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Julie M. Tiemeier

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Approved:

Christine M. Dacey, Ph.D., ABPP
Chair, Department of Psychology

W. Michael Nelson III, Ph.D., ABPP
Dissertation Chair

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Family Rituals and Child Psychopathology
in Families with Substance Abusing Mothers
### Dissertation Committee

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<td>W. Michael Nelson III, Ph.D., ABPP</td>
<td>Professor of Psychology</td>
</tr>
<tr>
<td>Member</td>
<td>Kathleen Hart, Ph.D., ABPP</td>
<td>Professor of Psychology</td>
</tr>
<tr>
<td>Member</td>
<td>Renee' Zucherro, Ph.D.</td>
<td>Assistant Professor of Psychology</td>
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Chapter I

Review of Literature

Substance abuse adversely affects families and children every day. Approximately, 25% of children in the United States lived with an alcoholic in 2004 (U.S. Department of Health and Human Services, 2004). There are more than 28 million Americans who are children of alcoholics; 11 million of those are under 18 years old. These are just children of alcoholics. If you add the number parents who are addicted to other drugs, the number would greatly increase.

Early research focuses on children of alcoholics; however, recently, there has been an increase in research about children of illicit substance abusers. Both bodies of research contain evidence of psychological and behavioral problems for these children. There is some evidence that children of illicit substance abusers experience more psychosocial maladjustment than children of alcoholics (Fals-Steward, Kelly, Fincham, Golden, & Logsdon, 2004). In this study, the research on children of alcoholics will be combined with research on substance abusing families because of the growing evidence of problematic environments created with both alcohol and illicit substance abuse. When a parent is alcohol or substance dependent, the environment the child encounters differs from that of a child from non-substance abusing parents. Furthermore, both clinicians and researchers need to remember a child’s psychopathology can be due to several factors, including the family environment.
sing parents often create different environments that can be characterized by disorder and chaos to the family’s every day schedule and holidays (Bennet & Wolin, 1990). Ross and Hill (2004) found families in which at least one parent is an alcoholic tend to be less predictable in the areas of nurturance, finance, and discipline as reported by parents on the Family Unpredictability Scale (Ross & Hill, 2000). Such characteristics described by Ross and Hill (2004) significantly affect the children in the family. For example, if an alcoholic parent shows affection sporadically and uses corporeal punishment some of the time, then the child is receiving mixed messages. Research has found that family stability can be a protective factor for depression in college students as well (Ivanova & Israel, 2005). Similarly, Fiese (1993) found the greater the similarity in perception of family rituals between father and adolescent, the less health-related anxiety symptoms were found in the adolescent as reported by the adolescent. This proposed study is designed to examine whether or not there are significant differences in family rituals of substance-abusing versus non substance-abusing families (as defined by the mother’s substance abuse) and whether there are significant differences in mother-reported psychopathology in their children.

Children of Substance Abusers

Having a substance abusing parent puts children at high risk for problems emotionally, behaviorally, cognitively, and within the family. These outcomes are likely due to the environment created when a parent is abusing one or more substances. Children of alcoholics and substance abusers are more likely to be exposed to child abuse (physical, sexual, and psychological), neglect, modeling of bad behavior, household dysfunction, financial restrictions, and access to drugs (U.S. Department of Health and
Children of maternal substance abusers had double the chance of being exposed to these risk factors as children nationwide with low income status and not living in a two-parent home being most prevalent (Conners et al., 2004). In light of these risks, research has found that these children are also more likely to experience depression, anxiety, attention deficit hyperactivity disorder (ADHD), oppositional defiant disorder (ODD), and psychiatric and psychosocial dysfunction (Johnson & Rolf, 1990; Sher, Walitzer, Wood, & Brent, 1991; U.S. Department of Health and Human Services, 2004; VanDeMark, Russell, O'Keefe, Finkelstein, Noether, & Gampel, 2005; West & Prinz, 1987). Stanger et al. (1999) found that children of drug abusers had more externalizing (e.g. aggression and acting out) and internalizing (e.g. sadness and worry) symptoms than control peers; however, their symptoms were not as problematic as children referred to a mental health clinic. Children of parents with drug addiction are also more likely to have low self-esteem, lack empathy for others, feel socially inadequate, score lower on achievement tests, and have a lack of control over their environment (Sher, Walitzer, Wood, & Brent, 1991; U.S. Department of Health and Human Services, 2004; VanDeMark, Russell, O'Keefe, Finkelstein, Noether, & Gampel, 2005; West & Prinz, 1987).

In a literature review of the children of substance abuse research, Deren (1986) summarized three common results found in studies. These results have been also been confirmed in more recent studies. First, substance abusing parents seem to have similar parenting practices (e.g. discipline, protectiveness, worry) as do comparison non-abusing parents. This surprising finding indicates that research needs to examine other aspects of the effect of substance abuse on the family and children. Substance abusing parents,
however, were more likely to be single parents, a member of a minority group, and have lower levels of education than comparison parents (Deren, 1986).

Second, some children of substance abusing families between the ages of three and seven performed lower on tests of cognition (including intelligence and perceptual motor performance tests) than children from non-abusing families. They also manifest more anxiety, insecurity, and shorter attention spans than children from non-abusing families. Approximately, 42% of these children (compared to 20% in comparison groups) had neurological deficits, mental retardation, and severe emotional problems, and were categorized as high risk for these problems. Another 15% of these children have these problems, which are considered moderate risk. This means about 57% of children aged three to seven from substance abusing families are likely to have educational and/or emotional problems (Deren, 1986).

Lastly, children of substance abusing parents between the ages of 8 and 17 also had more educational problems, including misconduct, absences, and school failure. Older children of substance abusing families were also more likely to be involved in delinquent behavior and to abuse alcohol or drugs themselves (Deren, 1986; Keller, Catalano, Haggerty, & Fleming, 2002).

West and Prinz (1987) found that although children of substance abusers are at high risk for problematic behaviors, some can still survive adolescence without any diagnosable psychopathology. Some of the risks may be mediated by the parent’s psychopathology, environmental stress surrounding the family, and perceived family cohesion/parental attachment that can be manifested in family rituals and routines (Chassin, Rogosch, & Barrera, 1991; Cronkite, Finney, Nekich, & Moos, 1990; El-
Children's ability to cope with alcoholic parents can greatly affect the internalizing and externalizing symptoms as reported by adult children (Smith et al., 2006). Hall (2007) studied college students who labeled themselves children of alcoholic parents and children whose parents were not alcoholic to see if there were any differences between the groups in self-esteem, family social support, and coping strategies. No differences were found in this sample, which has implications regarding the lasting results of having a parent who abuses alcohol or perhaps the differences between family environments (Hall, 2007). Due to a variety of mediators (i.e., stable family environment, family rituals, family cohesion, lack of parental psychopathology) and individual differences for the children, there is no standard personality profile for children of alcoholics (Calder & Kostyniuk, 1989; Johnson & Rolf, 1990).

Dube et al. (2001) examined the correlation between having an alcoholic family member and adverse childhood experiences (ACEs). ACEs included child abuse, neglect, witnessing domestic violence, household dysfunctions, and household mental illness. Strong relationships were found between having at least one parent who was an alcoholic and all of the ACEs. In fact, having an alcoholic parent doubled the risk of the ACEs for men and women. The strongest correlation was found between “any type of parental alcohol abuse and having a battered mother” (p. 1633). Not only did an alcoholic father greatly affect the mother’s well-being, but the child’s as well. The results of ACEs have been found to be cumulative in the child’s well-being and behaviors. The authors stress how important it is for clinicians to consider these ACEs when working with substance abusers and their families.
ning adult children of substance abusers has studied direct and indirect relationships between childhood experiences and parenting practices (Locke & Newcomb, 2004). An example of a direct relationship would be childhood maltreatment leading to the adult child’s poor parenting (as explained by observational learning). An indirect relationship example would be having a bad childhood (e.g. child abuse, witnessing domestic violence) that has lead to polysubstance use (as indicated by the self-medication hypothesis), which then leads to deficient parenting (as explained by the impaired functioning theory). Locke and Newcomb (2004) found support for the observational learning theory and impaired function theory through significant correlations between a mother’s childhood maltreatment and substance use that had an adverse affect on her own parenting. Although evidence supporting the self medication hypothesis was not present, Locke and Newcomb (2004) did find a positive correlation between substance-related problems and poor parenting, thus illustrating the presence of indirect effects.

Poor parenting sometimes involves emotional and physical neglect, and children of substance abusers are more likely to be neglected by their parents (up to 55%) than children of non-substance abusers (Conners et al., 2004; Locke & Newcomb, 2004). Besides drug use, Dunn, Tarter, Mezzich, Vanyukov, Kirisci, and Kirillova (2002) identified several characteristics of children of substance abusers that could be an origin or consequence of neglect. Children of substance abusing mothers are more likely to be born prematurely and/or with a low birth weight and have more difficult temperaments. Older children have been found to have more learning disabilities and attention deficit
particularly cocaine and heroin because of their severity, have also been linked to greater probability of neglect (Cash & Wilke, 2003).

Neglect is one factor that may lead to such problems in children of substance abusers as follows. Children of substance abusers are more likely to use drugs and alcohol themselves and are more likely to develop psychopathology than children of non-substance abusers (Barnes, 1990; Bidaut-Russell, Bradford, & Smith, 1994). Female adult children of alcoholics are more likely to have alcohol abuse or dependence than their control group counterparts. Male adult children of alcoholics are more likely to develop alcoholic and drug abuse or dependence, affective disorders, general anxiety disorder, panic disorder, and schizophrenia than their comparison counterparts (Bidaut-Russell, Bradford, & Smith, 1994).

Also examining differences in children’s symptoms, Puttler (1996) compared girls of substance abusers with a control group using the parent-reported Child Behavior Checklist (Achenbach, 1993). Girls of substance abusers had more parent-reported problem behaviors and more externalizing symptoms than their “normal” counterparts. Furthermore, girls in non-recovering alcoholic families compared to girls in recovering alcoholic families had lower intelligence scores and spelling scores, as well as more behavior problems and externalizing symptoms. Girls in the alcoholic recovering families functioned similarly to the control group. However, adolescents of recovered alcoholic fathers, when gender is combined, appeared to have more symptomatology than adolescents of non-alcoholic fathers as reported by the fathers using the Child Behavior Checklist (DeLucia, Belz, & Chassin, 2001). This suggests that having the parent in recovery does not influence the adolescent’s symptoms. Sons of substance abusing
to be more aggressive than sons of non-substance abusers as reported by their mothers on the Child Behavior Checklist and interviews (Moss, Mezzich, Yao, Gavaler, & Martin, 1995). Greater for women than men, self-deprecation seems to increase in children of alcoholics when compared to control peers as reported by college students. Adult male children of alcoholics have also reported themselves to be more autonomous than their peers (Berkowitz & Perkins, 1988).

By comparing children living with illicit substance abusing and non-substance abusing fathers, Fals-Steward et al. (2004) found that children living with a drug abusing father had higher levels of internalizing and externalizing symptoms as defined by both parents using the Child Behavior Checklist’s internalizing and externalizing subscales (Achenbach, 1993). Children living in homes with drug abuse experienced more physical violence and witnessed more marital conflict. Fathers reported more disciplinary dysfunction and less monitoring of their children when using drugs. Similar to Dube et al. (2001) which assessed ACE’s from adult children of alcoholics, a child witnessing physical marital conflict is more likely to have externalizing symptoms, such as acting out, than internalizing symptoms compared to children of non-substance abusers.

Eiden, Edwards, & Leonard (2007) tested a model of why children of alcoholics are more likely to experience externalizing symptoms than children from non-alcoholic families. They found that families with an alcoholic father when the child was between 12-18 months had lower maternal and paternal warmth and sensitivity at two years of age. Further, at the age of three the children were not as self-regulated as their normal counterparts. This lack of self-regulation, Eiden et al. (2007) hypothesized, is what leads to the acting out behavior. Studies such as Fals-Steward et al. (2004) and Eiden et al.
Using fathers with both parents as reporters. Further research is needed to identify the effects of maternal drug use.

Substance abuse offspring are also more likely to experience disruptions in household makeup compared to families without substance abuse. Keller, Catalano, Haggerty, and Fleming (2002) found that only adolescent girls had a higher probability of drug use as the number of family disturbances increased. For adolescent males, the authors found the child's age at the time of the family disturbances contributed to the amount of delinquency. Adolescents of crack-addicted mothers who are most likely to use drugs are older in age, have lower perceived maternal endorsement and warmth, and have more family conflicts than those who do not use drugs as assessed by the Family scale of the Family, Friends, and Self Scale (Lam, Cance, Eke, Fishbein, Hawkins, & Williams, 2007). King, Vidourek, & Wagner (2004) found that adolescents who use drugs also tend to come from families who did not spend time together.

In summary, children of substance abusers are at high risk for many behavioral and emotional problems. Although not all children who come from a substance abusing family will exhibit these problems, many do. Children of substance abusers are at high risk due to some parental practice differences, stressful environments, and relationship difficulties, all of which can result in fewer and less meaningful family rituals. These can lead to greater rates of parent-reported depression, anxiety, acting out, and substance use in children. If parental gender is specified, many studies focus on paternal drug use (DeLucia et al., 2001; Dube et al., 2001; Eiden et al., 2007; Fals Steward et al., 2004; Moss et al., 1995) and there is a need for maternal drug use research (with the exception of studies by Conners et al., 2004; Dunn et al., 2002; Locke & Newcomb, 2004). Such
further research on mothers who are drug abusers is needed because of the general findings that parents tend to agree on the total number of behavior problems but not on the specific behaviors individually (Christensen, Margolin, & Sullaway, 1992). Disagreement at the item level among maternal and paternal reports of their child(ren)’s behavior may lead to different results.

*Family Rituals*

One way the family system can be assessed is through family rituals. Family rituals have been defined as “powerful organizers of family life, supporting its stability during times of stress and transition” (Fiese et al., 2002, p. 290). Although the number of family rituals has decreased since the 1970’s, they still exist today (Fiese, 2006).

From dinnertime to birthday celebrations, family rituals vary greatly and have been divided into three categories: family celebrations, family traditions, and patterned routines (Wolin & Bennett, 1984). Each of these categories of family rituals should be assessed in families presenting to treatment to get a clear picture of how the family functions. Family celebrations center on what the family does for holidays and other festive cultural occasions. These family rituals are generally similar within cultures; however, each family creates its own uniqueness as well (Baxter & Braithwaite, 2006). Family traditions focus on individual family rituals, such as birthdays, anniversaries, or vacations. Patterned routines involve the every day activities of the family. For example, what does the family do during dinnertime or bedtime? All of these family rituals help shape each family as a whole and each member individually. Through rituals, stability, order, organization, limitations, and roles can be established. Family rituals are often...
passed down through generations and provide the family with meaningful acts, which can lead to greater emotional bonds (Baxter & Braithwaite, 2006; Roberts, 2003).

For example, family mealtime is a type of patterned routine that provides a chance for family members to interact and socialize. If the social interaction is positive, it can lead to better mental health outcomes in the children of the family. They also help the family determine its identity and make the members feel like they belong to a meaningful group. Direct communication during dinner can lead to less internalizing symptoms in children, while indirect communication observed by children during dinner can lead to greater risk of mental health problems (Fiese, Foley, & Spagnola, 2006).

These different types of family rituals are important to distinguish from routines. In routines, language and action is direct, there is little afterthought; they are repeated over time with few changes and can be directly observed. On the other hand, rituals involve language that is multilayered, symbolic communication, a threat to the group if interrupted, and an emotional aspect that can lead to feelings of belonging and appropriateness (Fiese, 2003). Patterened interactions, a type of ritual, is specifically different from a family routine based on the fact that the patterned interactions involve meaning and symbolism (Baxter & Braithwaite, 2006). When defining what a family does, these distinctions can be important.

Psychologists have developed different approaches in studying family rituals, although all look at each type (i.e. family traditions, family celebrations, and patterned routines) when studying family rituals. Some study rituals though a functional lens. These researchers ask about the functions of the rituals for the person and the family. For example, rituals may provide an individual with a role during dinner. Others study rituals
through a semiotic, or cultural, lens and ask about the meanings found in rituals. For example, the researcher may ask what significance going to church on Christmas has for the family. Yet other researchers look at rituals through a performance lens and view rituals as activities that build family values and meanings. In this lens, a researcher would examine why a family insists that all members attend a birthday dinner (Baxter & Braithwaite, 2006). Ideally, research will study the function, meaning, and performance of rituals in each of the three categories.

Through these lenses, Imber-Black (2003) described five themes found in family ritual research. First, routines and rituals are a part of every family and occur daily. Routines and rituals also provide members with a role and can help them understand the family’s view of itself. Often times a family will split up the duties of dinner. The children learn they are expected to be at dinner, talk about their days, and help clean up afterwards while the parents will cook, listen during dinner, and also help clean up. Through these roles, each family member feels needed and a part of the group. Third, rituals can be healing in that they can help families move on after a tragic incident. For example, when someone in the family dies, there are usually rituals (i.e. funerals) which can help the family grieve and start to move on. Rituals also provide a means of moving from one identity to the next for a member and the family as a whole. Confirmations, bar/bas mitzvahs, weddings, and having children are all examples of rituals which move a member of the family from one identity to another. Furthermore, rituals provide a way to form and express attitudes and values. Through the routine of rituals, family members learn what to expect and when to express their thoughts appropriately. Rituals can open communication in a family. Lastly, celebrations, both solemn and joyous, are a ritual
The themes of family rituals can show the diversity that appears among families. This diversity can also include a family’s commitment to family rituals and therefore families have been categorized based on their family rituals (Baxter & Braithwaite, 2006). Roberts (2003) described six types of families based on direct family observations. Under-ritualized families often do not celebrate changes within the family or larger cultural customs. Rigidly-ritualized families perform rituals in a very standardized way that does not allow for change. Skewed ritualization is a result of one ethnic side overpowering the other ethnic side’s rituals. For example, a family who celebrates the Mexican mother’s traditions but ignores the African American father’s traditions is a skewed ritualized family. Families who perform rituals out of responsibility, rather than meaning, are categorized as hollow ritual as event, not process. Other families may have rituals interrupted due to a distressing incident or societal change and are categorized as ritual process interrupted or unable to be openly experienced. Lastly, some families rely on flexibility while adapting rituals and are open to change.

Although Roberts (2003) categorized families by how they carry out rituals, Fiese (2003) did so based on ways in which the family follows rituals in their daily life and the emotional aspect of the family. Chaotic families do not use a lot of plans and there is no predictable pattern to interactions, which can either be viewed as a strong negative affect or an effort to have power over positive emotional expression. Rigid and hollow families have a strong emphasis on rituals but do not connect the meaning to them. These
families tend to be more controlling over the expression of emotions compared to other family types. Flexible and variable families allow members to participate in the family in their own way and on their own level (i.e., a six year old can participate just as a fifteen year old can). In enriched families, feelings are overregulated as part of the ritual or may be used for exploration.

Wolin and colleagues (2003) designated categories for families who have an alcoholic parent based on interviews about the three types of family rituals (family celebrations, family traditions, and patterned routines). These families could be categorized into Fiese's (2003) categories but once alcohol is involved Wolin’s (2003) categories become more accurate. In subsumptive families, rituals have changed drastically due to the alcohol. For example, alcohol may be present at the original rituals which can transform them into different rituals. Other families, called distinctive families, do not allow alcohol to be a part of the family rituals; therefore, the rituals are not affected. Intermediate subsumptive families do not show any particular pattern of rituals and are a mixture of the subsumptive type and the distinctive type. When determining type of family, family celebrations, family traditions, and patterned routines were all considered.

Haughland (2005) also described alcoholic father families by rituals which are very similar to Wolin et al. (2003). Again, all three parts of family rituals (family celebrations, family traditions, and patterned routines) were considered when determining family categories. First, there are protective families who do not experience much disruption in rituals because fathers still maintain their role in the family (similar to Wolin’s distinctive families). Second, there are emotionally disruptive families in which
the mothers try to maintain order in the family despite their alcoholic husbands. Third, there are exposing families who experience some change in rituals and major changes in the family atmosphere based on the phase of the father’s drinking (similar to Wolin’s subsumptive families). Lastly, chaotic families have major changes in rituals and the mothers do not compensate for the fathers’ drinking (also similar to Wolin’s subsumptive families).

Presence of alcohol is a determining factor for which category a family will be placed. Mothers were found to be very important in maintaining structure and order while the fathers were drinking. The father’s drinking can greatly affect the mother which in turn can affect the children. There was less predictability when the father was drinking and less control over what happened in the home (Haughland, 2005).

In alcoholic families who fit categories when rituals are absent (exposing and chaotic families), problems can be seen (Baxter & Braithwaite, 2006; Haughland, 2005; Wolin, Bennett, & Jacobs, 2003). Children in emotionally disruptive families tend to have more problematic behaviors as reported by both of their parents on the Child Behavior Checklist (CBCL; Achenbach, 1993) than children in protective families. Children in exposing and chaotic families had even higher parental reports of problematic behavior as determined by the CBCL when compared to the children in protective and emotionally disruptive families (Haughland, 2005).

Research has found that for substance abusing families, as the number of family rituals increase within the family, the parental distress and children’s shyness decreased. The amount of stress parents endure can greatly influence how they parent their children (Kinnebrew, 2004). Fiese (1993) found that adolescent children of alcoholics report
lower family ritual importance than control adolescents. Similarly, fathers and mothers also reported lower family ritual importance. There were significant differences between the family ritual meanings reported from adolescents and mothers. This implies that adolescents and mothers seem to have a disparate view of the family rituals. The reason this may happen among mothers and not fathers is because of the mother's role of preserving family rituals while the father drinks (Fiese, 1993).

Fiese (1993) also found that as family ritual importance increased, adolescent anxiety-related health decreased. Similarly, Fiese (1992) discussed how when family ritual meaningfulness increases and is agreed upon across generations, the adolescent child formed a more positive identity and sense of belonging. An implication of Fiese's (1993 and 1992) research is that children of alcoholics may have more anxiety symptoms, a more negative identity, and less of a sense of belonging than children of non-alcoholics.

Families with a substance abusing parent are more likely to come from a low socioeconomic status (Conners et al., 2004). Families in poverty typically have more chaotic families. They are less likely to share rituals because of parents' work, more children, and living arrangements. The lack of rituals and routines causes a chaos that affects the children's ability to self-regulate behaviors and emotions (Evans, Gonnella, Marcynszyn, Gentile, & Salepek, 2005; Keller et al., 2002). In a broader sense, families in poverty are also exposed to more danger and poor services when compared to families from higher incomes. These neighborhood differences also make the household more chaotic (Evans, 2004).

If and when the substance abusing parent seeks treatment, the family should be included because of the way the abuse has affected the family rituals and children.
Alcoholics from a more positive family, meaning a family high in cohesion and activities, had better treatment outcomes. Families should be educated about implementing family rituals (Collins, 1990; King et al., 2004).

If families are able to keep alcohol detached from the family rituals, then their children are less likely to become alcoholics themselves. Through keeping the family intact using the normal family rituals, which is usually done by the non-using parent, children of the family are less likely to use alcohol themselves as adults (Haughland, 2005; Wolin, Bennett, & Noonan, 1979). However, this does not explain why one child in a family becomes an alcoholic while another child does not. Bennett, Wolin, Reiss, and Teitelbaum (1987) took the research further and found that adult children who departed from their families' rituals (particularly dinner time and holiday rituals which are in the patterned routines and family celebrations categories) in childhood were less likely to become alcoholics than children of non-alcoholics. If children adapted the rituals, however, then they were more likely to become an alcoholic like their parent. Bennett et al. (1987) also found significant differences between children of alcoholics and children of nonalcoholics in that children of alcoholics were more dysfunctional.

O’Conner and Hoorwitz (2003) described how children enjoy rituals and develop the rituals in their own play. Rituals, including rituals within the family, provide children with understanding in a confusing world and are also a type of coping mechanism for children as they provide repetition and prediction (O’Conner & Hoorwitz, 2003).

Family rituals can also be a coping mechanism used to promote healthy choices. For example, in families with children who have asthma, meaningful rituals can be used to reduce anxiety in the child as well as to encourage treatment adherence (Markson 

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Rituals and routines also become important when someone in the family has a chronic illness. Rituals can help the family reorganize to fit the new aspects of the person with the chronic illness. Just like substance use, chronic illness can become a crisis for the family and rituals can be used to get the family through the crisis (Patterson, 2005). Rituals and routines can also promote healthy lifestyles for members of the family. For example, a family may take a walk together every night after dinner. Rituals such as this can be an easy way for the family to make healthiness part of every day life (Denham, 2003; Fiese, 2007).

Throughout the research, different assessment tools have been used to assess family rituals. Direct family observation and family interviews were most popular until Fiese & Kline (1993) developed the Family Rituals Questionnaire (FRQ). The FRQ provides a quantitative method for assessing family rituals. While the Family Routines Inventory (Jensen, James, Boyce, & Hartnett, 1983) and the Child Routines Inventory (Sytsma, Kelley, & Wymer, 2001) are also quantitative measures, they only assess routines. The FRQ is the only measure which assesses family celebrations, family traditions, and patterned routines as family rituals in a quantitative manner.

In summary, family rituals help define who families are as well as give each member a role and sense of belonging. All types of rituals (family traditions, family celebrations, and patterned routines) can be useful in times of crisis as they give stability and predictability to the family, which is especially needed for the children. If rituals are absent or not meaningful, as what often happens in families with a substance abusing parent, then there can be distressing effects on the children. Assessment of both the type
and number of family rituals and the meaning of the rituals are necessary for a full picture of the family.

The purpose of the present study is to compare family rituals in families with a substance abusing mother and families with a non-substance abusing mother. A comparison will also be made between maternal rating of their children's behavior between the two groups (substance abusing and non-substance abusing). Maternal substance abusers will be used because the majority of studies thus far have used paternal substance abusers (DeLucia et al., 2001; Dube et al., 2001; Eiden et al., 2007; Fals Steward et al., 2004; Haughland, 2005; Moss et al., 1995). Finally, the correlation among family rituals and various mother-reported child behaviors will be analyzed. Through having an understanding of this relationship, substance abuse and children's treatment can be better focused.
Chapter II

Rationale and Hypotheses

In 2004, approximately 25 percent of children in the United States lived with an alcoholic parent. Children of substance abusers have many different characteristics than children from non-substance abusing families. Children of substance abusers tend to experience more psychopathology, both internalizing and externalizing behaviors, and are more likely to use substances themselves (Barnes, 1990; Deren, 1986; DeLucia, Belz, & Chassin, 2001; Fals-Steward et al., 2004; Johnson & Rolf, 1990; Keller et al., 2002; Moss et al., 1995; Noether & Gamble, 2005; Puttler, 1996; Sher et al., 1991; Stanger et al., 1999; U.S. Department of Health and Human Services, 2004; VanDeMark et al., 2005; West & Prinz, 1987). This information is typically reported by both parents, only the mother, or self-reported (with adolescent and adult children).

Family rituals are operationally defined as “powerful organizers of family life, supporting its stability during times of stress and transition” (Fiese et al., 2002, p. 290). Family rituals provide children with stability, role definition, and family cohesion (O’Conner & Hoorwitz, 2003) and include family traditions, family celebrations, and patterned routines (Wolin & Bennett, 1984). Without these rituals, a child may exhibit unwanted symptoms and behaviors, including inability to self-regulate, alcohol addiction when the child becomes an adult, and less healthy choices (Baxter & Braithwaite, 2006; Evans et al., 2005; Keller et al., 2002; Wolin, Bennett, & Jacobs, 2003; Wolin, Bennett, & Noonan, 1979). Families with a substance abusing parent tend to have fewer family
rituals and routines (Fiese, 1993; Haughland, 2005). Children from these alcoholic families with fewer family rituals tend to have more parent-reported problematic behaviors (Haughland, 2005).

Although a number of researchers have studied family rituals or child psychopathology in drug-related families, Haughland (2005) and Kinnebrew (2004) are the only studies which examined family rituals and child psychopathology in families with a substance abusing parent. Some researchers have examined the effects of family conflict in substance abusing families on child psychopathology but have not studied family rituals specifically (Keller et al., 2002; King, Vidourek, & Wagner, 2004; Lam et al., 2007). Studies also focus on paternal substance abusers rather than maternal substance abusers when studying family rituals and child psychopathology (DeLucia et al., 2001; Dube et al., 2001; Eiden et al., 2007; Fals Steward et al., 2004; Haughland, 2005; Moss et al., 1995). However, reports of child psychopathology and family rituals come from several sources (both parents, father-only, mother-only, and/or self-reported from adolescents and adult children of drug abusers).

The proposed study will examine differences between family rituals and child psychopathology in families with or without substance abusing mothers in Cincinnati, Ohio. Previous research has examined these issues in families with a substance abusing father, but few studies have examined these issues when the mother is abusing substances. Perhaps with a better understanding of substance use affecting the family rituals and children, clinicians will be able to better formulate more effective treatment interventions.
Primary Hypotheses (stated in null terms):

H1: There are no one or more statistically significant differences in maternal ratings of family rituals (as defined by the FRQ two factors) between substance abusing mothers and the non-substance abusing maternal comparison group.

H2: There are no one or more statistically significant differences in maternal ratings of their children’s behaviors (as defined by the CBCL eight syndrome scales) between substance abusing mothers and the non-substance abusing maternal comparison group.

In order to better understand the relationships among maternal ratings of family rituals and maternal ratings of child behavior, a correlation table will be presented with the magnitude of the relationships among maternal ratings of family rituals (as defined by the FRQ total score and two factors) and maternal ratings of children’s behaviors (as defined by the CBCL total score, externalizing and internalizing scales, and eight syndrome scales).
Chapter III

Method

Participants

Participants will be drawn from two agencies—women enrolled in substance abuse treatment at First Step Home (FSH) and mothers of children enrolled in Santa Maria’s after-school program (all aged 18 years and older). FSH is a non-profit, residential treatment program, servicing substance-addicted women and their children. FSH has two residential facilities in low-income areas and served a total of 182 clients during fiscal year 2005/06. FSH serves multiple underserved populations: substance abusers (100%), women with children (42%), women with comorbid mental disorders (79%), the homeless (57%), and the African American population (48%). FSH provides educational and counseling services in the areas of abstinence, sober living, parenting, anger management, health care, and relationship building. FSH allows women to bring their children with them to treatment.

To serve as a comparison group, non substance abusing mothers who are in a similar socioeconomic class (lower socioeconomic status) will be recruited through after-school groups at Santa Maria Community Services in Price Hill. Santa Maria Community Services also serve underserved populations, including low socioeconomic, African American, and Appalachian populations. According to their records, approximately 75 percent of the individuals served in 2000 were Caucasian (largely of Appalachian descent), 20 percent African-American, 2 percent Hispanic, 1 percent Asian,
and 2 percent of other descent (Santa Maria Services, 2008). Also 37 percent of adults ages 25 and older lacked a high school diploma; the unemployment rate was 9 percent; 24 percent of families lived below poverty; and 46 percent were female head of households in 2000. It appears there likely may be some cultural differences between the two agencies where participants are drawn (e.g. Santa Maria is 70 percent Caucasian). While there is no research comparing cultural differences in family rituals, a matched comparison group will be obtained as best as possible.

**Power Issues**

Previous research (DeLucia et al., 2001; El-Sheikh & Buckhalt, 2003; Fals-Stewart et al., 2004; Fiese, 1993) on family rituals in alcoholic families has demonstrated an effect size of 0.12. For the purposes of this study, a medium effect size of 0.12 is assumed. To ensure an adequate amount of participants, Cohen (1992) suggests 30 participants per group for MANOVA; therefore, a total of 60 participants would ensure adequate power for the analyses proposed.

**Measures**

*Family Rituals Questionnaire (FRQ)*

The Family Rituals Questionnaire (FRQ; see Appendix C) has been developed by Fiese & Kline (1993) and is widely used in the family rituals research (interviews and observations are the only other means by which all aspects of family rituals are assessed as seen in Haughland, 2005). The FRQ is the only objective measurement that assesses a variety of family rituals (e.g., family traditions, family celebrations, and patterned routines) as well as the meaningfulness of those rituals. The FRQ is a forced choice scale between two statements with subsequent ratings as to how meaningful that ritual is to the
family. Respondents choose between two statements (e.g., either “Some families regularly eat dinner together” or “Other families rarely eat dinner together”). Then, participants choose either “really true” or “sort of true for our family”. Two factors are obtained from the FRQ: Ritual Meaning and Ritual Routine. Ritual Meaning refers to how important rituals are to the family. Ritual Routine refers to the number of rituals in which the family participates. Test-retest correlations over a four week period ranged from .60 (Dimension: Roles) to .88 (Total Score). Internal consistency ranged from .52 (Dimension: Continuation) to .90 (Total Score). The FRQ was chosen for this study because it is the only quantitative measure that assesses a variety of aspects of family rituals (family celebrations, family traditions, and patterned routines). An addition to the FRQ will be used after the standard administration in which the substance abusing mothers will be asked to circle any ritual during which substances were present and box any ritual during which alcohol was present. This will be done in order to assess drug and alcohol presence during rituals.

*Child Behavior Checklist (CBCL)*

The Child Behavior Checklist was developed by Achenbach (1993) and is widely used to assess child symptomatology. The CBCL is composed of 113 items related to a child’s behavior. It is completed by a parent or caregiver. Respondents rate the children’s behaviors on a Likert-scale (0=not true, 1=somewhat or sometimes true, 2=very true or often true). The CBCL items load onto eight syndrome scales (Anxious/Depressed, Withdrawn/Depressed, Somatic Complaints, Social Problems, Thought Problems, Attention Problems, Rule-Breaking Behavior, and Aggressive Behavior), which factor onto internalizing or externalizing scales. These scales can be
added together for a Total Score. The Internalizing scale refers to internalizing behaviors, including depression, anxiety, and withdrawal. The Externalizing scale refers to externalizing behaviors, including inattention, aggression, and rule-breaking. Internal consistencies of the Externalizing and Total Scores were in the .92 and .96 range, and the reliability of the Internalizing scale was .88 to .92. Test-retest correlations over a one-week period were .82 for Internalizing, .91 for Externalizing, and .91 for Total Score. The well-validated CBCL is often the benchmark for other behavior checklists and is highly correlated with similar measures (e.g., Conners' Parent Rating Scale and the Quay Problem Behavior Checklist). Strong discriminant validity was also demonstrated. The Mental Measurements Yearbook (2004) describes the CBCL as "unquestionably the most well articulated and well established of its kind."

Demographic Questionnaire

Basic demographic information sheets (see Appendix D) developed for this study will be used, one for the FSH group and one for the Santa Maria group. Questions will include race, socioeconomic status (as indicated by income), level of education, drug of choice (if applicable), and family member information (such as number and ages of children and parents).

Procedure

The FSH Executive Director has been consulted on this project, and there is significant interest. FSH Board of Directors approved the project on November 9, 2006. A letter of support for this project is attached in Appendix A. The Santa Maria Coordinator of After-school Programs has been consulted as well. A letter of support for this project is attached in Appendix B. Approval for the study will also be sought from
the Xavier University Institutional Review Board (IRB). As previously mentioned, there are likely some cultural differences between the two groups. Efforts to form a comparable comparison group will be made by monitoring the cultural composition of participants completing the questionnaires. Efforts will be made to equalize these groups as much as possible. As a last resort, efforts may be made to gain appropriate participants from other sources.

Mothers will be asked to gather in a group setting at each agency after a brief explanation to the larger group (see Appendix E). Once in a group setting at each agency, each mother will be asked to fill out each questionnaire in a standardized manner (see Appendix E). To ensure anonymity, a number system will be used to keep questionnaires together. They will be given a consent form (see Appendix F) which they will keep if they agree to participate. Thus, completion of the packet ensures their consent to participate in the study. Each mother will fill out the information based on her own family and one of their children between the ages of 4 and 18. If the mother has more than one child, she will be asked to fill out the questionnaire for the child with the most recent birthday. Due to a lack of reading skills, if necessary, the researcher will read the questionnaires aloud as the mothers fill them out. If a mother does not want to participate, she can return the forms in the envelope unanswered without any consequences. Mothers will also be given a referral resource (see Appendix G) on the back of the consent form in case they are concerned about their own or their child’s well-being and/or mental health. Envelopes containing questionnaires will not be opened until the researcher has left the agency to further ensure anonymity. Thus, in no way can the
responses of the participants be linked to the individual. Once data are analyzed, results will be presented to First Step Home and Santa Maria Services.
Chapter IV

Proposed Analyses

The purpose of this study is to determine if there are any differences in family rituals and mother-rated child psychopathology between substance abusing and non-substance abusing mothers. As a first step, independent sample t-tests will be conducted to examine the comparability of the two groups (age, race, educational level). In addition, means and standard deviations for the FRQ (total score and two factors) will be determined and evaluated against the college-age group means upon which the questionnaire was originally developed. In addition, the mean profiles on the CBCL will be plotted on profile sheets for both groups so as to examine how their scores compare to the normative group.

In order to test the main hypotheses, a MANOVA will be conducted to determine if there is a significant difference between two factor scores of the FRQ of substance abusing families versus non substance abusing families (Hypothesis 1). A MANOVA will also be used to compare mother-reported child psychopathology (Child Behavior Checklist: eight syndrome scales) between substance abusing and non substance abusing families (Hypothesis 2). If significant effects are found at the .05 level, then ANOVAs will be conducted to identify simple effects.

A correlation table for the measures and their factors will also be developed. Correlations will be conducted to determine if family rituals are significantly correlated
with maternal reported child psychopathology (CBCL). Descriptive statistics will also be presented regarding the mothers' reports of drug presence at family rituals.
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Appendix A

Letter from First Step Home
January 23, 2008

To Whom It May Concern:

First Step Home has been requested, through the dissertation process of Julie Tiemeier, to participate in a family rituals and child behaviors research project. This request was made to me in the spring of 2007. I realize, as the project evolves, changes and adjustments may be necessitated.

If there are further questions or other information needed in order for Julie to begin, please contact me at either 961-4663 or margo.spence@firststephome.org.

Sincerely,

Margo Spence
Executive Director
Appendix B

Letter from Santa Maria
January 23, 2008

To Whom It May Concern:

Santa Maria has been requested, through the dissertation process of Julie Tiemeier, to participate in a family rituals and child behaviors research project. This request was made to me in the fall of 2007. Carson School, YMCA director, and Santa Maria Community Services have all approved Julie’s project. I realize, as the project evolves, changes and adjustments may be necessitated.

If there are further questions or other information needed in order for Julie to begin, please contact me at either 363-9856 or hughes@cpsboe.k12.oh.us.

Sincerely,

Tracy Hughes
After School Program Coordinator
Appendix C

Family Rituals Questionnaire
Current Family Routines

On the following pages are descriptions of family routines and traditions. Every family is somewhat different in the types of routines and traditions that they follow. In some families routines and traditions are very important but in other families there is a more casual attitude toward routines and traditions.

On the top of each page you will find a heading for a family setting. Think of how your family typically acts or participates during these events. Read the two statements and choose the one that is most like your family. After choosing the statement that is most like your family, decide if the statement is really true or sort of true for your family. Circle the letter that best describes your current family.

When thinking of your family, think of yourself, your spouse, and your children. Some of the settings may also include other family members such as grandparents, aunts, uncles, and cousins. However, try to answer the questions as they best relate to your current family.

There are no right or wrong answers to each statement, so please try to choose the statement that most closely describes your family.

EXAMPLE:

<table>
<thead>
<tr>
<th>FOR OUR FAMILY</th>
<th>FOR OUR FAMILY</th>
</tr>
</thead>
<tbody>
<tr>
<td>REALLY</td>
<td>SORT OF</td>
</tr>
<tr>
<td>TRUE</td>
<td>TRUE</td>
</tr>
</tbody>
</table>

A     B  In some families one person does the dishes. BUT In other families everyone does the dishes. C  D

A     B  In some families there is little planning around breakfast. BUT In other families there is a lot of planning around breakfast. C  D

REMEMBER:
1. Read both statements and then choose the statement most like your family.
2. Decide if the statement is really true or sort of true of your family.
3. Circle the letter which best describes your family.
4. There should be only one letter (A, B, C, or D) circled per line.
# Dinnertime

Think about a typical dinnertime in your family.

<table>
<thead>
<tr>
<th>FOR OUR FAMILY</th>
<th>REALLY TRUE</th>
<th>SORT OF TRUE</th>
<th>BUT</th>
<th>FOR OUR FAMILY</th>
<th>REALLY TRUE</th>
<th>SORT OF TRUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>B</td>
<td>1. Some families regularly eat dinner together.</td>
<td>BUT</td>
<td>Other families rarely eat dinner together.</td>
<td>C</td>
<td>D</td>
</tr>
<tr>
<td>A</td>
<td>B</td>
<td>2. In some families everyone has a specific role and job to do at dinnertime.</td>
<td>BUT</td>
<td>In other families people do different jobs at different times depending on needs.</td>
<td>C</td>
<td>D</td>
</tr>
<tr>
<td>A</td>
<td>B</td>
<td>3. In some families dinnertime is flexible. People eat whenever they can.</td>
<td>BUT</td>
<td>In other families everything about dinner is scheduled; dinner is at the same time every day.</td>
<td>C</td>
<td>D</td>
</tr>
<tr>
<td>A</td>
<td>B</td>
<td>4. In some families, everyone is expected to be home for dinner.</td>
<td>BUT</td>
<td>In other families you never know who will be home for dinner.</td>
<td>C</td>
<td>D</td>
</tr>
<tr>
<td>A</td>
<td>B</td>
<td>5. In some families people feel strongly about eating dinner together.</td>
<td>BUT</td>
<td>In other families it is not that important if people eat dinner together.</td>
<td>C</td>
<td>D</td>
</tr>
<tr>
<td>A</td>
<td>B</td>
<td>6. In some families dinnertime is just for getting food.</td>
<td>BUT</td>
<td>In other families dinnertime is more than just a meal; it has special meaning.</td>
<td>C</td>
<td>D</td>
</tr>
<tr>
<td>A</td>
<td>B</td>
<td>7. In some families there is little planning around dinnertime.</td>
<td>BUT</td>
<td>In other families dinnertime is planned in advance.</td>
<td>C</td>
<td>D</td>
</tr>
</tbody>
</table>
# WEEKENDS

Think of a typical weekend with your family.

<table>
<thead>
<tr>
<th>FOR OUR FAMILY</th>
<th>FOR OUR FAMILY</th>
</tr>
</thead>
<tbody>
<tr>
<td>REALLY TRUE</td>
<td>SORT OF TRUE</td>
</tr>
<tr>
<td>A B 1. Some families rarely</td>
<td>BUT Other families regularly</td>
</tr>
</tbody>
</table>
       spend weekends       | spend weekends       |
       together.            | together.            |
| A B 2. In some families everyone | BUT In other families there are |
       has a specific job to | no assigned jobs on the |
       do on the weekend.    | weekend.             |
| A B 3. In some families there | BUT In other families there |
       are set routines and regular | are no set routines or |
       events on weekends.    | events on the weekends. |
| A B 4. In some families everyone | BUT In other families people |
       is expected to come to | pretty much come and |
       weekend events.        | go as they please.     |
| A B 5. In some families weekends | BUT In other families there |
       are pretty casual; there are | are strong feelings about |
       no special feelings about | spending weekend time |
       them.                   | together as a family.  |
| A B 6. In some families spending | BUT In other families there |
       time together at weekend | are no special family weekend |
       events is special.      | events.               |
| A B 7. In some families there is | BUT In other families there |
       much discussion and     | is very little discussion |
       planning around weekends.| or planning around weekend.|

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**VACATIONS**

Think of a typical vacation or vacations you have spent with your family.

<table>
<thead>
<tr>
<th>FOR OUR FAMILY</th>
<th>REALLY TRUE</th>
<th>SORT OF TRUE</th>
<th>BUT</th>
<th>FOR OUR FAMILY</th>
<th>REALLY TRUE</th>
<th>SORT OF TRUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>B 1. Some families regularly spend vacations together.</td>
<td>BUT Other families rarely spend vacations together.</td>
<td>C</td>
<td>D</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>B 2. In some families everyone has a job or task to do.</td>
<td>BUT In other families people do what needs to be done and take turns.</td>
<td>C</td>
<td>D</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>B 3. In some families vacations are times for something new and there are no routines.</td>
<td>BUT In other families there are set routines on vacation.</td>
<td>C</td>
<td>D</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>B 4. In some families it is OK if some members decide not to go on the vacation.</td>
<td>BUT In other families it is expected that everyone will go on the vacation.</td>
<td>C</td>
<td>D</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>B 5. In some families people feel strongly that family vacations are important family events.</td>
<td>BUT In other families there is a more casual attitude towards vacations; no one cares that much.</td>
<td>C</td>
<td>D</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>B 6. In some families vacations are just a time to relax or catch up on work.</td>
<td>BUT In other families the family vacation is more than just a trip; it is a family togetherness time.</td>
<td>C</td>
<td>D</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>B 7. In some families there is little planning around the vacation; we just go.</td>
<td>BUT In other families there is a lot of planning and discussion around the family vacation.</td>
<td>C</td>
<td>D</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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ANNUAL CELEBRATIONS

Think of celebrations that your family has every year. Some examples would be birthdays, anniversaries and perhaps the last day of school.

<table>
<thead>
<tr>
<th>FOR OUR FAMILY</th>
<th>REALLY TRUE</th>
<th>SORT OF TRUE</th>
<th>BUT</th>
<th>FOR OUR FAMILY</th>
<th>SORT OF TRUE</th>
<th>REALLY TRUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>B</td>
<td>1. Some families have regular and several annual celebrations.</td>
<td>For other families there are few annual celebrations or they are rarely observed.</td>
<td>C</td>
<td>D</td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>B</td>
<td>2. In some families people don't have assigned jobs for each celebration.</td>
<td>In other families everyone has a certain job to do during annual celebrations.</td>
<td>C</td>
<td>D</td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>B</td>
<td>3. In some families these celebrations have no set routines; it is hard to know what will happen.</td>
<td>In other families these celebrations are pretty standard; everyone knows what to expect.</td>
<td>C</td>
<td>D</td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>B</td>
<td>4. In some families everyone is expected to be there for the celebration.</td>
<td>In other families annual celebrations may not be a time for all members.</td>
<td>C</td>
<td>D</td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>B</td>
<td>5. In some families there are strong feelings at birthdays and other celebrations.</td>
<td>In other families annual celebrations are more casual; people aren't emotionally involved.</td>
<td>C</td>
<td>D</td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>B</td>
<td>6. In some families birthdays and anniversaries are important milestones to be celebrated in special ways.</td>
<td>In other families not a lot of fuss is made over birthdays and anniversaries; members may celebrate but nothing is particularly special.</td>
<td>C</td>
<td>D</td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>B</td>
<td>7. In some families there is a lot of planning and discussion around these celebrations.</td>
<td>In other families there is little planning and discussion around these celebrations.</td>
<td>C</td>
<td>D</td>
<td></td>
</tr>
</tbody>
</table>
SPECIAL CELEBRATIONS

Think of some special celebrations that happen in your family, special celebrations that may occur in families regardless of religion or culture. Some examples would be weddings, graduations and family reunions.

<table>
<thead>
<tr>
<th>FOR YOUR FAMILY</th>
<th>FOR YOUR FAMILY</th>
</tr>
</thead>
<tbody>
<tr>
<td>REALLY TRUE</td>
<td>SORT OF TRUE</td>
</tr>
<tr>
<td>A B 1. In some families, there are rarely special celebrations. BUT In other families, there are several special celebrations.</td>
<td></td>
</tr>
<tr>
<td>A B 2. In some families people don't have certain jobs or roles to do at special celebrations. BUT In other families people have certain jobs to do at special celebrations.</td>
<td></td>
</tr>
<tr>
<td>A B 3. In some families there is a set routine at these events; everyone knows what will happen. BUT In other families there is not a routine; every celebration is different.</td>
<td></td>
</tr>
<tr>
<td>A B 4. In some families it is hard to know who will be there; whoever can shows up. BUT In other families everyone is expected to attend special celebrations.</td>
<td></td>
</tr>
<tr>
<td>A B 5. In some families special celebrations are a time of high emotions and feelings. BUT In other families special celebrations are pretty low-key; there aren't a lot of strong emotions.</td>
<td></td>
</tr>
<tr>
<td>A B 6. In some families special celebrations have deep meaning for the family. BUT In other families special celebrations are the same as other occasions.</td>
<td></td>
</tr>
<tr>
<td>A B 7. In some families there is a lot of planning and discussion around these events. BUT In other families there is a little planning and discussion around these events.</td>
<td></td>
</tr>
</tbody>
</table>

Please go back now and circle (O) each item in which drugs were present. Please box (I) each item in which alcohol was present.

For example:

1. Some families regularly eat dinner together. BUT Other families rarely eat dinner together.

If you chose the statement on the left and drugs were usually present during dinner, then you would circle (O) the number 1. If alcohol was also usually present during dinner, then you would also box (I) number 1. If only alcohol was present during dinner, then you would only box (I) the number 1.

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Appendix D

Demographic Forms
Background Information (FSH)

Your Age: ______

Your Race/Ethnicity (circle):
African-American  Caucasian/White  Hispanic  Asian-American  Other: ______

Family Income/Year (circle):
less than $15,000  $16,000-30,000  $31,000-50,000  more than $50,000

Your Educational Level (circle):
Less than high school  High School  Some college  Finished college  Post college

When you were abusing substances which of the following did you abuse (Check all that apply)?
___ Alcohol  ___ Marijuana  ___ Barbiturates(Barbs, downers, reds)
___ Cocaine  ___ CrackCocaine  ___ Hallucinogens(acid, LSD, shrooms)
___ Prescription (Ritalin, valium)  ___ Methamphetamines(Crystal, crank)
___ Opiates(oxycontin, heroin)

At your highest level of use, how much did this negatively impact your family functioning (scale of 0-not at all to 100-very much/almost always): ______
0-----------------------------------------------------50-----------------------------------------------------------100
Not at all                                                Moderately                                             Almost always

Ages of Child (ren) who live in the home: __________________________

Any adult figures important to the child living in the home (Check all that apply):
___ Spouse  ___ Grandparent  ___ Sister/Brother  ___ Cousin
___ Partner  ___ Friend  ___ Aunt/Uncle  ___ Other ________

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Background Information (SM)

Your Age: _______

Your Race/Ethnicity (circle):
African-American  Caucasian/White  Hispanic  Asian-American  Other: ______

Family Income/Year (circle):
less than $15,000  $16,000-30,000  $31,000-50,000  more than $50,000

Your Educational Level (circle):
Less than high school  High School  Some college
                  Finished college  Post college

Have you used drugs or alcohol in a problematic way (trouble with the law, lost a
job, etc.) since having children (circle)?  YES  NO

If yes, when was your last use? _______________

If yes, which of the following did you abuse (Check all that apply)?
___ Alcohol  ___ Marijuana  ___ Barbiturates(Barbs, downers, reds)
___ Cocaine  ___ CrackCocaine  ___ Hallucinogens(acid, LSD, shrooms)
___ Prescription (Ritalin, valium)  ___ Methamphetamines(Crystal, crank)
___ Opiates(oxycontin, heroin)

If yes, at your highest level of use, how much did this negatively impact your family
functioning (scale of 0-not at all to 100-very much/almost always): ______
0---------------------------------------------------------------50---------------------------------100
Not at all  Moderately  Almost always

Ages of Child (ren) who live in the home: _______________________

Any adult figures important to the child living in the home (Check all that apply):
___ Spouse  ___ Grandparent  ___ Sister/Brother  ___ Cousin
___ Partner  ___ Friend  ___ Aunt/Uncle  ___ Other_________
Appendix E

Standardized Script
Initial Contact: Hello. My name is Julie. I’m collecting data for a school research project. If you are willing, I’d appreciate if you could come with me to fill out some forms about your family and children.

Once in room: Hello again. My name is Julie Tiemeier. I’m a graduate student at Xavier University. I am here today to collect data for my research project, which is part of my graduating requirements. In these envelopes I have three forms I’d like you to fill out. (Pass out packets) First in your packet you will find a consent form. By keeping this consent form, you are giving your consent to be a participant in the research project. If you are not comfortable being a part of this study, you can simply return the forms to the envelope and turn them in blank without any consequences. Hopefully, you are interested in helping me by filling out the three forms. One of the forms asks for demographic information. The blue form you will fill out based on one of your children between the ages of 4 and 18. If you have more than one, please fill it out based on your child with the most recent birthday. The other form asks you questions about your family. Please read through the directions and answer the questions. When you are finished, return the forms to the envelope and turn the envelope into me. Your name will not be associated with your packet of information in any way. I also have mental health resources in case you are concerned about yourself or your child on the back of the consent form. If you have trouble reading, I’d be happy to read the forms to you. If you have any questions or do not understand, please feel free to ask me. Thank you for your participation.
Appendix F

Informed Consent Form
INFORMED CONSENT DOCUMENT

You are being given the opportunity to volunteer to participate in a project conducted through Xavier University, First Step Home, and Santa Maria Services.

The project will consist of three forms for you to fill out. These forms will ask you about your family’s behaviors, child’s behaviors, and your own information. You were selected as a participant because you are part of First Step Home’s rehabilitation program or part of Santa Maria’s after-school program. You will be given the forms in an envelope. Please take out the forms and fill out each one completely. When you are finished, put them back in the envelope and return them to the researcher. If you do not wish to provide the information asked, please just return your empty forms to the envelope and return it to the researcher. The forms will take you approximately one hour to fill out and may ask you some personal questions. Please answer in an open and honest manner.

There are not any benefits or compensation to you personally but First Step Home and Santa Maria will be given the results to use in their program development. All the information you provide will be kept confidential. Your name will not be attached to any information; instead your forms are assigned a number which is also not associated with your name. Data will be stored in a locked file to ensure your privacy. After the study is complete, your forms will be destroyed. You have the right to refuse to participate or withdraw from participating at any time without penalty. Refusal or withdrawal will have no effect on any future services you may be entitled to from First Step Home or Santa Maria. If you decide to participate in the project, please keep this form.

If you have any questions at any time during the study, you may contact Julie Tiemeier at 513-675-0731 or Dr. W. Michael Nelson III at 513-745-3298. Questions about your rights as a research participant should be directed to the Chair or the Chair of Xavier University’s Institutional Review Board at (513) 745-2870.

I have been given information about this research study and its risks and benefits and have had the opportunity to ask questions and to have my questions answered to my satisfaction. I freely give my consent to participate in this research project by keeping this form.

THE DATE APPROVAL STAMP ON THIS CONSENT FORM INDICATES THAT THIS PROJECT HAS BEEN REVIEWED AND APPROVED BY XAVIER UNIVERSITY’S INSTITUTIONAL REVIEW BOARD. THIS APPROVAL IS VALID FOR ONE YEAR.
Appendix G

Referral Resource
If you are concerned about your child’s mental health, please seek help and contact one of the following agencies:

- Catholic Social Services of SW Ohio ............................................. 513-241-7745
- Center for Children and Families ............................................. 513-221-4673
- Central Clinic’s Child and Family Treatment Center ............... 513-558-5878
- Children’s Home of Cincinnati ............................................. 513-272-2800
- NORCEN Behavioral Health Systems ..................................... 513-761-6222

If you are concerned about your mental health, please seek help and contact one of the following agencies:

- Central Clinic for Adults ...................................................... 513-558-5801
- Crossroads ............................................................................ 513-475-5300
- Family Services ..................................................................... 513-921-6300
- Ikron Corporation ................................................................ 513-621-1117
- Talbert House ....................................................................... 513-853-6930

If you need immediate and/or serious help, please contact Mental Health Access Point at 513-558-8888.

You can also contact the researcher, Julie, at 513-675-0731 for additional resources.
Chapter V: Dissertation

Abstract

Family rituals and child behaviors in families with a substance abusing mother ($n = 26$) were compared to families with a non-substance abusing mother ($n = 26$). Each mother completed a demographic form, a Child Behavior Checklist, and a Family Rituals Questionnaire. There were no significant differences found in mother-reported family rituals between families with a substance abusing mother and those with a non-substance abusing mother, but there were differences in mother-reported children's internalizing and externalizing behaviors of anxiety, depression, withdrawn, social, thought, rule-breaking, and aggressive behaviors. Implications for future research were outlined.
Family Rituals and Child Psychopathology
in Families with Substance Abusing Mothers

Substance abuse adversely affects families and children every day. Approximately, 25% of children in the United States lived with an alcoholic in 2004 (U.S. Department of Health and Human Services, 2004). There are more than 28 million Americans who are children of alcoholics; 11 million of those are under 18 years old (U.S. Department of Health and Human Services, 2004). These are just children of alcoholics. If the number of parents who are addicted to other drugs were added, the number would greatly increase.

Children of Substance Abusers

Recent research suggests increased rates of psychological and behavioral problems for children of alcoholics and substance abusers (Johnson & Rolf, 1990; Moss, Mezzich, Yao, Gavaler, & Martin, 1995; Sher, Walitzer, Wood, & Brent, 1991; VanDeMark, Russell, O’Keefe, Finkelstein, Noether, & Gampel, 2005; West & Prinz, 1987). There is some evidence that children of illicit substance abusers experience more psychosocial maladjustment than children of alcoholics as reported by parents and teachers (Fals-Steward, Kelly, Fincham, Golden, & Logsdon, 2004).

Having a substance abusing parent puts children at high risk for problems emotionally, behaviorally, cognitively, and within the family. Stanger et al. (1999) found that children of drug abusers had more externalizing (e.g., aggression, acting out) and internalizing (e.g., sadness, worry) symptoms as reported by parents than control peers; however, their symptoms were not as problematic as children referred to a mental health clinic. Research has found that children of substance abusers are more likely to
experience depression, anxiety, attention deficit hyperactivity disorder (ADHD), oppositional defiant disorder (ODD), and psychiatric and psychosocial dysfunction (Johnson & Rolf, 1990; Moss et al., 1995; Sher et al., 1991; VanDeMark et al., 2005; West & Prinz, 1987).

In examining differences in children’s symptoms, Puttler (1996) compared daughters of substance abusers with a control group using the mother and father-reported Child Behavior Checklist (CBCL, Achenbach, 1993). Daughters of substance abusers had more parent-reported problem behaviors and more externalizing symptoms (e.g., aggression, acting out) than their “normal” counterparts. Girls in recovering alcoholic families functioned similarly to the normal group with higher intelligence scores and spelling scores, as well as fewer behavior problems and externalizing symptoms than girls in non-recovering alcoholic families. Similarly, Andreas and O’Farrell (2008) found that fathers’ greater involvement in treatment of alcohol dependence was correlated with fewer externalizing behaviors in their children. However, adolescents of recovered alcoholic fathers, when gender is combined, appeared to have more symptomatology than adolescents of non-alcoholic fathers as reported by the fathers using the CBCL (Achenbach, 1993; DeLucia, Belz, & Chassin, 2001). This suggests that having the parent in recovery does not necessarily have a direct, immediate negative influence on the adolescent’s symptoms.

West and Prinz (1987) found that although children of substance abusers are at high risk for problematic behaviors, some can still get through adolescence without any diagnosable psychopathology as well as having comparable self-esteem and coping strategies as adolescents whose parents are not alcoholics (Hall, 2007). Some of the risks
may be mediated by the parent's psychopathology, environmental stress surrounding the family, and perceived family cohesion/parental attachment that can be manifested in family rituals and routines (Chassin, Rogosch, & Barrera, 1991; Cronkite, Finney, Nekich, & Moos, 1990; El-Sheikh & Buckhalt, 2003; Merikangas, Dierker, & Szatmari, 1998). Due to a variety of mediators (i.e., stable family environment, family rituals, family cohesion, lack of parental psychopathology) and individual differences for the children, there is no standard personality profile for children of alcoholics (Calder & Kostyniuk, 1989; Johnson & Rolf, 1990).

Children of alcoholics have also reported more family-related stress than control group peers (Hussong, Bauer, Huang, Sher, Chassin, & Zucker, 2008). Children of substance abusers are more likely to experience disruptions in household makeup compared to families without substance abuse. Keller, Catalano, Haggerty, and Fleming (2002) found that adolescent girls had a higher probability of drug use as the number of family disturbances increased. For adolescent males, it was found that the child’s age at the time of the family disturbances contributed to the amount of delinquency. Adolescents of crack-addicted mothers who are most likely to use drugs are older in age and have more family conflicts than those who do not use drugs as assessed by the Family scale of the Family, Friends, and Self Scale (Lam, Cance, Eke, Fishbein, Hawkins, & Williams, 2007). King, Vidourek, & Wagner (2004) found that adolescents who use drugs also tend to come from families who did not spend time together.

**Family Rituals**

Researchers theorize that substance abusing parents often create different environments that can be characterized by disorder and chaos to the family's every day
Family rituals have been defined as "powerful organizers of family life, supporting its stability during times of stress and transition" (Fiese et al., 2002, p. 290).

Family rituals vary greatly and have been divided into three categories: family celebrations, family traditions, and patterned routines (Wolin & Bennett, 1984). Family celebrations center on what the family does for holidays and other festive cultural occasions and are generally similar within cultures (Baxter & Braithwaite, 2006). Family traditions focus on individual family rituals, such as birthdays, anniversaries, or vacations. Patterned routines involve the everyday activities of the family. Through rituals, stability, order, organization, limitations, communication, and roles can be established (Imber-Black, 2003). Family rituals are often passed down through generations and provide the family with meaningful acts, which can lead to greater emotional bonds (Baxter & Braithwaite, 2006; Roberts, 2003).

Direct communication during rituals can lead to fewer internalizing symptoms (e.g., sadness, worry) in children, while indirect communication observed by children during rituals can lead to greater risk of mental health problems (Fiese, Foley, & Spagnola, 2006).

Mothers were found to be very important in maintaining structure and order while the fathers were drinking. In alcoholic families in which rituals are absent, internalizing and externalizing behavior problems have been found (Baxter & Braithwaite, 2006; Haughland, 2005; Wolin, Bennett, & Jacobs, 2003). Children in families in which the mother was trying to maintain rituals (as assessed through an interview) despite their alcoholic husbands, tend to have more problematic internalizing and externalizing
behaviors as reported by both of their parents on the CBCL than children in families who do not experience much disruption in rituals because their fathers maintain their role in the family. Children in families with absent rituals had even higher parental reports of problematic internalizing and externalizing behavior as determined by the CBCL when compared to the children in which the father maintains his role and in which the mother maintains rituals (Haughland, 2005).

Fiese (1993) found that as family ritual importance increased, adolescent anxiety-related health decreased. Similarly, Fiese (1992) found that when family ritual meaningfulness increases and is agreed upon across generations, the adolescent child formed a more positive identity and sense of belonging.

Families with a substance abusing parent are more likely to come from a low socioeconomic status (Conners et al., 2004). Families in poverty typically have more chaotic families. They are less likely to share rituals because of parents' work, more children, and living arrangements. The lack of rituals and routines causes a chaos that affects the children’s ability to self-regulate behaviors and emotions (Evans, Gonnella, Marcynszyn, Gentile, & Salepek, 2005; Keller et al., 2002).

The purpose of the present study is to compare family rituals in families with a substance abusing mother and families with a non-substance abusing mother. It was expected that families with a substance abusing mother would report not only fewer family rituals but also less importance (meaning) of family rituals than families with a non-substance abusing mother. A comparison was also made between maternal rating of their children’s behavior between substance abusing and non-substance abusing mothers, hypothesizing that substance abusing mothers will report their children having more
problem behaviors than children of non-substance abusing mothers. Maternal substance abusers were used because the majority of studies thus far have used paternal substance abusers (DeLucia et al., 2001; Dube et al., 2001; Fals Steward et al., 2004; Haughland, 2005; Moss et al., 1995).

Method

Participants

Volunteer participants for this study were women (M age = 32.25 years; SD = 7.29 years) with a child between the ages of 6 and 18 (M age = 9.46 years; SD = 3.16 years). Women at First Step Home (n=26), a non-profit, residential treatment program servicing substance-addicted women and their children served as the experimental group. The average length of stay for women who complete treatment is 90 days. On a scale from 0-100, substance abusing mothers rated that their drug use had a considerable negative impact on their family functioning (M = 76.90, SD = 23.83).

A non-substance abusing control group (n=26) was composed of women who had children enrolled in three after-school programs (n=20) and women enrolled in adult education classes (n=6). This resulted in a total sample of 52 women. No significant differences existed for age, race, or education level between the control and experimental groups (see Table 1).

Substance abusing mothers self-reported their number of drugs of choice (M = 2.92, SD = 1.78) as follows: 54% abused cocaine, 50% abused alcohol, 46% abused opiates, 42% abused marijuana, 35% abused crack, 19% abused prescription drugs, 12% abused barbiturates, 4% abused hallucinogens, and 4% abused methamphetamine.

Measures
Family Rituals Questionnaire (FRQ)

The Family Rituals Questionnaire (FRQ; Fiese & Kline, 1993; see Appendix C, p. 44) is widely used in the family rituals research and is the only objective measurement that assesses a variety of family rituals (e.g., family traditions, family celebrations, and patterned routines) as well as the meaningfulness of those rituals. The FRQ is a 49-item forced choice scale between two statements with subsequent ratings as to how meaningful that ritual is to the family. Respondents choose between two statements (e.g., either “Some families regularly eat dinner together” or “Other families rarely eat dinner together”). Then, participants choose either “really true” or “sort of true for our family.” Two factors are obtained from the FRQ: Ritual Meaning and Ritual Routine. Ritual Meaning refers to how important rituals are to the family. Ritual Routine refers to the number of rituals in which the family participates. A total score is calculated to obtain a total number of family rituals while taking meaning of those rituals into account. Test-retest correlations over a four week period ranged from .60 (Dimension: Roles) to .88 (Total Score). Internal consistency ranged from .52 (Dimension: Continuation) to .90 (Total Score).

Child Behavior Checklist (CBCL)

The Child Behavior Checklist (Achenbach, 1993) is widely used to assess child symptomatology. The CBCL is composed of 113 items related to a child’s behavior and is completed by a parent or caregiver. Respondents rate the children’s behaviors on a Likert-scale (0=not true, 1=somewhat or sometimes true, 2=very true or often true). The CBCL items load onto eight syndrome scales (Anxious/Depressed, Withdrawn/Depressed, Somatic Complaints, Social Problems, Thought Problems,
Attention Problems, Rule-Breaking Behavior, and Aggressive Behavior), which factor onto internalizing or externalizing scales. These scales can be added together for a Total Score. The Internalizing scale refers to internalizing behaviors, including depression, anxiety, and withdrawal. The Externalizing scale refers to externalizing behaviors, including inattention, aggression, and rule-breaking. Internal consistencies of the Externalizing and Total Scores were in the .92 and .96 range, and the reliability of the Internalizing scale was .88 to .92. Test-retest correlations over a one-week period were .82 for Internalizing, .91 for Externalizing, and .91 for Total Score. The well-validated CBCL is often the benchmark for other behavior checklists and is highly correlated with similar measures (e.g., Conners’ Parent Rating Scale and the Quay Problem Behavior Checklist). Strong discriminant validity was also demonstrated. The Mental Measurements Yearbook (2004) describes the CBCL as “unquestionably the most well articulated and well established of its kind.”

Procedure

This study was approved by a university Institutional Review Board (IRB) (see Appendix A), the board of directors of the substance abuse agency (see Appendix A, p. 41), and program coordinators of the other agencies (see Appendix B, p. 43).

At First Step Home, mothers were gathered in a room and asked to participate in the study. After the initial group at First Step Home and for the control group, mothers were asked individually to participate in the study. Approximately five mothers from First Step Home and three mothers from the control group settings refused to participate in the study. Mothers were informed of the process to ensure anonymity and were given a consent form which they kept if they agreed to participate. Each mother was given a
packet with the consent form (which included referral sources on the back), demographic information form, Child Behavior Checklist, and Family Rituals Questionnaire and filled them out based on her own family and one of her children between the ages of 6 and 18. If the mother had more than one child, she was asked to fill out the questionnaire for the child with the most recent birthday for randomization, as was done in another study similar to this one (VanDeMark et al., 2005). When participants completed their packets, they handed them back to the researcher.

Five participants were excluded from the control group because they endorsed having abused substances recently that have negatively impacted their life. Four participants from both the experimental and control groups were excluded because of skewed answering (as defined by circling all answers in one column which implicated that they did not read the questions). Thus, 35 women filled out the questionnaires for the non-substance abusing mothers group and 30 women filled out the questionnaires for the substance abusing mothers group.

Results

The means of the scales on the Family Rituals Questionnaire and the Child Behavior Checklist are presented in Table 2. It should be noted that none of the CBCL factors, for either group, fell within the clinically significant range (T score > 65) when compared to the CBCL normative sample.

There were no significant differences between mothers who abused substances and those who did not in their self-reported FRQ total number of family rituals, \( t(50) = -0.15, p = .88 \), as well as in their self-report of family ritual meaning and family routines, Wilks' \( \Lambda = 0.96, F(2, 49) = 1.01, p = .37 \).
Substance abusing mothers reported higher problem total behaviors than non-substance abusing mothers on the CBCL, $t(50) = -3.24, p < .01$. Significant differences were found between internalizing and externalizing behaviors, Wilks’ $\Lambda = .83$, $F(2, 49) = 5.01, p = .01$. Post-hoc univariate ANOVAs indicated that substance abusing mothers reported significantly higher internalizing behaviors, $F(1, 50) = 9.94, p < .01$, and externalizing behaviors, $F(1, 50) = 7.43, p = .01$, than non-substance abusing mothers. Significant differences were also found in mother-reported child behaviors between substance abusing mothers and non-substance abusing mothers using the CBCL, Wilks’ $\Lambda = .68$, $F(8, 43) = 2.52, p = .02$. Post-hoc univariate ANOVAs indicated that substance abusing mothers reported higher problems in their children on the following factors: Anxiety/Depression, $F(1, 50) = 13.74, p < .01$, Withdraw/Depression, $F(1, 50) = 5.76, p = .02$, Social Behavior, $F(1, 50) = 9.30, p < .01$, Thought Problems, $F(1, 50) = 7.58, p = .01$, Rule Breaking Behavior, $F(1, 50) = 8.13, p = .01$, and Aggressive Behavior, $F(1, 50) = 6.75, p = .01$, and similar problems with Somatic Behaviors, $F(1, 50) = 3.47, p = .07$, and Attention Behaviors, $F(1, 50) = 2.20, p = .14$, than non-substance abusing mothers.

In an attempt to better understand the relationship among maternal ratings of family rituals and maternal ratings of child behavior, a correlation table was constructed to analyze the magnitude of the relationships among maternal ratings of family and maternal ratings of children’s behaviors. There were no significant correlations between mother-reported family rituals and their report of child behaviors (see Table 3).
Discussion

The primary goal of the present study was to examine any differences in the report of substance abusing mothers and control mothers regarding their family rituals and behaviors of their children. This was particularly important because previous research has focused on the reports of paternal drug use on family rituals and child behaviors (DeLucia et al., 2001; Dube et al., 2001; Fals Steward et al., 2004; Fiese, 1993; Haughland, 2005; Moss et al., 1995) rather than maternal drug use. Previous research has established a relationship between substance abuse and less predictability and fewer family rituals and routines (Baxter & Braithwaite, 2006; Haughland, 2005; Wolin, Bennett, & Jacobs, 2003).

There were no significant differences on the Family Rituals Questionnaire between mothers in a substance abuse rehabilitation facility and mothers without a substance abuse problem. This indicates that substance abusing mothers in rehabilitation do not report differences in the meaning or importance of family rituals and number of family routines and rituals when compared to mothers without a substance abuse problem. In light of the fact that there are no norms for the FRQ, it is difficult to interpret what a total sample mean of 96.92 means. Because the range of the FRQ total score is 49 to 196, this sample reported a little less than half of the highest possible score on the FRQ. In relation to other studies that use the FRQ, this sample reported a similar total score mean as the normal sample of undergraduate students in which the FRQ was developed ($M = 96.8$; Fiese & Kline, 1993). In Fiese (1993) college-age children of alcoholics reported an average of 26.29 on the Family Meaning factor which is reporting
more importance of family rituals than the current study's substance abusing mothers who reported an average of 11.40 on the Family Meaning factor.

Fiese (1993) found that adolescents with a substance abusing parent (mother or father) reported that family rituals were less important in the family than adolescents with a non-substance abusing parent. This difference was not found in mother-reported family rituals, meaning that mothers of children of alcoholics reported the same importance of family rituals as a control group consisting of mothers of non-children of alcoholics. The present study supports these findings that mothers do not report differences in the importance (meaning) of family rituals based on substance abuse grouping. Perhaps assessing the adolescents in family rituals would have provided different results, as seen in Fiese (1993).

Haughland (2005) categorized substance abusing families by their family rituals. One category consisted of families in which few disruptions in rituals (as assessed in an interview) were found if the alcoholic father continued his role in the family despite his alcohol abuse (Haughland, 2005). The present study did not assess the substance abusing mother's role in family rituals; however, it is possible that these mothers, like the alcoholic fathers, continued their roles in the family and in family rituals. It may be that they have used drugs for a long time and their maintenance level is low and, therefore, at the same level as control mothers. However, results of the present study are not consistent with the other Haughland (2005) categories in which families have disruptions in rituals because of a substance abusing parent (e.g., changes in routines and family atmosphere changes when substances are present). Only five mothers in the present study reported substance presence at family rituals and four mothers reported alcohol
presence at family rituals; therefore, approximately one-third of substance abusing mothers had drugs present which may influence family ritual disruption.

The present study also needs to be viewed with research that found family disruption in families (e.g., substance abuse, instability of caregivers, residential instability, and little father involvement) in poverty as reported by mothers in intake interviews (Conners et al., 2004); however, family rituals were not studied specifically. Thus, while families with a substance abusing mother may be at risk for some family disruptions, they may not be at risk for specific disruptions in family rituals. Consistent with the findings that there were no significant differences in self-reported family rituals, there were no significant correlations between mother-reported child behaviors and family rituals.

Previous research has shown a relationship between substance abuse and negative child behaviors (Johnson & Rolf, 1990; Sher et al., 1991; VanDeMark et al., 2005; West & Prinz, 1987). In the present study, this was confirmed with substance abusing mothers reporting significantly higher ratings of their children's problem behaviors than non-substance abusing mothers on the following factors: Anxiety/Depression, Withdraw/Depression, Social, Thought, Rule-Breaking Behavior, Aggressive Behavior, Internalizing Behaviors, Externalizing Behaviors, and total score behaviors. This means that substance abusing mothers reported more symptoms of depression, anxiety, withdrawing, social problems, thought difficulties, rule-breaking behaviors, and aggression in their children compared to non-substance abusing mothers; however, they did not report more symptoms of inattention and somatic complaints. The means of behaviors reported by substance abusing mothers were not in the clinical range of the
CBCL, however. This is consistent with Stanger et al. (1999) who found that children of drug abusers had more externalizing and internalizing symptoms as reported by parents than control peers; however, their symptoms were not as problematic as children referred to a mental health clinic.

Although differences in behavior of children of substance abusers are well established in the literature, this study only replicated some of the differences, specifically in depression, anxiety, thought, and aggressive symptoms (Johnson & Rolf, 1990; Moss et al., 1995; Sher et al., 1991; VanDeMark et al., 2005; West & Prinz, 1987). Symptoms of inattention and somatic symptoms were not replicated in the current study. This implies that there really is not a standard profile for children of substance abusers, meaning behavior findings in the research differ for children of substance abusers, which was indicated by previous research (Calder & Kostyniuk, 1989; Johnson & Rolf, 1990; West & Prinz, 1987). These differences in behavior findings could be due to studies using different measures (e.g., CBCL, Personality Inventory for Children, interviews) and/or reporters of behavior (e.g., mothers, fathers, teachers, and children). At face value, data suggest that substance abusing mothers do not report ritual differences but do report more behavioral problems with their children (as measured by the CBCL), thus implying that perhaps more family rituals do not significantly impact mother-reported child behaviors.

There were several limitations in this study. First, the length of the Family Rituals Questionnaire may have deterred many mothers from accurately completing the measure which appeared as skewed by eight participants who circled answers down a whole column while the measure contained reverse scored items; these eight data sets
were eliminated from the analysis. Despite attempts to screen for possible invalid responding it is still unclear as to the validity of mother-reported family rituals. Second, the Family Rituals Questionnaire does not have norms; therefore, interpreting data is difficult. A structured interview may have been useful in assessing family rituals.

Another limitation is the fact that substance abusing mothers were already in treatment. Treatment is a major disruption in families and the directions are not clear on the Family Rituals Questionnaire as to the time frame to use when completing this measure. The FRQ says to think about what is typical for the reporter’s family; therefore, it is unknown if mothers rated family rituals presently, during treatment, and/or prior to their treatment. Cattapan and Grimwade (2008) found that substance abusing parents felt as though they maintained family routine as they entered treatment and could present examples of when that routine was broken during their drug use. Further, mothers were in different phases of their treatment. Some of the women had just arrived and others had been in treatment for an extended amount of time; however, this was not assessed. Future research could include mothers who have yet to receive treatment for drug use to compare family rituals from non-substance abusing mothers or substance abusing mothers in treatment.

Furthermore, future research should consider how other significant adults may be influencing family rituals. In the research on paternal substance abusers, it has been found that mothers often try to continue family rituals (Haughland, 2005). It can only be speculated if there are significant adults stepping in for the mother when she is abusing substances just as the mother steps in to maintain family rituals when the father is abusing substances. Substance abusing mothers in this study reported having an average
of 1.77 other significant adults living in the home with them and their child. Perhaps these other significant adults (i.e., spouse, grandparent) are fulfilling the task of continuing family rituals when mothers are in treatment.
References


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## Table 1

**Demographic Variables for Participants**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Non-Substance Abusing</th>
<th>Substance Abusing</th>
<th>Total Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$n = 26$</td>
<td>$n = 26$</td>
<td>$n = 52$</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean (in years)</td>
<td>31.80</td>
<td>33.10</td>
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<tr>
<td>Standard Deviation</td>
<td>7.91</td>
<td>6.40</td>
<td>7.17</td>
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<tr>
<td>Range</td>
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<td>African-American</td>
<td>43.3%</td>
<td>36.7%</td>
<td>40.0%</td>
</tr>
<tr>
<td>Caucasian/White</td>
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<td>60.0%</td>
<td>55.0%</td>
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<tr>
<td>Hispanic</td>
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<td>3.3%</td>
<td>3.3%</td>
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<tr>
<td>Asian-American</td>
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<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Other: Biracial</td>
<td>3.3%</td>
<td>0.0%</td>
<td>1.7%</td>
</tr>
<tr>
<td><strong>Education Level</strong></td>
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<td>Less than High School</td>
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<tr>
<td>High School</td>
<td>46.7%</td>
<td>53.3%</td>
<td>50.0%</td>
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<tr>
<td>Some College</td>
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<td>30.0%</td>
<td>30.0%</td>
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<td>Finished College</td>
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<tr>
<td>Post College</td>
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*Note. Age ($n(50) = .25, p = .81$). Race/Ethnicity ($X^2(3, N = 52) = 3.07, p = .38$). Education Level ($X^2(3, N = 52) = 1.34, p = .72$).*
Table 2

*Means and Standard Deviations for Family Rituals Questionnaire and Child Behavior Checklist*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Non-Substance Abusing</th>
<th>Substance Abusing</th>
<th>Total Sample</th>
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<tr>
<td></td>
<td>n = 26</td>
<td>n = 26</td>
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<td><strong>Family Rituals Questionnaire</strong></td>
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<td></td>
<td></td>
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<tr>
<td>Meaning</td>
<td>11.40 (1.99)</td>
<td>12.04 (2.57)</td>
<td>11.72 (2.30)</td>
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<tr>
<td>Routine</td>
<td>5.03 (.84)</td>
<td>4.93 (1.20)</td>
<td>4.98 (1.03)</td>
</tr>
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<td>Total</td>
<td>96.58 (12.12)</td>
<td>97.26 (20.45)</td>
<td>96.92 (16.65)</td>
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<td></td>
</tr>
<tr>
<td>Anxiety/Depression</td>
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<tr>
<td>Withdrawn/Depression</td>
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<td>59.62 (10.45)*</td>
<td>56.87 (8.64)</td>
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<td>Somatic</td>
<td>54.73 (7.41)</td>
<td>59.08 (9.32)</td>
<td>56.90 (8.62)</td>
</tr>
<tr>
<td>Social</td>
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<td>59.62 (9.40)*</td>
<td>56.35 (8.34)</td>
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<tr>
<td>Thought</td>
<td>53.50 (6.82)</td>
<td>60.38 (10.77)*</td>
<td>56.94 (9.58)</td>
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<tr>
<td>Attention</td>
<td>55.73 (8.00)</td>
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<td>58.63 (8.61)</td>
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<tr>
<td>Rule-Breaking Behavior</td>
<td>54.50 (6.61)</td>
<td>62.77 (13.23)*</td>
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<td>53.92 (7.66)</td>
<td>61.50 (12.74)*</td>
<td>57.71 (11.09)</td>
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<tr>
<td>Internalizing Behaviors</td>
<td>46.69 (11.59)</td>
<td>58.73 (15.65)*</td>
<td>52.71 (14.93)</td>
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<tr>
<td>Externalizing Behaviors</td>
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<td>53.83 (14.63)</td>
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<tr>
<td>Total</td>
<td>45.85 (13.65)</td>
<td>58.85 (15.22)*</td>
<td>52.35 (15.74)</td>
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* indicates significant differences between groups at p < .05
Table 3

*Family Ritual and Child Behavior Correlations*

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<td>5. Withdrawn/Depression</td>
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<td>.67*</td>
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<td>.57*</td>
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<td>8. Thought</td>
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<td>.52*</td>
<td>.56*</td>
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<td>.09</td>
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<td>-.12</td>
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<td>14. Total</td>
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Table 3

Continued

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<td>10. Rule-Breaking Behavior</td>
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<td>.85*</td>
<td>.89*</td>
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</tr>
</tbody>
</table>

* indicates significance $p < .01$
Appendix A

IRB Approval Letter

April 15, 2008

Julie Tiemeier
5433 Moeller Ave., Apt. 12
Cincinnati, OH 45212

Dear Ms. Tiemeier:

The IRB reviewed your protocol # 0511-3, Family Rituals and Child Psychopathology in Families with Substance Abusing Mothers. The IRB has approved your study using expedited review procedures. Approval expires 4/15/09. A progress report is due by that date. A form is enclosed for your convenience and is also available at http://www.xavier.edu/irbform.htm.

If you wish to modify your study, it will be necessary to obtain IRB approval prior to implementing the modification. If there are any adverse events or modifications to the study, please notify the IRB immediately.

We wish you success with your research!

Sincerely,

Charles J. Grossman, Ph.D.
Interim Chair

Charles J. Grossman

PS: There is a typographical error in your protocol summary. B.b.i. last sentence should read “All mothers who endorse drug use will be included in the substance abuse group for purposes of data analysis.”

C: Dr. W. Michael Nelson, Faculty Advisor, ML 6511

Enclosures: Stamped informed consent form
Progress Report Form
Family Rituals and Child Psychopathology
in Families with Substance Abusing Mothers

Problem

Past research has found that children of alcoholics and substance abusers have problematic symptoms, including increased rates of depression, anxiety, attention deficit hyperactivity disorder, oppositional defiant disorder, and other emotional, behavioral, and cognitive problems (Johnson & Rolf, 1990; Moss, Mezzich, Yao, Gavaler, & Martin, 1995; Sher, Walitzer, Wood, & Brent, 1991; VanDeMark, Russell, O’Keefe, Finkelstein, Noether, & Gampel, 2005; West & Prinz, 1987). Research has also shown that homes of substance abusing families are more chaotic and see changes in family rituals (Conners et al., 2004; Haughland, 2005). Most of this research includes families in which the father abuses substances. This study examined differences in family rituals and child behaviors in families in which the mother abuses substances.

Methods

Participants

Volunteer participants for this study were women with a child between the ages of 6 and 18 (n=52). Women at a non-profit, residential treatment program servicing substance-addicted women and their children served as the experimental group (n=26). A non-substance abusing control group (n=26) was composed of women who had children enrolled in three after-school programs (n=20) as well as women enrolled adult education classes (n=6). No significant differences existed for race, age, education level, or number of other adults living in their home between the control and experimental groups.
Procedure

Approval for this study was obtained from a university institutional review board committee and the residential facility. Before being asked to complete the demographic sheet and the test instruments, each mother was informed of the process to ensure anonymity and was given a consent form which they kept if they agreed to participate. Each mother was given a packet with the consent form (which included mental health referral sources on the back), demographic information form, Child Behavior Checklist (CBCL), and Family Rituals Questionnaire (FRQ) and filled them out based on her own family and one of her children between the ages of 6 and 18.

Results

No significant differences were found for the total family rituals on the Family Rituals Questionnaire, $t(50) = -0.15, p = .88$, or on mother-reported family ritual meaning and family routines, Wilks’ $\Lambda = 0.96, F(2, 49) = 1.01, p = .37$.

Substance abusing mothers reported higher problem total behaviors than non-substance abusing mothers on the CBCL, $t(50) = -3.24, p < .01$. Further, a significant difference was found between internalizing and externalizing behaviors, Wilks’ $\Lambda = .83, F(2, 49) = 5.01, p = .01$. Post-hoc univariate ANOVAs indicated that substance abusing mothers reported their children as exhibiting significantly higher internalizing behaviors, $F(1, 50) = 9.94, p < .01$, and externalizing behaviors, $F(1, 50) = 7.43, p = .01$, than non-substance abusing mothers. Significant differences were found in mother-reported child behaviors between substance abusing mothers and non-substance abusing mothers using the CBCL, Wilks’ $\Lambda = .68, F(8, 43) = 2.52, p = .02$. Post-hoc univariate ANOVAs indicated that substance abusing mothers reported higher problems with
Anxiety/Depression, $F(1, 50) = 13.74, p < .01$, Withdraw/Depression, $F(1, 50) = 5.76, p = .02$, Social Behavior, $F(1, 50) = 9.30, p < .01$, Thought Problems, $F(1, 50) = 7.58, p = .01$, Rule Breaking Behavior, $F(1, 50) = 8.13, p = .01$, and Aggressive Behavior, $F(1, 50) = 6.75, p = .01$, and similar problems with Somatic Behaviors, $F(1, 50) = 3.47, p = .07$, and Attention Behaviors, $F(1, 50) = 2.20, p = .14$, than non-substance abusing mothers.

Discussion

Previous research has found a relationship between substance abuse and more chaotic family environments (Baxter & Braithwaite, 2006; Haughland, 2005; Wolin, Bennett, & Jacobs, 2003). No significant differences on the Family Rituals Questionnaire indicates that substance abusing mothers in rehabilitation do not report differences in the importance of family rituals (meaning) and number of family routines and rituals when compared to mothers without a substance abuse problem.

The present study supports the findings of Fiese (1993) that mothers do not report differences in the importance (meaning) of family rituals based on substance abuse grouping which is unlike adolescent reported importance of family rituals. Haughland (2005) categorized substance abusing families by their family rituals. One category consisted of families in which few disruptions in rituals (as assessed in an interview) were found if the alcoholic father continued his role in the family despite his alcohol abuse (Haughland, 2005). However, results of the present study are not consistent with the other Haughland (2005) categories in which families have disruptions in rituals because of a substance abusing parent. Consistent with the findings that there were no
significant differences in self-reported family rituals, there were no significant correlations between mother-reported child behaviors and family rituals.

Although differences in behavior for children of substance abusers are well established in the literature, this study only replicated some of the differences, specifically in depression, anxiety, thought, and aggressive symptoms (Johnson & Rolf, 1990; Moss et al., 1995; Sher et al., 1991; VanDeMark et al., 2005; West & Prinz, 1987). Symptoms of inattention and somatic symptoms were not replicated. This implies that there really is not a standard profile for children of substance abusers, meaning behavior findings in the research differ for children of substance abusers, which was indicated by previous research (Calder & Kostyniuk, 1989; Johnson & Rolf, 1990; West & Prinz, 1987).

There were several limitations in this study. First, the length of the Family Rituals Questionnaire may have deterred many mothers from accurately completing the measure which was seen by skewed answering by eight participants who were eliminated from the analysis. Another limitation is the fact that substance abusing mothers were already in treatment; due to the ambiguous directions on the FRQ, it is unknown if mothers were reporting family rituals during treatment or before treatment.

Future research should consider how other significant adults may be influencing or continuing family rituals when the mother is absent due to being in drug treatment. It can only be speculated if there are significant adults stepping in for the mother when she is abusing substances just as the mother steps in to maintain family rituals when the father is abusing substances (Haughland, 2005).