Published in final edited form as:

Alcohol Treat Q. 2017 ; 35(3): 200–212. doi:10.1080/07347324.2017.1317483.

Relationship Themes Present between Parents and Children in Recovery Homes

Brandon Isler^a, Megan Mineau, BA^a, Bronwyn Hunter, PhD^b, Sarah Callahan, MA^a, Noah Gelfman, BA^a, Yvita Bustos^a, Isabel Dovale^a, Andrew Peterson, BA^a, and Leonard A. Jason, PhD^a

^aCenter for Community Research, DePaul University, Chicago, Illinois, USA

^bDepartment of Psychology, University of Maryland, Baltimore, Maryland, USA

Abstract

Approximately 12.5% of children have a parent with a substance use disorder. These children are likely to experience developmental delays, especially if they are placed into foster care. Oxford House recovery homes provide a useful setting that allows children to live with their parents after treatment for substance use. A sample of parents and their children who lived in Oxford Houses were interviewed, using mixed methods, and the outcomes suggest that Oxford Houses may provide a stable and supportive setting for parents and their children.

Keywords

children; sober-living environment; interpretative phenomenological analysis; substance use recovery

Drug and alcohol use are serious social issues that affect parents, children, and their communities. Approximately 9.4% of Americans struggle with substance use disorders (SUDs; Grant et al., 2004), and those who use substances are far more likely to experience comorbid mental illness, poverty, and abuse (Mark, Woody, Juday, & Kleber, 2001). In addition to these social and individual disadvantages, challenges related to SUDs are exacerbated at the institutional level. Of those who are currently incarcerated in federal and state facilities, a high percentage have been convicted for nonviolent or drug-related offenses (Taxy, Samuels, & Adams, 2015). Parents who experience addiction, especially those who have been convicted of felony offenses, frequently have difficulty securing affordable housing and gainful employment, which perpetuates a vicious cycle of poverty and relapse (Jason, Olson, Foli, 2008). Unstable housing and employment may also affect parents' ability to maintain child custody while struggling with addiction or being able to sufficiently provide for a family (d'Arlach, Curtis, Ferrari, Olson, & Jason, 2006).

CONTACT Brandon Isler, bisler@mail.depaul.edu, Center for Community Research, DePaul University, 990 W Fullerton Ave. Suite 3100, Chicago, IL 60614.

All authors approved the manuscript and this submission. The authors report no conflict of interest.

Parental absence and disorganized family structure due to alcohol and drug use increase the risk of childhood attachment issues that may persist into adulthood (Flores, 2004). These issues can manifest as difficulties with interpersonal relationships due to a lack of emotional regulation and distress tolerance skills. Therefore, children of parents who have SUDs are more prone to addiction, but there are other factors explaining increased risks of addiction, such as the genetic factors, especially for alcohol (McGue, Sharma, & Benson, 1996). On the other hand, the presence of children in families with SUDs has been shown to increase optimism and problem awareness in their parents (Droege, Stevens, & Jason, 2015).

Few residential substance use recovery programs allow children to live with their parents. This undermines the efficacy of these programs in two ways. First, it severely limits parents' intrinsic motivation for remaining in the program for a sufficient length of time. Many parents only participate in treatment long enough to have their children returned to them, which may result in relapse and the potential for parents losing custody of their children again (Grella, Scott, Foss, Joshi, & Hser, 2003; National Institute on Drug Abuse, 2000). Additionally, regardless of their parents' intrinsic or extrinsic motivation, children are often placed in foster care or with other family members for the duration of the treatment program (Barber & Delfabbro, 2003). Children in foster care are at a higher risk for developing a variety of developmental issues relative to their peers. For example, research has shown that children growing up in foster care are more likely to experience trouble educationally, emotionally, socially, and behaviorally (Clausen, Landsverk, Ganger, Chadwick, & Litrownik, 1998). Approximately 400,000 children are currently in the foster care system, which highlights the need for improvement at the policy level. It is clear that children are adversely affected by the absence of their parents. As an example, Murray, Farrington, and Sekol (2012) found that children who have had a parent who was incarcerated were more likely than their peers to exhibit antisocial behavior. Past parental incarceration has been associated with lower family income, parental education, higher levels of parental depression, inappropriate and inconsistent discipline, youth problem behaviors, and serious delinquency (Kjellstrand & Eddy, 2011). However, there have been inconsistent findings about the relation between parental incarceration and future antisocial behavior. The most consistent findings apply to children who have a father who is incarcerated (Hairston, 1998). Many of these issues are a direct result of the American justice system favoring punishment over rehabilitation. This is a consequence of the systemic prohibition of narcotics and "tough on crime" legislation (Pettit & Western, 2004).

Oxford House (OH) is a network of more than 2,000 recovery homes that provides an alternative approach to treating those with SUDs. OHs are democratically run and encourage participation in a combination of 12-Step programming along with community-based support. Residents of OH in comparison to those not provided this aftercare setting following treatment demonstrate more positive outcomes in the form of recovery, employment, and decreased involvement with the justice system (Byro, Jason, Ferrari, & Olson, 2012).

Another novel feature of some OHs is the capacity to allow children to live in these settings with their parents (d'Arlach, Curtis, et al., 2006). Ortiz, Alvarez, Jason, Ferrari, and Groh (2009) compared the characteristics of individuals living in OHs with and without children

and concluded that women in OHs who care for children may require additional resources and assistance compared to men. Legler et al. (2012) interviewed adults who were living in OHs that allowed children to live in the house with their parent. Findings indicated that children in the house supported the recovery of house members and on improving parent–child relationships. In general, studies on these OHs have shown high levels of parent reports of child satisfaction (d’Arlach, Olson, Jason, & Ferrari, 2006), but children living in these settings had not been directly interviewed. Similarly, houses with parents and children have been shown to foster assertiveness and self-confidence in the women residents, which are important aspects of the recovery process specifically faced by females (Davis et al., 2006; Timpo et al., 2014).

The democratic nature of OH may be responsible for increasing self-confidence, assertiveness, and, subsequently, abstinence. This study seeks to gain further insight into the dynamics of the parent–child relationships in OHs. There have only been a few studies to date on the topic of children living in recovery settings. In addition, no OH studies have directly interviewed children or youth regarding their experience living in these recovery settings. The current mixed-method study interviewed youth as well as their parents living in these recovery settings to gain a better understanding of the perceptions children and parents have about their experiences while living in these settings.

Method

Participants

Participants in this study included 12 parents who each had at least one child living in an OH (when more than one child was living in an OH, only one was chosen by the parent to be interviewed). We contacted several OHs that allowed children to live with their parents in the house. Eleven mothers and one father as well as four boys and eight girls participated in this study. The one participant who was a father participated in the study with his daughter. See Table 1 for a description of the demographics on the child and parent samples. Children’s average age was 13.42 years ($SD = 4.94$), whereas parents’ average age was 36.83 ($SD = 7.92$) years. Of the participants, 70.8% were Caucasian, 20.8% identified as “other,” and 8.3% were African American. Of the parents, 50% were unemployed, and 91.7% were receiving public assistance at the time of the interview. The mean number of hours per week worked parents who were employed was 36.43 ($SD = 6.20$). The most frequent drug of choice was methamphetamine (50%). However, there was some use of alcohol and other drugs, including marijuana, cocaine, and heroin. Qualitative data were collected from all 24 participants, but several parents and/or children did not completed the quantitative measures.

Procedure

Approval from the DePaul Institutional Review Board was obtained prior to beginning this study. The OH database was searched to identify houses that permit women or men with children to reside in the house with their children. A group of these OHs were telephoned and flyers with information about the study were mailed to these houses. Inclusion criteria required that the child be at least eight years old and that a parent who resided in the OH had full custody to provide consent for participation. Interested participants engaged in

semistructured interviews that occurred in person and over the phone. The parents and their children provided consent and assent prior to the interviews, and participants were compensated with \$5 gift cards for Dunkin Donuts, Burger King, or McDonald's for their participation. Participation was self-report, completely voluntary, and names were omitted from surveys to ensure participant anonymity.

Materials

Sociodemographic questions—Information was gathered on the parents' and children's race, gender, level of education, birth place, annual income, employment status, amount of public assistance received (if any), involvement with Department of Child and Family Services (if any), the parent's length of time in recovery, and their substance of choice.

Open-ended questions—Several open-ended questions qualitatively assessed parents' and children's social experiences in OHs. Parents were asked who they went to for advice, their general experience with OH, if there were other children living in the house besides their own, how the children interacted with each other, what their children knew about OH and addiction, and how their children helped and/or hindered their recovery. Children were asked similar questions but geared toward the children's perspective. Notable variations from the parent section of the questionnaire were about the purpose of OH, how children interacted with each other in the house, if the children were responsible for any chores around the house, and if the children attended house meetings.

Social Support Questionnaire for Children—Children and parents completed a version of the Social Support Questionnaire for Children (SSQC; Gordon, 2011) for children, which is a 50-item, self-report measure that assesses the degree of social support received from parents, relatives, nonrelative adults, siblings, and peers. This inventory has been shown to have high internal validity and consistency for measuring social support (Gordon, 2011). Additionally, scores on the SSQC positively correlate with children's adjustment and positive coping behaviors (Gordon, 2011). Each item was answered by a Likert-type scale ranging from 0 to 3 (0 = *never* to 3 = *always*). The highest score a participant could receive on a subscale was 40 and the highest sum score that a person could receive was 200. The higher participants' scores, the higher their perceived levels of social support. The SSQC version that the parents completed was modified to include an OH member rather than a partner reference. Children completed the original Gordon (2011) inventory.

Stress in Children Questionnaire—The Stress in Children Questionnaire (SiC; Osika, Friberg, & Wahrborg, 2007) measured perceived stress in children and parents. The scale contains 21 self-report items that are recorded on a Likert-type scale. Osika et al. (2007) found that this inventory was valid and reliable. There are three primary factors of this measure: lack of well-being, distress, and lack of social support. Parents and children completed the same questionnaire.

Data analysis

Responses to the open-ended questions were coded and analyzed using interpretative phenomenological analysis (IPA). IPA provides an idiographic focus on people interpreting specific occurrences depending on their context (Pietkiewicz & Smith, 2014). Questions were asked regarding how the children affected their parent's recovery as well as parents' and children's overall quality of life. Two researchers independently identified superordinate themes. After the themes were identified, the researchers collaborated and selected the most prominent themes that accurately reflected the experiences of the participants. Themes that emerged from the parent's perspective included feeling at home, seeking treatment to be a better parent, newfound self-confidence, and viewing recovery as a team/family effort. Each theme is discussed below.

Results

Qualitative outcomes

Feeling at home—Social environments can play a major role in recovering from addiction, especially in the effort to abstain from one's substance of choice and persistence in seeking help (McIntosh & McKeganey, 2000). This first theme suggested that OH's success stems from its ability to facilitate strong social bonds between the residents. This theme is exemplified by one of the residents' anecdotes about relapsing but returning to OH because other residents reached out and provided a social safety net:

I enjoyed it because I went home and relapsed for five days and the girls called me and told me to come back, they love me and to come back. That's when I knew it was the place for me. [It's a] loving, supportive environment.

Another parent commented, "We do activities together. Generally we get along. It's like a family. Movie night, meetings, holidays." A child described his experience in OH in the following way, "It gives us a place to stay and sleep and have fun."

The surrogate family created by the parents and children in the OH was an important contributing factor to the residents' self-efficacy. These OHs provided residents with the resources they needed to support themselves and others by bringing together a number of people with similar problems. In fact, many parents stated that their OH required them to develop positive social skills such as trust and accountability, "It's been incredible, learning how to trust women. They provide support like I haven't experienced before in previous relationships." This parent was, for the first time in her life, meeting people that she felt was worthy of trust. This support and reliability helps residents in times of hardship and lowers the risk of relapse. Residents experienced trust, accountability and respect in OHs, and this sense of security and feeling at home contributed to the residents' abstinence.

Seeking treatment to be a better parent—Many of the residents that were interviewed attributed their success to the presence of their children. Traditionally, children would be taken by child protective services until the parent successfully completed court-ordered treatment. This would continue cyclically, exposing the child to the risks of foster care, disorganized parenting and a semitransient lifestyle while giving the parent little incentive to

truly recover. Thus, OH helped break this cycle by providing parents with permanent housing where they can live with their children while recovering from their addiction. In general, parents reported positive experiences in OH, "It's been huge cause she supports me a thousand percent. Without OH we wouldn't be together." Another parent said, "Having him there gives me motivation [crying]. I feels blessed to have him back. I say I love him and frequently apologize."

These are just two of the many responses that describe the positive role their children played in their recovery. By living with their children, residents gain many advantages they wouldn't otherwise possess in traditional recovery settings that did not allow for the presence of children. Parents were motivated to succeed, in part, through developing a positive relationship with their children. Combined with the low-rent and drug-free environment, parents were given the ability to financially provide for their children and also recover from their substance use. Previous studies have shown how important a role children play in recovery (Kim, Davis, Jason, & Ferrari, 2006). The literature has also demonstrated repeatedly the negative outcomes of children being raised by parents with untreated SUDs (McKeganey, Barnard, & McIntosh, 2002). Recovery settings like OH help to empower not only adults in recovery, but also their children.

Providing an environment where children have the potential to create successful interpersonal relationships in a stable environment is crucial to their psychosocial development. Despite being displaced from their homes for a number of reasons, the children interviewed were very positive about their experience living in these recovery settings. One child described her feelings about living in OH in the following way, "I like it a lot. It feels safe and it's really fun." The manner in which the child integrates to the cohabiting residents is equally impactful on the child's development as the child's process of adapting to a new environment. One child described this process during her interview, "Well, it's the only place that I can live, [and] it's pretty good. There are people in the house that are nice and help."

Newfound self-confidence—Newly acquired social skills, including trust and accountability, were discussed previously, but these were externally directed. The most important aspect of recovery is the internal changes to the user's self-identity and their view of the world (McIntosh & McKeganey, 2000). An important theme extracted from the surveys is the process of parents beginning to see themselves as positive role models who provide for their children, establishing a sense of agency and self-confidence. One parent commented, "I don't think it would make a difference either way, because I'm so committed to recovery."

Many OH residents had been involved in the criminal justice system, abusive relationships or had experienced homelessness. By living in an OH, where group decisions are made democratically, residents are encouraged to take responsibility for their own actions. This change of perspective may be what allows residents to recover for themselves and their children (McKeganey et al., 2002). Their newly emerging self-confidence and identity change was also catalyzed by the presence of the residents' children, as many residents

directly attributed their success to their children. The important role of children in their parents recovery has been documented elsewhere (McIntosh & McKeganey, 2000).

Viewing recovery as a team effort—A critical element of the OH model is the strong communal bonds formed among the residents. Members of the OH have a valuable resource in the form of other residents. Everyone is dealing with problems stemming from their substance use; this fosters a strong sense of empathy and sense of community. “(I can get advice from) anyone.” This is one response from a parent when she was asked whom she could go to for advice about a problem. Almost every adult interviewed in this study shared this sentiment, highlighting the social support that the residents provide for one another. The findings indicate that few of the parents had maintained close relationships with their parents or relatives. This is possibly due to substance use and the resulting alienation that commonly coincides with the recovery process. When asked about their familial support for their recovery, one parent stated, “It’s ok, but I sometimes wish I had more support from my family.” A child discussing what she liked about her OH had this to say, “Well, it’s the only place that I can live, it’s pretty good, there are people in the house that are nice and help.”

Another reason participants may have felt particularly close to other residents is the lack of support for problems outside of the recovery setting. After their substance use had separated them from healthy, productive relationships, OH has helped them form new ones. Many residents, as mentioned above, place a high value on these relationships, subsequently creating a sense of support for something greater than themselves. Besides the ideological and emotional aspects of this support, more practical effects were also observed during the interviews, such as manifested in this parent’s comment, “It’s nice to have support. Nice to have help with son. Kind of a trip living with a lot of women but it’s good.”

Many participants of this study talked about the help they received from other residents taking care of their children. This is yet another benefit observed stemming from the sense of community. The residents trusted one another to care of their children and were then able to work more hours, run errands, and make appointments they otherwise would not have had the time to do without the aid of the other adults participating in OH.

Quantitative outcomes

Quantitative results compared youth responses to parent responses using a Mann-Whitney *U* test. For the SiC, parents scored higher on average ($M = 44.40$, $SD = 5.48$) than children ($M = 41.90$, $SD = 8.48$). As dyads, $M = 43.15$, $SD = 7.07$. For the SSQC, parents scored lower on average ($M = 123.55$, $SD = 33.54$) than children ($M = 136.33$, $SD = 29.91$). As dyads, $M = 130.22$, $S = 31.64$. These scores are considered relatively high in all cases. For descriptive information pertaining to the subscales of the SSQC, refer to Table 2. The only significant difference between scores comparing parents and children was on the SSQC parent scale (Mann-Whitney $U = 17$, $Z = -3.034$, $p = .002$), indicating that the children derived a higher degree of social support than their parents derived from their parents.

Pearson product–moment correlation coefficients were used to determine if there were any significant relationships between the SiC stress and SSQC support scores. Analyses were conducted to assess the correlation of each variables for only children, only parents and for

the dyads together. For children, the two scores were significantly correlated, $r(8) = .780$, $p < .01$. For parents, there was a weak, positive and nonsignificant correlation, $r(8) = .314$, $p > .05$. For the dyads, there was a moderate, positive significant correlation between the two survey scores, $r(18) = .478$, $p < .05$.

Discussion

Our results indicate that most children enjoyed living with their parents at OH. Parents reciprocated this sentiment, which supports the findings of previous, similar studies (Fals-Stewart, Fincham, & Kelley, 2004; Tracy & Martin, 2007). This satisfaction is possibly due to the relative appeal, or lack thereof, of alternate living arrangements. Many children of parents who use substances often end up in foster care before or during their parents' admission into inpatient treatment; children living in foster homes are more likely to experience emotional and behavioral problems than if they had been raised by parents who were high risk (Bass, Shields, & Behrman, 2004; Harden, Clyman, Kriebel, & Lyons, 2004). According to our qualitative and quantitative measures, children perceived high levels of social support from their parents, adult residents, and the children living with them. Children also made frequent mention of the safety of their OHs. This may be indicative of their previous experiences in environments where drug use and other illicit activities were present.

This study found an inverse correlation between stress and social support, and this would be expected, as those with higher support felt less stress. In addition, another finding of interest was that children felt more support from their parents, than their parents felt from their own parents. This suggests that children were obtaining more social support from their parents as they were living in the OHs, in comparison to what their parents had received as youth.

Our findings highlight the symbiotic benefits of children living in a treatment setting. It is very possible that parents living in these OHs are better equipped to support their children, as there are multiple adults in the home that are striving for self-improvement willing to support the development of these children. Having additional parental support can take stress off of parents who could be at higher risk for relapse if the responsibilities of parenting become overwhelming. The consistent presence of several authority figures also enables the parents to discipline more authoritatively and allows children to grow up in a more stable, predictable, and supportive environment. Children living in OHs with other children also regularly reported that they enjoyed the presence of their peers. This may indicate a positive influence on their social development and interpersonal efficacy.

There are certainly motivations for sobriety that are independent of the child's presence in an OH. Personal motivation drawn from the desire to improve can be independent of one's child (Hogan, 1998). Regardless of the source of motivation, having a desire for sobriety and its maintenance can have a substantial benefit for their children over time. It is clear from this study that many OH residents have drawn motivation to stay abstinent from the presence of their children. The support of their children often times play a crucial role in self-regulation. Losing custody of a child typically damages their self-esteem and perpetuates the cycle of helplessness and substance use. The reinstated presence of their child reestablishes a sense of purpose and motivation for self-improvement during the recovery process.

There were several limitations in this study. For example, our sample was relatively small ($N = 24$), and participants may have answered less freely talking to strangers interviewing them over the phone. Importantly, many children who lived with their parents in OH did not qualify for the study because they were younger than age 8 years and/or the resident parent did not have full custody to provide consent for the child's participation. In addition, this study did not utilize a control group. Future research might also employ a wider set of quantitative measures tapping other domains of parent-child functioning. There is also a need for more longitudinal studies to be able to make more firm and causal statements about possible changes that occur in the parents and children in these recovery settings.

In conclusion, the previous literature supports the notion that, in general, levels of satisfaction are high in parents and their children who live in OHs. This pilot study shows promising results and suggests that these settings might create unique opportunities for parents and their children to overcome past barriers to their relationships. These promising results, the first ones that have included interviews with parents and their children, suggest the need for a more comprehensive study to better understand the role of children and their parents in the process of substance use recovery.

Acknowledgments

Funding

The authors appreciate the financial support from the National Institute on Drug Abuse (DA19935), and the National Center on Minority Health and Health Disparities (MD002748).

References

- Barber, JG., Delfabbro, PH. Placement stability and the psychosocial well-being of children in foster care. New York, NY: Routledge; 2003.
- Bass S, Shields MK, Behrman RE. Children, families, and foster care: Analysis and recommendations. *The Future of Children*. 2004; 14(1):5–29.
- Byro E, Jason LA, Ferrari JR, Olson B. Benefits and costs associated with mutual-help community-based recovery homes: The Oxford House model. *Evaluation and Program Planning*. 2012; 35(1): 47–53. DOI: 10.1016/j.evalprogplan.2011.06.006 [PubMed: 22054524]
- Clausen JM, Landsverk J, Ganger W, Chadwick D, Litrownik A. Mental health problems of children in foster care. *Journal of Child and Family Studies*. 1998; 7(3):283–296. DOI: 10.1023/A:1022989411119
- d'Arlach L, Curtis CE, Ferrari JR, Olson BD, Jason LA. Substance-abusing women and their children: A cost-effective treatment option. *Journal of Social Work Practice in the Addictions*. 2006; 6:71–90. DOI: 10.1300/J160v06n04_05
- d'Arlach L, Olson BD, Jason LA, Ferrari JR. Chapter 11: Children, women, and substance abuse: A look at recovery in a communal setting. *Journal of Prevention & Intervention in the Community*. 2006; 31(1/2):121–131. [PubMed: 16595392]
- Davis MI, Dziekan MM, Horin EV, Jason LA, Ferrari JR, Olson BD. Chapter 12: Women leadership in Oxford House: Examining their strengths and challenges. *Journal of Prevention & Intervention in the Community*. 2006; 31(1/2):133–143. [PubMed: 16595393]
- Droege JR, Stevens EB, Jason LA. Children's impact on adults' substance use problem awareness and treatment optimism: The role of harm. *Journal of Drug Education*. 2015; 45(3–4):185–194. DOI: 10.1177/0047237915612172 [PubMed: 26499316]

- Fals-Stewart W, Fincham FD, Kelley ML. Substance-abusing parents' attitudes toward allowing their custodial children to participate in treatment: A comparison of mothers versus fathers. *Journal of Family Psychology*. 2004; 18(4):666–671. DOI: 10.1037/0893-3200.18.4.666 [PubMed: 15598172]
- Flores, PJ. *Addiction as an attachment disorder*. Lanham, MA: Jason Aronson; 2004.
- Gordon, AT. Unpublished doctoral dissertation. Houston Baptist University; Houston, TX: 2011. Assessing social support for children: Development and initial validation of the Social Support Questionnaire for Children.
- Grant BF, Stinson FS, Dawson DA, Chou SP, Dufour MC, Compton W, Kaplan K. Prevalence and co-occurrence of substance use disorders and independent mood and anxiety disorders: Results from the national epidemiologic survey on alcohol and related conditions. *Archives of General Psychiatry*. 2004; 61(8):807–816. DOI: 10.1001/archpsyc.61.8.807 [PubMed: 15289279]
- Grella C, Scott C, Foss M, Joshi V, Hser V. Gender differences in drug treatment outcomes among participants in the Chicago Target Cities Study. *Evaluation and Program Planning*. 2003; 26:297–310.
- Hairston CF. The forgotten parent: Understanding the forces that influence incarcerated fathers' relationships with their children. *Child Welfare*. 1998; 77(5):617–639. [PubMed: 9744076]
- Harden BJ, Clyman RB, Kriebel DK, Lyons ME. Kith and kin care: Parental attitudes and resources of foster and relative caregivers. *Children and Youth Services Review*. 2004; 26(7):657–671.
- Hogan DM. The psychological development and welfare of children of opiate and cocaine users: Review and research needs. *Journal of Child Psychology and Psychiatry*. 1998; 39(05):609–620. [PubMed: 9690925]
- Jason, LA., Olson, BD., Foli, K. *Rescued lives: The Oxford House approach to substance abuse*. New York, NY: Routledge; 2008.
- Kjellstrand JM, Eddy JM. Parental incarceration during childhood, family context, and youth problem behavior across adolescence. *Journal of Offender Rehabilitation*. 2011; 50(1):18–36. [PubMed: 21423568]
- Kim KL, Davis MI, Jason LA, Ferrari JR. Structural social support: Impact on adult substance use and recovery attempts. *Journal of Prevention & Intervention in the Community*. 2006; 31(1/2):85–94. http://dx.doi.org/10.1300/J005v31n01_08. [PubMed: 16595389]
- Legler R, Chiaramonte D, Patterson M, Allis A, Runion H, Jason LA. The effects of children on the process of recovery in Oxford Houses. *Journal of Applied Medical Sciences*. 2012; 1:41–50. [PubMed: 23875179]
- Mark TL, Woody GE, Juday T, Kleber HD. The economic costs of heroin addiction in the United States. *Drug and Alcohol Dependence*. 2001; 61(2):195–206. [PubMed: 11137285]
- McGue M, Sharma A, Benson P. Parent and sibling influences on adolescent alcohol use and misuse: Evidence from a U.S. adoption cohort. *Journal of Studies on Alcohol*. 1996; 57:8–18. <http://dx.doi.org/10.15288/jsa.1996.57.8>. [PubMed: 8747496]
- McIntosh J, McKeganey N. Addicts' narratives of recovery from drug use: Constructing a non-addict identity. *Social Science & Medicine*. 2000; 50:1501–1510. [PubMed: 10741584]
- McKeganey N, Barnard M, McIntosh J. Paying the price for their parents' addiction: Meeting the needs of the children of drug-using parents. *Drugs: Education, Prevention and Policy*. 2002; 9(3): 233–246. <http://dx.doi.org/10.1080/09687630210122508>.
- Murray J, Farrington DP, Sekol I. Children's antisocial behavior, mental health, drug use, and educational performance after parental incarceration: A systematic review and meta-analysis. *Psychological Bulletin*. 2012; 138(2):175–210. DOI: 10.1037/a0026407 [PubMed: 22229730]
- National Institute on Drug Abuse. *Principles of drug addiction treatment: A research-based guide*. Rockville, MD: Author; 2000.
- Ortiz E, Alvarez J, Jason LA, Ferrari JR, Groh D. Abstinence social support: The impact of children in Oxford House. *Journal of Groups in Addiction & Recovery*. 2009; 4:71–81. [PubMed: 20827390]
- Osika W, Friberg P, Wahrborg P. A new short self-rating questionnaire to assess stress in children. *International Journal of Behavioral Medicine*. 2007; 14(2):108–117. DOI: 10.1007/BF03004176 [PubMed: 17926439]

- Pettit B, Western B. Mass imprisonment and the life course: Race and class inequality in US incarceration. *American Sociological Review*. 2004; 69(2):151–169. DOI: 10.1177/000312240406900201
- Pietkiewicz I, Smith JA. A practical guide to using interpretative phenomenological analysis in qualitative research psychology. *Psychological Journal*. 2014; 20(1):7–14. DOI: 10.14691/CPPJ.20.1.7
- Taxy, S., Samuels, J., Adams, W. Drug offenders in federal prison Estimates of characteristics based on linked data. Washington, DC: US Department of Justice, Bureau of Justice Statistics; 2015.
- Timp P, Price T, Salina D, Witek C, Pommer N, Jason LA. Women leaders in Oxford House. *Journal of Addictive Behaviors, Therapy & Rehabilitation*. 2014; 3(2)doi: 10.4172/2324-9005.1000119
- Tracy EM, Martin TC. Children's roles in the social networks of women in substance abuse treatment. *Journal of Substance Abuse Treatment*. 2007; 32(1):81–88. DOI: 10.1016/j.jsat.2006.06.008 [PubMed: 17175401]

Table 1

Descriptive frequencies of parent and child Oxford House population.

Variable	M (SD)	Range
Age		
Child	13.42 (4.94)	9–23
Parent	36.83 (7.92)	28–54
<i>Recovery length (months)</i>	41.33 (37.06)	12–120
<i>Hours work per week</i>	36.42 (6.20)	28–43

Table 2

Social Support Questionnaire for Children (SSQC) descriptive statistics.

Subscale		<i>n</i>	<i>M</i>	<i>SD</i>
SSQC: OH Resident	Parents	11	29.55	5.85
	Children	12	26.58	8.27
SSQC: Parent	Parents	11	15.36	11.27
	Children	12	29.33	5.50
SSQC: Friend	Parents	11	29.18	6.40
	Children	12	25.67	7.85
SSQC: Relative	Parents	11	21.45	11.67
	Children	12	26.58	5.60
SSQC: Adult	Parents	11	28.00	6.00
	Children	12	28.17	6.35

Note. OH = Oxford House.