)? _____

31. למה? (סיבות) _____

32. האם ניסית אי פעם להפסיק להשתמש בסמים?

() כן (אם כן, אנה ענה/י על שאלות 33,34,35,36)

() לא (אם לא, אנה עבור/עברי לשאלה 36)

33. איפה?

() ברית המועצות לשעבר (בריה"מ)

() ישראל

() ישראל ובריה"מ

34. כמה פעמים? _____

35. עם מי?

() לבד

() בעזרת מישהו

() לבד ובעזרת מישהו

36. למה ניסית להפסיק?

() לחץ של המשפחה

() סמכות משפטית

() סיבות רפואיות

() אחר (אנה ציין/י) _____

37. האם השתמשת בסמים לפני ההגירה?

() כן

() לא

38. האם ניסית להפסיק להשתמש אחרי ההגירה?

() כן

() לא

39. כמה זמן היית נקי (בחודשים) מאז ההגירה? _____

40. במשך חיידך, האם צרכת את אחד או יותר מהחומרים הבאים?

בנוסף, אנה ציין/י את גילך כאשר לראשונה צרכת את החומר.

(סמן/י את התשובה הנכונה ביותר לכל חומר וציין/י את גיל תחילת השימוש).

סיגריות (או כול טבק אחר) כן לא גיל _____

_____ גיל	לא	כן	בירה
_____ גיל	לא	כן	יין (לא יין לקידוש)
_____ גיל	לא	כן	וודקה וויסקי וכו'
_____ גיל	לא	כן	מריחואנה
_____ גיל	לא	כן	חשיש
_____ גיל	לא	כן	אקסטזי
_____ גיל	לא	כן	סמים ממריצים (ספיד וכו')
_____ גיל	לא	כן	קוקאין
_____ גיל	לא	כן	קראק
_____ גיל	לא	כן	אופיום
_____ גיל	לא	כן	הרואין/קוק פרסי
_____ גיל	לא	כן	LSD. ד. ס. ד.
_____ גיל	לא	כן	חומרים נדיפים

תרופות מרשם

_____ גיל	לא	כן	משככי כאבים (קודאין, אוקסיקונטין וכו')
_____ גיל	לא	כן	תרופות הרגעה (קלונקס וכו')
_____ גיל	לא	כן	תרופות מרשם אחרות
_____ גיל	לא	כן	חומרים לא חוקיים אחרים (אנא ציין את שם החומר) _____
_____ גיל	לא	כן	חומרים חוקיים לא ידועים (אנא ציין את שם החומר) _____

- 41. במהלך חייך, האם הזרקת סמים?**
 אם כן, איזה סם/ים?
 הרואין/ קוק פרסי
 קוקאין
 תרופות מרשם (בנוודאיזפינים)
 אקסטזי
 סמים אחרים

42. במשך החודש האחרון, האם צרכת את אחד מהחומרים האלה?

- (סמן את התשובה הנכונה ביותר לכל חומר)
 סיגריות (או כול טבק אחר)
 בירה
 יין (לא יין לקידוש)

לא	כן	וודקה וויסקי וכו'
לא	כן	מריחואנה
לא	כן	חשיש
לא	כן	אקסטזי
לא	כן	סמים ממריצים(ספיד וכו')
לא	כן	קוקאין
לא	כן	קראק
לא	כן	אופיום
לא	כן	הרואין/קוק פרסי
לא	כן	LSD. ל.ס.ד.
לא	כן	חומרים נדיפים

תרופות מרשם

לא	כן	משככי כאבים (קודאין, אוקסיקונטין וכו')
לא	כן	תרופות הרגעה (קלונקס וכו')
לא	כן	תרופות מרשם אחרות
לא	כן	חומרים לא חוקיים אחרים (אנא ציין את שם החומר) _____
לא	כן	חומרים חוקיים לא ידועים (אנא ציין את שם החומר) _____

43. במשך החודש האחרון,

לא	כן	האם הזרקת סמים?
		אם כן, איזה סם/ים?
לא	כן	הרואין/ קוק פרסי
לא	כן	קוקאין
לא	כן	תרופות מרשם (בנוודאיזפינים)
לא	כן	אקסטזי
לא	כן	סמים אחרים

44. במשך החודש האחרון, האם שתית 5 או יותר משקאות אלכוהוליים בהזדמנות אחת?

() כן

() לא

45. במשך החודש האחרון, האם נסעת במכונית כאשר הנהג שתה?

() כן

() לא

46. במשך החודש האחרון, האם נהגת במכונית או באופנוע אחרי ששתית?

() כן

() לא

47. האם את/ה משתמש/ת בסמים אחרים בזמן שאת/ה נקי/ה מהרואין?

() כן (אם כן, אנא ענה/י על שאלה 48)

() לא (אם לא, אנא עבור/עברי לשאלה 49)

48. במה את/ה משתמש/ת?

() אלכוהול

() אופיום

() מריחואנה/חשיש

() אקסטזי

() ספיד (ואמפטמינים אחרים)

() תרופות הרגעה (וואליום)

() קוקאין

() מתאדון

() LSD

() אחר (אנא ציין שם) _____

49. האם את/ה מעוניין/ת להפסיק להשתמש בסמים?

() כן (אם כן, אנא ענה/י על לשאלה 50)

() לא (אם לא, אנא עבור/עברי לשאלה 51)

50. למה את/ה מעוניין/ת להפסיק?

() נמאס לך להשתמש בסמים?

() אין לך כסף?

() רוצה את משפחתך חזרה?

() רוצה את בריאותך חזרה?

() אחר (אנא ציין/י) _____

51. האם את/ה מאמין/ה שביכולתך להפסיק להשתמש בסמים?

() כן

() לא

52. האם את/ה חושב/ת שטיפול במכורים דוברי רוסית יהיה טוב יותר אם יהיו יחידות טיפול

מיוחדות לדוברי רוסית בלבד - עם אנשי צוות דוברי רוסית בלבד?

() כן

() לא

53. האם את/ה מעשן/ת סיגריות?

- () כן (אם כן, אנא ענה/י על לשאלה 54)
 () לא (אם לא, אנא עבור/עברי לשאלה 55)

54. כמה סיגריות את/ה מעשן/ת כל יום? (סמן/י אחד)

- () פחות מ- 10 סיגריות
 () 10 - 20
 () 21 - 40
 () יותר מ- 40

55. האם אביך שותה/שתה אלכוהול?

- () כן (אם כן, אנא ענה/י על לשאלה 56)
 () לא (אם לא, אנא עבור/עברי לשאלה 57)

56. אביך שותה/שתה אלכוהול

- () לפעמים
 () לרוב (או תמיד)

57. האם אמך שותה/שתתה אלכוהול?

- () כן (אם כן, אנא ענה/י על לשאלה 58)
 () לא

58. אמך שותה/שתתה אלכוהול

- () לפעמים
 () לרוב (או תמיד)

59-62. במהלך חיידך, במהלך השנה האחרונה ובמהלך החודש האחרון, האם:

(הקף את התשובה הנכונה ביותר עבור כל שאלה)

במהלך החודש האחרון:		במהלך השנה האחרונה:		במהלך חיידך:		
לא	כן	לא	כן	לא	כן	
לא	כן	לא	כן	לא	כן	האם הימרת?
לא	כן	לא	כן	לא	כן	האם נאמר לך שיש לך בעיית הימורים?
לא	כן	לא	כן	לא	כן	הימורים השפיעו על הקשרים

						המשפחתיים שלך?
לא	כן	לא	כן	לא	כן	הימורים השפיעו על העבודה שלך?

שאלון ו'

SBQ- R Suicide Behaviors Questionnaire.

1. האם אי פעם היו לך מחשבות אבדניות או ניסית להתאבד?
 - א. מעולם לא
 - ב. קרה שמחשבה זו חלפה במוחי, אך לא מעבר לכך
 - ג. הייתה לי תכנית התאבדות, אך מעולם לא ניסיתי להוציא אותה לפועל
 - ג. הייתה לי תכנית התאבדות ובאמת רציתי למות
 - ד. ניסיתי להתאבד, אך לא באמת רציתי למות
 - ד. ניסיתי להתאבד ובאמת רציתי למות

2. במהלך השנה האחרונה, באיזה תדירות חשבת על התאבדות?
 - א. אף פעם
 - ב. לעיתים רחוקות (פעם אחת)
 - ג. לפעמים (פעמיים)
 - ד. לעיתים קרובות (3-4 פעמים)
 - ה. לעיתים קרובות מאוד (5 פעמים או יותר)

3. האם אי פעם אמרת לאדם אחר שאתה מתכוון להתאבד או שאתה שוקל התאבדות?
 - א. לא
 - ב. כן, פעם אחת, אך לא באמת רציתי למות
 - ב. כן, פעם אחת ובאמת רציתי למות
 - ג. כן, יותר מפעם אחת אך לא באמת רציתי או שקלתי התאבדות
 - ג. כן, יותר מפעם אחת ובאמת רציתי או שקלתי להתאבד

4. מהי הסבירות שיום אחד תנסה להתאבד?
 - א. אין שום סיכוי
 - ב. אין סיכוי
 - ג. ממש לא סביר

- ד. לא סביר
- ה. ישנה סבירות נמוכה
- ו. יתכן
- ז. סבירות גבוהה

תוכן העניינים

80	תקציר
1	הקדמה
1	סקירת ספרות
1	1. מהו סם?
2	2. הפרעות שימוש בסמים
4	2.1 הפרעת שימוש באלכוהול
5	2.2 הפרעת שימוש באופיואידים
6	3. גישות תיאורטיות וגורמי סיכון
8	3.1 סדר חברתי
8	3.2 סטייה חברתית
8	3.3 כוחות חברתיים
9	3.4 משפחה
9	3.5 קבוצת השווים
9	3.6 חינוך
10	3.7 תקשורת
10	3.8 תהליך התיוג
10	3.9 מאפיינים ביולוגיים ופסיכולוגיים
12	4. שימוש בסמים בקרב נשים
13	5. הורות
15	5.1 אימהות המתמודדות עם מחלות מדבקות
16	5.2 מתח הורי
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תקציר

שימוש בסמים, הנה תופעה כלל עולמית לה השפעה רבה על בריאות הציבור. בעוד שרמות ודפוסי השימוש בסמים משתנים ממדינה למדינה, ישנה הסכמה כי שימוש בסמים איננו עולה בקנה אחד עם הורות נאותה. הורות בקרב משתמשים בסמים עלולה להיות כאוטית, לא עקבית ובלתי צפויה. שימוש בסמים בקרב אימהות בפרט, מהווה בעיה חברתית. מטרת המחקר הנוכחי הנה לזהות ולבחון את מאפייניהן האישיים של אימהות אשר משתמשות בסמים, דפוסי השימוש שלהן וההשפעה של גורמים אלו על מיומנויות הורות ומצבי סיכון.

המחקר כלל מדגם של 41 אימהות אשר השתמשו בסמים במהלך חייהן, וכיום מקבלות טיפול במסגרת מרכז מתאדון בבאר-שבע. לצורך איסוף הנתונים, נערכו ראיונות אישיים במהלכם סייעו עובדי מרכז המתאדון לאימהות להשיב על שאלונים למילוי עצמי. הנתונים נאספו במהלך שנת 2014. השאלונים בהם נעשה שימוש הינם: *Alcohol Use Disorders Identification Test (AUDIT)* - כלי לזיהוי רמות צריכה של אלכוהול; *Substance Use Survey Instrument (SUSI)* - כלי אשר בוחן מאפיינים אישיים, דפוסי שימוש בסמים ונטילת סיכונים; *Parenting Stress Index (PSI-SF) short form* - שאלון אשר מעריך גורמי מתח אשר מקורם בהורה, בילד, ובקשר הורה-ילד. שאלון זה כולל היגדים הבוחנים נושאים כמו מצוקה הורית, קושי באינטראקציית הורה-ילד וקשיי התנהגות אצל הילד; *Parent Child Relationship Inventory (PCRI)* - שאלון אשר מעריך כיצד ההורה תופס את הקשר עם ילדיו; *Generalized Anxiety Disorder Scale (GAD-7)* - שאלון הבוחן תסמינים של הפרעת חרדה מוכללת ומעריך את מידת חומרתם; *Health-Related Anxiety Questions* - שאלון אשר מעריך ארבעה תחומי חיים אשר עלולים להיות מושפעים מחרדה: שינה, תיאבון, קשרים חברתיים והיכולת להתרכז בעבודה או בלימודים; *The Suicidal Behaviors Questionnaire- Revised (SBQ-R)* - כלי הבוחן ארבעה היבטים שונים של אובדנות. קידוד וניתוח הנתונים נעשה במסגרת המרכז האזורי לחקר שימוש לרעה בסמים ואלכוהול ("רדאר"), המחלקה לעבודה סוציאלית, אוניברסיטת בן גוריון. ניתוח הנתונים נעשה תוך שימוש במבחני מאן-וויטני עבור מדגמים קטנים.

מהממצאים עלה כי ליקויים בתפקוד כדוגמת קושי בניהול חיי חברה, קושי להתרכז בעבודה או לימודים, אובדן תיאבון ובעיות בשינה, הושפעו מסוג החומר בו נעשה שימוש בקרב האימהות המשתתפות. אימהות אשר עשו שימוש גם באלכוהול וקנאביס, דיווחו על רמות גבוהות יותר של מתח ובעיות בהורות, בהשוואה לאימהות אשר לא עשו שימוש בחומרים אלו. אימהות אשר עשו שימוש גם בתרופות מרשם, כמו גם אימהות לילדים מעל גיל 18 דיווחו על רמות חרדה גבוהות יותר בהשוואה לאימהות שלא עשו שימוש בתרופות מרשם וילדיהם היו מתחת לגיל 18. כמו כן, אימהות לילדים מעל גיל 18 התקשו לגייס את ילדיהן לשיתוף פעולה, או להתמודד עם התנהגותו של הילד. רמות חרדה גבוהות דווחו גם בקרב אימהות אשר ריצו תקופת מעצר/ מאסר, בהשוואה לאימהות שלא נעצרו או נאסרו. באופן מפתיע, אימהות אשר עשו שימוש בחומרים אופיאטיים הציגו רמות דחק נמוכות בהשוואה לאימהות שלא עשו שימוש בחומרים אלו.

התנהגות אבדנית של אימהות העושות שימוש בסמים נבדקה אף היא במחקר הנוכחי. הממצאים הראו כי אימהות בעלות רמות גבוהות יותר של מחשבות אבדניות או ניסיונות אבדניים, דיווחו על רמות גבוהות יותר של מתח בנוגע לתפקידן כהורה. אימהות אלה דיווחו על רמות גבוהות של אכזבה ודחייה של ילדיהם אותן. הן חוו את האינטראקציה בינן לבין ילדיהן כלא מספקת. אימהות בעלות רמות גבוהות יותר של מחשבות אבדניות דיווחו על קושי לזכות בשיתוף פעולה מצד ילדם.

מחקר חלוץ זה בחן מיומנויות הוריות בקרב אימהות אשר משתמשות בסמים, תוך שימוש בגישה מבוססת ראיות. מהממצאים עולה כי נשים אשר עושות שימוש בסמים מתמודדות עם קשיים בגידול ילדיהן אשר עלולים לפגום ביכולתן לדאוג לצרכיהם. מחקר זה הינו מחקר ראשון הנערך בקרב אימהות אשר מקבלות טיפול במסגרת מרכזי מתאדון בישראל. שירותים כדוגמת מרכזי מתאדון, צריכים להיות ערים לקשר בין שימוש בסמים, ליקויים בתפקוד וקשיים ביישום מיומנויות הוריות.

בעקבות מחקר זה עולה החשיבות לערוך מחקרים נוספים בקרב אימהות אשר עושות שימוש בסמים, כמו גם בקרב אבות, במטרה לפתח מענים יעילים לחיזוק מיומנויות הוריות בקרב אוכלוסייה זו.

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חיבור זה מהווה חלק מהדרישות לקבלת התואר "מוסמך למדעי הרוח והחברה"

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תאריך : _____

חתימת יו"ר הועדה המחלקתית : _____

אייר תשע"ה

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