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Treatment Desires and Symptomatology among Substance Abusing Homeless Mothers: What I Want versus What I Need

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Abstract

The current study sought to identify information that may inform treatment providers regarding services for, and engagement of, substance abusing homeless mothers. Shelter-recruited, substance abusing homeless mothers' desires for treatment in several commonly reported problem areas including substance use, parenting, depressive symptoms/mood, physical health and childhood abuse history were assessed. The correspondence between mother's desire for treatment and self-reported problem severity was also examined. The majority of mothers reported at least some desire (versus no desire at all) for assistance with substance use, depressive symptoms/mood and parenting. A series of independent-sample T tests and chi-square tests showed that mothers indicating any treatment desire in the areas of substance use, depressive symptoms/mood, health problems and sexual abuse also reported higher levels of severity in the corresponding problem areas. The findings imply that psychosocial treatment should be available to all homeless mothers entering the shelter system, especially given that problem severity appears to be a fair indicator of interest in treatment.

Introduction

The number of homeless families requesting housing and assistance has increased dramatically in recent years.¹ Most of these families are led by single mothers with young children in their care.² Despite the high rates of substance use and psychiatric problems, homeless women with young children have little contact with mental health professionals, psychiatric services, and substance use treatment programs.³ This is of concern as concurrent psychosocial and health problems among homeless mothers are known to complicate attempts to exit homelessness.⁴ One reason suggested within the literature for the lack of treatment engagement is the limited and conflicting information regarding women's treatment desires as assessed through research methods.^{5,6}

In general, researchers often provide treatment recommendations based upon the self-reported problem behaviors including rates of mental health and substance use disorders of a particular target population. Service providers and researchers have consistently identified substance use and mental health treatment, parenting skills training, and medical treatment as areas of need among homeless mothers.^{4,7} In addition, high rates of childhood physical and sexual abuse among homeless women is well-documented, with some research suggesting that interventions addressing trauma can improve treatment retention rates and reduce chronic homelessness.⁸ While basing the need for intervention on problem severity is

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Conflict of Interest Statement

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logical, it is unknown whether these women actually desire such treatment and whether desire for treatment is associated with problem severity.

In the only study identified related to treatment desires among those experiencing homelessness, Herman and colleagues⁵ investigated the needs for assistance among homeless adult men and women. The authors found that respondents were most interested in immediate needs such as housing, employment, and steady income. Relatively few respondents were interested in receiving assistance for emotional, alcohol, or drug problems. However, Herman et al. did not assess the severity of alcohol or drug use, or mental health conditions. Therefore, it was unclear whether the low interest in receiving assistance for emotional, alcohol, or drug use was related to the severity of problems in those domains. In addition, the study sample did not include homeless mothers with children in their care, and the authors stated that these mothers have different characteristics and treatment desires than homeless adults without children in their care.⁵ For example, homeless mothers have the additional responsibility of caring for their children and may experience additional stressors associated with parenting in general. Compared to homeless women without children in their care, these women are younger, less educated, report less steady employment, receive less help from family and friends, and rely more on public assistance.⁹ Moreover, Herman et al.'s study was conducted in 1994, and there is evidence showing that characteristics of homeless mothers may have changed since that time. Weinreb and colleagues documented the changing demographics of the homeless population by comparing two samples (1993 and 2003) of homeless mothers on sociodemographic variables and physical and mental health status.¹⁰ Homeless mothers in the 2003 sample evidenced significantly higher rates of posttraumatic stress disorder, depression, poorer physical health, and lower incomes than homeless mothers in the 1993 sample.

Despite the high rates of substance use, mental health and related problems that these mothers face, studies indicate that contact with mental health services is low (5% for children, 12% for mothers).^{11,12} A national demonstration project on treatment for homeless persons with mental illness from 1993 to 1998 found that clients' and providers' perceptions of service needs differed significantly which likely led to low levels of service engagement (e.g., 27% of 5,450 individuals contacted during outreach).^{13,14} It follows that more information on the service needs and desires among homeless mothers might serve to increase service engagement. Moreover, research has shown that some mothers deny substance use problems for fear their children will be removed from their custody, or that the family will be removed from the shelter or otherwise denied shelter services.¹⁵ Separation of family members is a significant issue for homeless families, and fear of having a child taken away from mother's care may prevent mothers from seeking treatment,¹⁶ even if such treatment is desired.

Current Study

The current study sought to clarify contradictory findings in the literature by assessing domain-specific treatment desires among a particularly at-risk population, substance abusing homeless mothers, as well as the correspondence between treatment desires and problem severity. This study can help clarify the perceived importance of psychosocial and substance abuse treatment services for homeless mothers, which has been emphasized in some studies but not in others. The first goal of this study was to examine whether substance abusing homeless mothers' stated any desire, versus no desire, for treatment in five specific domains - substance use, depression/mood, parenting, healthcare, and childhood trauma. The second goal of the current study was to explore the correspondence between these homeless mothers' treatment desires in each specific domain and the severity of their problem behaviors in those corresponding domains. Some research suggests that those who seek treatment services also have more severe presenting problems,^{17,18} thus, it was expected that

the mothers with any self-reported desire for treatment in a particular problem area would report higher problem severity in that area compared to those reporting no desire for such treatment.

Methods

Participants

All participants were involved in the first stage of an ongoing, multi-stage study funded by the National Institute on Drug Abuse (R01DA023908) with substance abusing homeless mothers of young children in a large Midwestern city. Homeless mothers were recruited through referrals from a local family shelter. Eligible participants (N=102) lacked a fixed, adequate overnight residence,¹⁹ met DSM-IV criteria²⁰ for psychoactive substance use or alcohol disorder, had a biological child between the ages of 2 to 6 years in their physical custody, were currently residing at a temporary homeless shelter for families, and did not show evidence of unremitted psychosis or other condition which would impair the mother's ability to understand and participate in the intervention or consent for research participation (determined by the Computerized Diagnostic Interview Schedule-IV²¹ section on schizophrenia). Mothers with preschool children were chosen for two reasons: 1) to maintain homogeneity of the sample (e.g., mother's parenting tasks and stressors differ by age of child with school age children not requiring full-day child care), and 2) so that children are minimally old enough so that internalizing and externalizing behaviors could be assessed by the mother for the larger study. None of the participants reported currently being in treatment for substance abuse or psychological problems. Demographic characteristics of the current sample are presented in Table 1. Most of the homeless mothers in the current sample were African Americans (71.6%). On average, the homeless mothers were 27.01 years old, had 2.82 children, and 11.67 years of education. Childhood physical or sexual abuse was reported by 65.7% and 56.9% of the homeless mothers, respectively. They had been currently homeless for 60 days on average.

Procedure

The local family shelter where the participants were recruited provides emergency shelter and critical services for homeless families from several townships adjacent to a major Midwestern city. The shelter director reports that annually, nearly 900 families seek emergency shelter. The reported ethnic distribution of families utilizing shelter services is 70% African American or Black, 27% White, non-Hispanic, 2% Latina and 1% Native American. The shelter director reports that 89% of the women have children 6 years old and younger and an estimated 50% of these women have current substance abuse difficulties. Families usually transition to residential programs or other community-based housing programs within approximately 3 weeks (see website www.ywcacolumbus.org).

The shelter staff identified potentially eligible mothers and contacted the project coordinator to schedule an initial assessment interview. The interviews were conducted at the shelter at a convenient time for the mothers. Once the informed consent was obtained, mothers were screened for eligibility using the Computerized Diagnostic Interview Schedule Version IV (CDIS-IV)²¹ sections on substance abuse/dependence and schizophrenia. No mothers met criteria for schizophrenia. Approximately one in four mothers that were screened met the criteria for this study. All of the eligible mothers agreed to participate in the study. Participants meeting the eligibility criteria and who agreed to participate continued with the assessment battery and were compensated with a \$40 gift card. Those not meeting eligibility criteria were compensated with a gift bag filled with food, toiletries and toys for children.

Measures

Data were collected using interviewer and self-administered questionnaires. The demographics/homeless experiences questionnaire assessed age, race/ethnicity, and childhood sexual and physical abuse experiences.

Treatment Desires—Client's treatment desires were assessed using the What I Want from Treatment questionnaire (WIWFT).²² The WIWFT is a 69-item measure using a 4-point Likert scale that documents services potentially offered in a substance use treatment program, with each item referring to a different domain. Participants are asked about whether they want the potential services from treatment or not. Response categories include 'no,' 'maybe,' 'yes,' and 'YES!'. Seven items pertaining to the client's desire for help with alcohol and drug use, depression, parenting, physical health problems, and experiences of childhood sexual and physical abuse were used in the current study. The participants were dichotomized into 'interested' and 'not interested' based on their response of each item. Those with responses including 'maybe,' 'yes,' or 'YES!' were coded as the 'interested' group. Those with the response of 'no' were coded as the 'not interested' group. Forchimes et al. identified four response categories of the WIWFT, defined as intrapersonal and interpersonal needs, affective concerns and external demands. The reliabilities of those four subscales based on their factor analysis ranged from .60 to .85.²³ However, only 23 out of the 69 items were included in those four subscales, including only two of the seven items that were relevant to the focus of the current study. Therefore, we did not use the subscales identified in Forchimes et al.'s study. Instead, we used the original responses to each of the seven items of interest to our study with the goal to dichotomize participants into two groups with no versus any interest in treatment for that particular item.

Associated Problem Behaviors

Substance Use: Frequency of alcohol and drug use was assessed using the Form 90 interview.²⁴ The Form 90 is a semi-structured interview that combines the timeline follow-back procedure and grid averaging to record the participant's daily use of different substances for the past 90 days. This measure yields the percent days of alcohol use and the percent days of illicit drug use in the past 90 days, as well as the average standard drinks per day. Test-retest correlations have ranged from .62 to .99 for the different drugs of abuse among teen runaways.²⁵ The Form 90 has undergone several tests for reliability and validity among substance abusing adults (Tonigan, Miller & Brown, 1996; Westerberg, Tonigan & Miller, 1998) and has shown utility with substance abusing homeless women (Yahne, Miller, Irvin-Vitela, & Tonigan, 2002).

Problem consequences of substance use were measured using the Inventory of Drug Use Consequences (InDUC-2L).²⁶ The InDUC-2L yields five subscales assessing lifetime physical consequences, interpersonal consequences, intrapersonal consequences, impulse control, and social responsibilities. Respondents indicate whether or not they have ever experienced the consequences of alcohol or drug use. Higher scores indicate more problem consequences caused by alcohol or drug use. In the current study, Cronbach alphas ranged from .74 to .86 for these five subscales.

Depressive Symptoms: Symptoms of depression were assessed using the Beck Depression Inventory-II (BDI-II).²⁷ The BDI-II consists of 21 items, each of which has four self-evaluative statements scored as follows: (0) I do not feel sad, (1) I feel sad, (2) I am sad all the time and I can't snap out of it, and (3) I am so sad or unhappy that I can't stand it. The total scores range from 0 to 63, with higher scores indicating higher levels of depressive symptoms. According to the BDI-II manual, respondents could be categorized as minimally/nondepressed (total scores range from 0 to 13), mildly depressed (total scores range from 14

to 19), moderately depressed (total scores range from 20 to 28), and severely depressed (total scores range from 29 to 63; Beck et al.). In the current study, when calculating the total BDI-II score, three cases with more than two missing item scores (more than 10% of the total items) were treated as missing. There were three cases with only one or two missing item (less than 10% of the total items) scores. The missing item scores were replaced with the mean of the completed item scores when calculating the total BDI-II scores among those three cases. Internal consistency for the present study was 0.93.

Parenting: The Parenting Stress Index Short Form (PSI-SF) is a 36-item measure of parenting stress experienced by parents of young children.²⁸ The PSI-SF yields 3 subscales - parental distress, parent-child dysfunctional interaction, and difficult child - as well as an overall parenting stress score. Responses range from 1 (strongly disagree) to 5 (strongly agree) with higher scores indicating greater stress. There were three cases with one missing item in the difficult child subscale, which has a total of twelve items. For those cases, the missing item score was replaced by the mean of completed item scores when calculating the total score of the difficult child subscale. Internal consistency for the scales in the present study ranged from .84 to .95.

Health Problems: The Short-Form-36 version 2 (SF36v2)²⁹ provides an estimate of respondents' general health. The measure yields 8 subscales assessing physical health, mental health, and composite physical and mental health scores, as well as a total score. Four scales assessing physical health were used in the present study, including physical functioning, role-physical, bodily pain and general health. Higher scores indicate better health and physical functioning. The SF36v2 has previously been used with homeless mothers and demonstrated adequate reliability.¹⁰ The Cronbach alphas ranged from .73 to .91 in the current study.

Analyses

Participants were dichotomized into two groups for each domain based on their report of their treatment desires for that particular domain. Those who answered 'No' were considered as not interested in treatment, whereas those who answered 'Maybe', 'Yes' or 'YES!' were considered to be interested in treatment. In order to address the first goal of this study, to characterize the treatment desires among women, frequency distributions were computed indicating the number and percentage of homeless mothers reporting no versus any desire for treatment (as reported on the WIWFT) in the areas of substance use, depressive symptoms, parenting, health problems and childhood abuse respectively. For the second goal, to compare treatment desire associated with the corresponding problem behaviors, a series of two-tailed independent sample t-tests were computed. In particular, the means of the corresponding problem behaviors (frequency, quantity and consequences of drug and alcohol use, level of depressive symptoms, parenting stress, reported health status) were compared among those with and without any desire for treatment in a particular domain based upon their self-reports on WIWFT. For example, the frequency of drug use during the past 90 days was compared between the two groups with and without any desire for treatment with drug use. Effect sizes (Cohen's d) were provided for those comparisons yielding significant differences. Additionally, chi-square tests were used to examine if mothers that indicated any treatment desire for their experiences of childhood abuse were more likely to have experienced childhood physical or sexual abuse. Bonferroni adjustment was used to control for the overall Type I error rate at 0.05 ($p < .05/24 = 0.002$).

Results

Among the seven items querying treatment desires (see Table 2), depressive symptoms and parenting were the top two areas, with the most homeless mothers indicating interest in treatment. Eighty-five homeless mothers (83.3%) were interested in help with depressive symptoms, while 77 mothers (75.5%) were interested in help to be a better parent. Substance use was also an area that a majority of homeless mothers indicated treatment desire. Approximately 70% of the homeless mothers wanted help to decrease drug use, and more than 60% of the homeless mothers wanted help to decrease alcohol use. Health problems and childhood abuse were the areas that the homeless mothers indicated the least treatment desires. Less than half of the mothers wanted help with health problems, and only about one-third of the mothers wanted to discuss their own experience of being physically or sexually abused. Marijuana, alcohol, and opiates were the most commonly reported drugs of abuse in the current sample. The overall means and standard deviations of the problem behavior variables for the full sample and for the two groups dichotomized based on their self-reported desire for treatment (no desire vs. some desire for treatment in that specific area), including drug and alcohol use, depressive symptoms, parenting stress and physical health problems, are reported in Table 3.

A series of independent-sample T-tests showed that problem severity differentiated mothers who were interested in treatment from those who were not interested in treatment across several domains. Mothers interested in treatment for drug use reported a higher percent days of drug use during the past 90 days than their counterparts with no interest in treatment for drug use [$t(100) = -4.32, p < 0.002$]. Those who were interested in treatment for alcohol use reported a higher percent days of alcohol use [$t(100) = 5.71, p < 0.002$], and more standard drinks per day [$t(94) = -4.39, p < 0.002$]. Those who were interested in treatment for depression reported higher levels of depressive symptoms than those who were not interested [$t(94) = -3.75, p < 0.002$]. Also, among the 54 mothers who scored in the moderate or severe range of depressive symptoms (scores > 20), 52 (96.3%) of them indicated that they wanted help with depression or moodiness, further highlighting a positive relationship between depressive symptoms and treatment desire. Those who were interested in treatment for physical health reported more bodily pain and associated interference [$t(100) = 3.64, p < 0.002$], as well as lower positive perceptions of their own general health [$t(99) = 4.31, p < 0.002$] than those who were not interested in physical health treatment. In addition, those who experienced childhood sexual abuse were more likely to want to discuss sexual abuse than those who did not experience sexual abuse during childhood [$\chi^2(1) = 11.05, p < 0.002$].

In contrast, problem consequences associated alcohol and drug use did not differentiate those who were interested in treatment for alcohol or drug use from those who were not interested ($p > 0.002$). None of the subscales of parenting stress differentiated mothers who were interested in how to be a better parent from those who were not interested ($ps > 0.002$). In terms of childhood physical or sexual abuse, chi-square tests showed no significant difference between those reporting interest in treatment for physical abuse and those reporting no interest in terms of whether they were more likely to have experienced physical abuse ($p > 0.002$). In other words, self-reported experience of physical abuse was unrelated to a reported desire for treatment.

Discussion

Overall, the current study showed that among a sample of substance abusing homeless mothers, depression, parenting, and substance use were three problem areas that a majority of the mothers (more than 60%) indicated any interest in treatment (versus no interest at all).

In the other two areas, physical health and childhood abuse, less than half of the mothers indicated any interest in assistance. Assessment of problem severity was domain-specific and differentiated mothers with and without treatment desires for substance use, depression, physical health, and childhood sexual abuse. Those who indicated treatment desires in a particular domain reported higher levels of problem severity in that domain than those who indicated no interest in treatment. In addition, treatment desires were not related to problem severity in parenting or physical abuse. To our knowledge, this is the first study to assess treatment desires for five frequently reported associated problem behaviors among homeless women with young children and how treatment desire corresponds with problem severity. This information may be helpful for tailoring treatment services and understanding the low treatment engagement rates reported in the literature.^{30,31}

The first goal of the current study was to investigate substance abusing homeless mothers' stated desires for treatment, any desire versus no desire at all, in the five domains - substance use, depression/mood, parenting, healthcare, and childhood trauma. The findings indicated that the majority of mothers indicated at least some interest in treatment for depression, parenting and substance use, which is counter to the findings of Herman et al. who found that respondents were most interested in assistance with immediate needs rather than assistance for emotional or alcohol and drug problems. The inconsistencies between the current findings and previous findings may be due to the differences between the study samples. The participants in Herman et al.'s study did not have children in their care, and it was unclear whether they had substance use problems. As noted earlier, substance abusing women with children have different characteristics, stressors and supports,⁹ suggesting different treatment needs and desires given their active parenting role. Indeed, while respondents in Herman et al.'s study reported low need for assistance with substance use, some research indicates that children may serve as motivators for substance and mental health treatment among their parents.³² This is further supported by the finding in this study that the majority of women requested assistance for parenting. Additionally, the findings reported here run parallel to the changing mental health characteristics of homeless mothers observed by Weinreb and colleagues,¹⁰ suggesting that the reported increase in mental health needs over time may be associated with increased desire for assistance in those areas.

The second goal of the current study was to examine the relationship between problem severity and treatment desires. It was expected that the severity of corresponding problem behaviors would differentiate the mothers with and without any desire for treatment. This hypothesis was generally supported. Level of parenting stress and the presence of a history of physical abuse were not significantly associated with any desire for assistance in those areas. However, as substance use, physical health and depressive symptoms increased, so did desire for treatment in those areas. These findings suggest that women are open to concurrent focus on these symptoms even during their housing crisis. Therefore, assessing these symptoms among shelter-residing women is a good opportunity for engaging them in needed services that may improve the likelihood that they will exit homelessness and ultimately improve the quality of their life.

Some studies identify a history of childhood abuse in the etiology of substance use and homelessness,³³ therefore, addressing trauma experiences might enhance substance abuse treatment outcomes and housing stability, at least for some women. This study found a higher incidence of self-reported childhood sexual abuse among the homeless mothers interested in treatment for sexual abuse than among those who were not interested in such treatment. However, given that only approximately half of the women that reported childhood abuse desired assistance in this area, therapeutic focus on childhood trauma might need to be approached carefully in close collaboration with the client (e.g., monitoring readiness), perhaps once stabilization in other life areas occurs. Therapeutic focus on

childhood abuse prior to treatment readiness might lead to treatment drop-out, and many studies cite that trauma focused therapies often struggle with low retention rates.³⁴ Since childhood abuse is an area that some, but not all, homeless mothers need and want to discuss, it could be conceptualized as a therapeutic component tailored to clients' treatment readiness.

Physical health is another topic that problem severity differentiated the mothers with and without any treatment desires. However, less than half of the mothers indicated any desire for treatment in this area. This finding supports research showing that those experiencing homelessness may be less likely to seek medical care due to competing priorities³⁵ (i.e. need for food, shelter) and perceived barriers to attaining such care.³⁶ In addition, some research suggests that among homeless adults, medical need may be associated with treatment seeking only for health problems with serious long-term consequences.³⁷ In the current study, mothers who were interested in help with health problems reported higher levels of bodily pain and lower levels of positive perceptions of general health. Therefore, addressing medical need among those mothers with at least some desire for treatment, as well as for those with lower levels of physical health, may also serve to retain those women in intervention efforts. In addition, alleviation of bodily pain and improving their physical health in general might help alleviate their alcohol and/or drug use, since some research suggests that people use alcohol or drug as a way of self-medication for pain.^{38,39}

In the current study, most of the homeless mothers wanted help to become a better parent, but parenting stress did not differentiate homeless mothers who indicated some interest in learning how to be a better parent from those who were not interested. Future research should investigate other potential variables associated with treatment desires for parenting among homeless mothers, for example, child's internalizing and externalizing behaviors, mothers' self-efficacy, or mothers' social support. Mothers' desires to become a better parent may also be associated with their homeless status, their own substance use or with their depressive symptoms. Therefore, it is possible that as their homelessness, substance use and/or depressive symptoms remit, they will be more physically and emotionally available for their children. Future research may find that the improvement in homelessness, substance use and depressive symptoms is associated with a reduction in parenting stress, or an increase in parenting skills among substance abusing homeless mothers.

Limitations

This study is limited by the use of a sample of convenience recruited from a temporary shelter for homeless families in a large Midwestern city. The sample presented here might not represent homeless families in other areas of the country in terms of racial and ethnic diversity, economic background, and patterns of alcohol and drug use. Also, as the sample was limited to women meeting diagnostic criteria for a psychoactive substance use disorder, the results may not be generalizable to non-substance abusing homeless mothers.

Implications for Behavioral Health

Given that domain specific problem severity is a reliable estimate of women's desire for treatment across some important problem areas (e.g., substance use, depression, physical health and sexual abuse), the findings suggest that psychosocial counseling should be available and offered to all mothers entering the homeless shelter system. Several studies suggest that other needs, especially those associated with housing and employment may be considered more immediate,³⁴ but the current findings indicate that parenting, mood, and substance use are highly desired areas of treatment for the majority of mothers. While funding is often a barrier to service provision, research suggests that focus on psychosocial issues such as these can improve efforts to exit homelessness.^{4,8} Treatment for physical

health and sexual abuse could be optional, based on the needs and the treatment desires of the homeless mothers. Also, more research is needed to untangle the underlying reasons for lack of treatment desire among these mothers. Efforts to increase desire for assistance, such as through the use of motivational interventions or through first addressing women's primary treatment desires and developing trust and connection, might improve treatment engagement and outcomes across a range of overlapping domains.

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Table 1

Characteristics of the sample (N = 102)

Variables		n(%)	Mean (SD)	Range
Age (years)			27.0 (6.3)	18–41
Ethnicity	African-American/Black	73 (71.6%)		
	White, non-Hispanic	17 (16.7%)		
	Other	12 (11.8%)		
Education (years)			11.67 (1.5)	8–15
No. of children			2.82 (1.62)	1–8
Childhood abuse	Sexual	67 (65.7%)		
	Physical	58 (56.9%)		
Age at first homeless experience			23.01 (7.44)	3–40
Number of days currently homeless			60.29 (198.08)	0–1825
Primary drug of use	Alcohol	37 (36.3%)		
	Marijuana	43 (42.2%)		
	Opiates	11 (10.8%)		
	Cocaine	6 (5.9%)		
	Tranquilizers	2 (2.0%)		
	Sedatives/Downers	2 (2.0%)		
	Stimulants/Uppers	1 (1.0%)		

Table 2Self-reported treatment desires from What I Want From Treatment²¹

Do you want this from treatment?	Not Interested		Interested		
	'No' n (%)	'Maybe' n (%)	'Yes' n (%)	'YES!' n (%)	Total n (%)
I want help to decrease my drinking.	39 (38.2%)	12 (11.8%)	26 (25.5%)	25 (24.5%)	63 (61.8%)
I want help to decrease my use of drugs (other than alcohol).	31 (30.4%)	10 (9.8%)	36 (35.3%)	25 (24.5%)	71 (69.6%)
I want help with some health problems.	57 (55.9%)	10 (9.8%)	20 (19.6%)	15 (14.7%)	45 (44.1%)
I want help with depression or moodiness.	17 (16.7%)	16 (15.7%)	28 (27.5%)	41 (40.2%)	85 (83.3%)
I want to discuss having been physically abused.	63 (61.8%)	17 (16.7%)	11 (10.8%)	11 (10.8%)	39 (38.2%)
I want to discuss having been sexually abused.	71 (69.6%)	12 (11.8%)	8 (7.8%)	11 (10.8%)	31 (30.4%)
I want help to be a better parent.	25 (24.5%)	17 (16.7%)	21 (20.6%)	39 (38.2%)	77 (75.5%)

Table 3
Comparison of treatment needs with substance use, parenting, and physical and mental health problems

	Total Sample (n = 102)	Range	Treatment needs		t	df	Sig. (2-tailed)	Effect size (Cohen's d)
			Interested in treatment	Not interested in treatment				
			M(SD)	M(SD)				
<u>Drug use</u>								
% days illicit drug use	55.01 (40.04)	0 – 100	65.46 (36.00)	31.09 (39.05)	-4.32	100	<.001	0.92
Physical consequences	3.60 (2.10)	0 – 8	3.78 (2.18)	3.18 (1.85)	-1.28	94	0.20	
Interpersonal consequences	3.59 (2.96)	0 – 10	3.82 (2.97)	3.04 (2.94)	-1.19	94	0.24	
Intrapersonal consequences	4.26 (2.73)	0 – 8	4.63 (2.74)	3.36 (2.51)	-2.12	94	0.04	
Impulse control	4.10 (2.60)	0 – 11	4.51 (2.64)	3.07 (2.24)	-2.55	96	0.01	
Social responsibility	2.82 (2.35)	0 – 7	3.01 (2.38)	2.38 (2.37)	-1.22	94	0.23	
<u>Alcohol use</u>								
% days alcohol use [†]	4.83 (9.01)	0 – 71.0	1.25 (0.53)	0.56 (0.63)	-5.71	69.64	<.001	1.19
Average standard drinks [†]	22.05 (26.65)	0 – 95.6	0.65 (0.40)	0.29 (0.39)	-4.39	94	<.001	0.91
Physical consequences	3.60 (2.10)	0 – 8	3.75 (1.89)	3.38 (2.39)	-0.79	63.57	0.43	
Interpersonal consequences	3.59 (2.96)	0 – 10	3.78 (2.84)	3.30 (3.17)	-0.78	94	0.44	
Intrapersonal consequences	4.26 (2.73)	0 – 8	4.57 (2.62)	3.79 (2.85)	-1.38	94	0.17	
Impulse control	4.10 (2.60)	0 – 11	4.55 (2.34)	3.39 (2.86)	-2.18	96	0.32	
Social responsibility	2.82 (2.35)	0 – 7	3.14 (2.28)	2.32 (2.40)	-1.66	94	0.10	
<u>Mental health</u>								
Depressive symptoms	22.52 (12.99)	0 – 60	24.57 (12.33)	11.88 (11.32)	-3.82	97	<.001	1.04
<u>Parenting</u>								
Parental distress	36.04 (10.29)	12 – 60	35.84 (9.63)	36.64 (12.29)	0.30	34.10	0.80	
Parent-child dysfunctional interaction	28.99 (14.33)	12 – 60	26.26 (12.56)	37.40 (16.35)	3.12	33.69	0.00	
Difficult child	34.46 (11.95)	12 – 60	33.20 (11.59)	38.36 (12.47)	1.90	100	0.06	
Total stress	99.49 (30.98)	40 – 175	95.30 (27.45)	112.40 (37.74)	2.09	32.65	0.44	
<u>Physical health</u>								
Physical functioning	24.29 (5.06)	10 – 30	22.87 (5.32)	25.42 (4.58)	2.60	100	0.01	
Role-physical	14.09 (4.97)	4 – 20	12.84 (4.91)	15.07 (4.84)	2.29	100	0.02	
Bodily pain	7.86 (2.69)	2 – 12	6.82 (2.68)	8.67 (2.43)	3.64	100	<.001	-0.72

	Total Sample (n = 102)	Range	Treatment needs		t	df	Sig. (2-tailed)	Effect size (Cohen's d)
			Interested in treatment <i>M(SD)</i>	Not interested in treatment <i>M(SD)</i>				
General health	16.42 (4.34)	6 – 25	14.63 (4.09)	17.85 (4.01)	3.98	99	<.001	–0.80
Interested in treatment (n) Not interested in treatment (n) Chi-square test								
<u>Childhood abuse</u>								
<u>Physical abuse</u>								
Yes	27	31		3.62				
No	12	31						
<u>Sexual abuse</u>								
Yes	28	39	11.05*	0.70				
No	3	30						

*The test met the Bonferroni-adjusted significance threshold ($p < .002$).

[†] indicates log transformation prior to analyses