An Exploration of the Factors Influencing Parental Self-Efficacy for Parents Recovering From Substance Use Disorders Using the Social Ecological Framework

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Background: The evidence strongly links parental self-efficacy (PSE) to parenting behaviors and child health outcomes.

Purpose: The purpose of this article is to apply the social ecological model to the exploration of contextual factors that influence PSE for parents recovering from substance use disorders (SUDs).

Methods: An integrative review of the literature was conducted on PSE, parenting behaviors, and parents recovering from alcohol and other SUDs through the application of the social ecological model.

Results: The results indicated that there are many individual, interpersonal, and environmental variables that influence PSE for parents with or without addiction.

Conclusions: Because PSE is a strong predictor of parenting behaviors and child health outcomes, interventions designed to improve PSE may improve the overall health outcomes of families affected by SUD. These interventions would need to address intrapersonal factors of guilt and shame associated with addiction, parenting knowledge (individual), social support (interpersonal), social networking of church, and other community support programs. The integral role of community support, multiagency collaboration (organizational), and national policies (policy) impacting funding for SUD should also be considered. Intervening on multiple ecological systems simultaneously can mitigate negative factors predictive of PSE, improve access to healthcare and service delivery, and transform and sustain positive behavioral changes for parents recovering from SUD.

Keywords: addiction, parental efficacy, parental self-efficacy, parents with substance use disorders, self-efficacy, social ecological model, substance abuse, substance abusers

A recent survey indicated that over 8 million children lived with at least one parent who was dependent on alcohol or illicit drugs (Substance Abuse and Mental Health Services Administration [SAMHSA], 2009). Parental substance use disorder (SUD) is a major risk factor for negative health outcomes for children (Child Welfare Information Gateway, Administration for Children and Families, U.S. Department of Health and Human Services, 2009). These findings coupled with the national estimated economic impact of illegal drug use at $193 billion (SAMHSA, 2011a) support the need for effective parenting interventions that promote drug abstinence and recovery efforts for parents with SUD. According to Arria, Moe, and Winters (2010), there is great potential for clinicians to target parents in recovery for early intervention initiatives that seek to mitigate the intergenerational transmission of alcohol and other drug problems by modifying parenting behaviors. These initiatives would need to address the personal and environmental factors that influence perceived parenting capability (parental self-efficacy [PSE]) and parenting behaviors during the recovery process (Arria et al., 2010).

Evidence strongly links PSE to parenting behaviors and child health outcomes (Coleman & Karraker, 2000; Sevigny & Loutzenhiser, 2010; Shumow & Lomax, 2002). Higher PSE levels are generally associated with better parent and child health outcomes, whereas lower PSE levels are associated with poorer parent and child health outcomes (Coleman & Karraker, 2000; Jones & Prinz, 2005). Bandura’s theory of cognitive learning states that self-efficacy is fundamentally necessary in order for an individual to learn a behavior and make a change (Bandura, 1982). According to Bandura, “efficacy in dealing with one’s environment is not a fixed act or simply a matter of knowing what to do. Rather, it involves a generative capability in which cognitive, social, and behavioral skills must be organized into integrative courses of action to serve innumerable purposes” (p. 122). Thus, a parent must possess a firm belief
in his or her parenting capabilities to produce effective parent- 
ing behaviors (Bandura, 1982).

Parents recovering from SUD experience unique and com- 
plex challenges that should be considered both contextually 
and independently (Kendler, Prescott, Myers, & Neale, 2003; 
Wilke, Kamata, & Cash, 2005). PSE, when connected to SUD 
in the literature, was often examined within the context of child 
outcomes associated with maternal drug use or nonuse (Beatty, 
Cross, & Shaw, 2008; Gance-Cleveland, Mays, & Steffen, 2008; 
Jones & Prinz, 2005). There has been relatively little research 
done on paternal self-efficacy in recent decades (Murdoch, 
2012), and no research has been found that explicitly names 
factors contributing to PSE for parents (men or women) recov- 
ering from SUD. However, there have been personal and 
environmental factors identified for mothers and fathers with 
a history of SUD that have influenced parenting behaviors, 
and these influences will be examined for their potential effect 
on PSE (Bennett, 1995; Cannon, Lubar, & Baldwin, 2008; 
Kendler et al., 2003; Rhodes, Bernays, & Hournoller, 2010). 
The purpose of this article is to present the results of an inte- 
grative review of the personal and ecological factors, guided 
by the social ecological framework (SEM), that may influence 
PSE for parents recovering from SUD.

CONCEPTUAL DEFINITIONS: PSE, SUD, 
AND RECOVERY

For the purposes of this review, PSE is conceptually defined 
as a personal belief or judgment regarding one’s perceived abil- 
ity to exercise positive influence on the development and 
behavior of one’s children through competent organized parent- 
ing behaviors (Coleman & Karraker, 1997; de Montigny & 
Lacharité, 2005). SUDs are conceptually framed within the 
broad DSM IV classification that includes both substance 
abuse and substance dependence of any one or several catego-
ries of addictive substances including alcohol, prescription, 
and illicit drugs (Grant, 2004; Wilke et al., 2005).

There are few studies regarding the prevalence and pro-
cesses of recovery in the general population and for parents 
in particular (White, Arria, & Moe, 2011). According to Arria 
et al. (2010), there is a paucity of research that addresses the 
changes in the family environment when one or both parents 
are in recovery, and few studies have evaluated the impact of 
recovery on child functioning. Recovery is conceptually framed 
by the SAMHSA as “a process of change through which indi-
viduals improve their health and wellness, live a self-directed 
life, and strive to reach their full potential” (2011). SAMHSA’s 
Administrator, Pamela S. Hyde, remarked that a working de-
inition of recovery allows policy makers, clinicians, researchers, 
and others involved with this population to better develop, test, 
and measure interdisciplinary and comprehensive interven-
tions designed to promote health to those in need of these 
services (SAMHSA, 2011b).

THEORETICAL FRAMEWORK

Perceived efficacy is developed from four principal sources 
of information (Bandura, 1982). These sources are the follow-

SEM

An appropriate framework for exploring the multiple factors 
influencing health behavior is the SEM, which proposes that 
human development takes place through constant interchange 
between the individual and his or her environment (Bronfenbrenner, 
1994). These dynamic processes vary based on the character-
isics of the developing individual, the state of the immediate 
and remote environment, and the nature of the specific devel-
mental outcomes (Bronfenbrenner, 1994). The ecological 
environment is categorized into four levels: the microsystem, 
mesosystem, exosystem, and macrosystem (Bronfenbrenner, 
1994). The SEM systems convey the idea that changes in one’s 
more immediate (microsystem and mesosystem) and more dis-
tant (exosystem and macrosystem) social environment influ-
ence changes in an individual’s personal development and 
behavioral patterns (Bronfenbrenner, 1994).

The ecological factors that can influence PSE for parents in 
recovery require consideration for the development of effec-
tive interventions to improve health behavior patterns in this 
population. Ideally, change should occur at multiple levels 
of the SEM to promote positive health outcomes for an indi-
vidual (Glanz & Bishop, 2010). According to the National 
Institutes of Health (2009), researchers designing and testing 
terventions cannot overlook the personal, social, and envi-
ronmental factors that influence individual decision making 
regarding health and “conditions under which knowledge 
leads to action versus inaction” (p. 3). Ecological systems broadly 
categorized as microsystem, mesosystem, exosystem, and mac-
rosystem emphasize multiple levels of influence taking place 
at the individual, interpersonal, organizational, community, 
and policy levels (Glanz & Bishop, 2010; McLeroy, Bibeau, 
Steckler, & Glanz, 1988) The purpose of this review is to apply 
the five levels of ecological influence utilizing the SEM fram-
work to explore factors influencing PSE for parents in recovery 
from SUD.

MATERIALS AND METHODS

A process of integrative review of the literature was employed 
to identify factors that may influence PSE directly or indirectly 
for recovering parents (Whitemore & Knafl, 2005). This re-
view included a sample of studies, published from 1990 to 
2012 within the Cumulative Index for Nursing and Allied 
Health, PsycInfo, PubMed, and Google Scholar databases. 
One classic study published before 1990 was also included.
The initial search using the search term phrases social ecological model and parental self-efficacy, social ecological model and perceived parental efficacy, parental self-efficacy and parents and substance abuse and recovery, or parental self-efficacy and substance abusers yielded no relevant results. The author expanded the search using broader keywords: perceived parental efficacy, parental self-efficacy and health behavior, self-efficacy and substance abuse, and alcohol and drugs and parental self-efficacy. Subject headings included parents, parenting, self-efficacy, parental attitudes, and substance abuse. This search strategy yielded 69 articles. Inclusion criteria for in-depth review were full-text articles and reference and abstract availability. Articles were included if the research identified SUD factors that could potentially influence parenting beliefs and behaviors or factors that generally predicted PSE. Source types were academic journals and periodicals. In addition to database searches, per the Whitemore and Knaf (2005) method of integrative review, journal hand searching, cross-searching, networking, and a review of reference lists of relevant articles yielded additional articles for consideration. Studies were excluded if they were not written in English, if they discussed PSE only within the context of child outcomes, and if the study excluded potential factors that influenced PSE or parenting behaviors.

The final search yielded 34 relevant articles after the application of inclusionary criteria. A matrix was created to facilitate organization and analysis of the studies selected for inclusion. Studies were analyzed utilizing the Critical Appraisal Skills Programme (n.d.) Checklist, and study findings were categorized using the SEM framework. The main objective of the integrative review was to identify factors that may influence PSE for parents with a history of SUD.

RESULTS
All studies addressed personal and/or ecological factors that may influence PSE or parenting behaviors. The majority (16) of the studies reviewed were quantitative designs using surveys, instruments, direct observation, parent reporting, and medical charts for data collection (Bondy & Mash, 1999; Cannon et al., 2008; Copenhaver, Lee, Merz-Beyus, & Faghri 2010; Fife, McCreary, Brewer, & Adegoke, 2011; Kendler et al., 2003; Le & Lambert, 2008; Leerkes & Crockenberg, 2002; Montgomery, Burlew, Kosinski, & Forcehimes, 2011; Murdock, 2012; Raver & Leadbeater, 1999; Salo et al., 2009; Sevigny & Loutzenhiser, 2010; Shumow & Lomax, 2002; Teti & Gelfand, 1991; Wilke et al., 2005). Eight studies provided information about the conceptual framing of SEM or PSE (Bandura, 1982; Bronfenbrenner, 1994; Coleman & Karraker, 1997, 2000; de Montigny & Lacharité, 2005; Glanz & Bishop, 2010; Jones & Prinz, 2005; Locke & Bandura, 2003). Eight studies used a qualitative method to collect data from sample groups (Baldwin, Rawlings, Marshall, Conger, & Abbott, 1999; Bennett, 1995; Campbell-Grossman, Hudson, Keating-Leffler, & Fleck, 2005; Carter, 1996; Coyer, 2001, 2003; Erhmin, 2001; Rhodes et al., 2010). One article was used to examine how organizations could promote service delivery and improve health outcomes for parents with SUD (Green, Rockhill, & Burrus, 2008). Information regarding federal agencies and legislation addressing SUD, one substance abuse policy overview, and one public media study were used to examine the influence of macrosystems on PSE for parents with SUD (Eliason & Skinstad, 1995; Fornili & Burda, 2010; U.S. Department of Health and Human Services, 2012).

Individual/Intrapersonal Factors
Potential individual factors impacting PSE for parents recovering from SUD included general self-efficacy (GSE); neurophysiological changes associated with drug type, effects, and length of use; prior parental experience and parental identity; gender; socioeconomic status (SES); parenting knowledge; developmental history; physiological and emotional state (maternal stress, maternal guilt and shame); and sobriety maintenance (Bandura, 1982; Cannon et al., 2008; Coleman & Karraker, 1997; Coyer, 2001, 2003; de Montigny & Lacharité, 2005; Erhmin, 2001; Montgomery et al., 2011; Sevigny & Loutzenhiser, 2010). The literature substantiates that substance-abusing mothers typically have limited intrapersonal resources for maintaining their personal health or the health of their children (Aday, 2001; Coyer, 2001; Erhmin, 2001; Shumow & Lomax, 2002). Mothers in recovery from SUD commonly experience lower SES and lower educational attainment and report higher levels of dysfunctional developmental histories (i.e., physical, emotional, or sexual abuse or neglect as children), prolonged stress, and often, lower levels of motivation (Coyer, 2001; Eliason & Skinstad, 1995; Wilke et al., 2005). In addition, studies indicate these limited individual resources are associated with high rates of depression among recovering individuals (Baldwin et al., 1999; Eliason & Skinstad, 1995; Wilke et al., 2005).

GSE has been described as a dynamic and constantly evolving personality construct influenced by intrapersonal factors, situational demands, and task changes (Coleman & Karraker, 1997). Studies have shown that GSE is a predictor for maternal self-efficacy (MSE; Sevigny & Loutzenhiser, 2010) as well as paternal self-efficacy (Murdock, 2012). Murdock concluded that parental competence is important for both maternal and paternal self-efficacy as MSE was predicted by hostile or coercive parenting behaviors and child behavior problems, whereas supportive parenting behaviors emerged as a predictor variable for paternal self-efficacy. Gender differences called for specialized interventions that would improve self-efficacy for each parent group (Murdock, 2012). Although both of these studies had homogenous sampling of married parents with no identified substance abuse, GSE may still be a strong factor influencing PSE for the parent in recovery. As Coleman and Karraker (1997) pointed out, “stressful circumstances draw more heavily on all parental resources, including those of a cognitive nature; therefore, logically one would expect that, under duress, self-efficiency would exert a greater impact on parenting quality” (p. 62).

Neurophysiological changes resulting from the type, length of time, and amount of drug use may influence PSE for these parents. In one study, results showed that mean scores regarding personal beliefs about one’s self and abilities were significantly
different for recovering substance abusers (RSAs) in all five assessment indexes (e.g., physical, emotional, and/or sexual abuse; depression; familial history; forlornness; and inadequacy). According to Cannon et al. (2008), one can conclude that “the overall trend is negative for the RSA group and this group reports significantly more instances (real or imagined) of abuse, neglect, inadequacy and forlornness than controls” (p. 232). This research is important in assessing factors contributing to relapse for RSAs as it relates to perceived personal beliefs about one’s capabilities. It also serves to provide critical information regarding the functional relationship of cortical regions in addiction (Cannon et al., 2008).

One study, which used the SEM framework to explore accountability for alcoholism in families, noted that families focused more on the negative behavior of the alcoholic when under the influence than how the problem originated (Bennett, 1995). Particularly, troubling alcoholic behaviors that were identified consisted of not completing tasks that he or she was expected to complete, doing perceived meddling or unpleasant behaviors, and taking on an unlikeable disposition when intoxicated (Bennett, 1995). Negative parental experiences not only led to negative thoughts about parental identity but also contributed to the ongoing vicious cycle of addiction. One father who participated in this study described himself as “totally irresponsible. It was a vicious circle. When I sobered up, I had guilty feelings about neglecting my wife and the kids, and then I drank some more” (Bennett, 1995).

Parental blame, guilt, and shame associated with addiction and relapse were commonly reported in the literature and may affect PSE for the parent in recovery (Bennett, 1995; Ehrmin, 2001; Rhodes et al., 2010). These parents frequently worried about the effect of their addiction on their children’s health and tended to blame themselves for any negative effects (Bennett, 1995; Coyer, 2001; Ehrmin, 2001). Ehrmin (2001) noted that unresolved feelings of guilt and shame associated with perceived failure in the maternal role during active addiction were a critical issue and possible barrier to successful treatment for a sample of African American women in a residential treatment program.

Just as addiction had a powerful negative influence on parenting behaviors, reported findings suggested that the opposite may be so with length of sobriety over time. Mothers particularly have reported improvement in perceived parenting beliefs and behaviors after they stopped using drugs. One mother in Coyer’s (2001) sample reported: “I remember times that I couldn’t get up because I was tired. I couldn’t do none of the things I can do now…. It feels good to get up and see my kids off to school…. I feel like a mother now” (p. 47).

Mothers with a history of SUD have reported negative developmental history that affected the way they perceived themselves (Coyer, 2001; Eliason & Skinstad, 1995; Wilke et al., 2005). Many report dysfunctional families of origin where parental drug use, abuse, and neglect were experienced. In Coyer’s (2001) sample, all mothers identified low self-esteem described as lack of emotional support, abuse, and perceived inequity of treatment in their family of origin. With childhood experiences of dysfunctional family dynamics and poor parental modeling, these parents reported lack of knowledge about effective parenting skills and age-appropriate developmental needs of children (Coyer, 2003; Eliason & Skinstad, 1995).

Lastly, the physical and emotional state of parents in recovery influenced PSE. The conditions particularly identified for the recovering parent included low self-esteem, guilt, shame, depression, addiction, relapse, poverty, and sobriety (Baldwin et al., 1999; Teti & Gelfand, 1991; Wilke et al., 2005). Influences of maternal depression, social–marital supports, and perceptions of infant temperament were mediated by MSE (Teti & Gelfand, 1991). In Teti and Gelfand’s (1991) study, MSE was significantly related to maternal behavioral competence, independent of the effects of other mother variables. More importantly, when the effects of self-efficacy were controlled, there were no longer significant correlations between parenting competence and social–marital supports, or maternal depression (Teti & Gelfand, 1991). The authors concluded that MSE mediated the relationship between maternal competence and other psychosocial variables including maternal depression. Building on the Teti and Gelfand (1991) results, Le and Lambert (2008) found that maternal depression was the only significant predictor of MSE at 12 months postpartum for 40 low-income Latina mothers at high risk for depression. In this case, maternal depression was predictive over all other cultural and contextual variables.

Studies suggested that several intrapersonal factors influenced parenting behaviors for adults in recovery. Mothers with SUD typically have limited intrapersonal resources (i.e., GSE, positive modeling, parenting knowledge, and healthy physical and emotional state) necessary for maintaining personal health or the health of their children (Coyer, 2001; Ehrmin, 2001; Gewirtz et al., 2009; Shumow & Lomax, 2002). There is much less in the literature on individual characteristics predictive of paternal self-efficacy, although three studies were found that identified ecological factors for both parents (Bennett, 1995; Murdock, 2012; Sevigny & Loutzenhiser, 2010). Please see Table 1 for the results of factors influencing PSE for parents recovering from SUD using the SEM model.

### Interpersonal Resources

Interpersonal resources, which include social support, familial relationships, religious involvement, living arrangements with children, and child characteristics, may significantly influence PSE for parents in recovery. Parenting stress and family relational functioning (i.e., intimate partner relationship satisfaction, family functioning) emerged as significant predictors of PSE in fathers of toddlers, whereas GSE and relational functioning predicted PSE for mothers (Sevigny & Loutzenhiser, 2010). Raver and Leadbeater (1999) conducted a study nearly a decade previously to explore MSE for mothers of toddlers in the ecological context of poverty (Raver & Leadbeater, 1999). The results of the research suggest that higher MSE was associated with reduced risks for women experiencing higher parent–child conflict levels. The child’s
<table>
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<tr>
<th>SEM Level</th>
<th>SEM Level Focus</th>
<th>Factors Influencing PSE</th>
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<tbody>
<tr>
<td>Individual/intrapersonal</td>
<td>Knowledge, self-concept, attitudes, behaviors, skills, developmental history</td>
<td>• Chronic stress</td>
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<td>• Socioeconomic status</td>
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<td>• Depression</td>
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<td>• Level of education</td>
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<td>• Parenting satisfaction</td>
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<td>• Neurophysiological changes</td>
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<td>• Physiological and emotional state (maternal stress, maternal guilt and shame)</td>
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<td>• Parental identity</td>
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<td>• Gender</td>
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<td>• Sobriety</td>
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<td></td>
<td>• General self-efficacy</td>
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<td>(Cannon et al., 2008; Carten, 1996; Coleman &amp; Karraker, 1997, 2000; Coyer, 2003, 2001; Ehrmin, 2001; Eliason &amp; Skinstad, 1995; Jones &amp; Prinz, 2005; Kendler et al., 2003; Le &amp; Lambert, 2008; Leekes &amp; Crockenberg, 2002; Montgomery et al., 2011)</td>
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<tr>
<td>Interpersonal</td>
<td>Formal and informal social network and support systems (i.e., family, coworkers, peers, and friends)</td>
<td>• Spousal and family dynamics</td>
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<td>• Child behavioral patterns and temperament</td>
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<td>• Social support networks</td>
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<td>• Living arrangements with children</td>
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<td>(Bennett, 1995; Bondy &amp; Mash, 1999; Copenhaver et al., 2010; Coleman &amp; Karraker, 1997, 2000; Coyer, 2003, 2001; Eliason &amp; Skinstad, 1995; Fife et al., 2011; Leekes &amp; Crockenberg, 2002; Murdock, 2012; Raver &amp; Leadbeater, 1999; Rhodes et al., 2010; Sevigny &amp; Loutzenhiser, 2010; Shumow &amp; Lomax, 2002; Teti &amp; Gelfand, 1991; Wilke et al., 2005)</td>
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<tr>
<td>Organizational</td>
<td>Social institutions and organizational characteristics (e.g., churches, worksites, schools, healthcare settings)</td>
<td>• Interagency collaboration among child welfare, criminal justice, and health care</td>
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| | | |... (Continued)
temperamental difficulty was inversely related to low MSE levels with lower levels of parent–child conflict (Raver & Leadbeater, 1999).

Living arrangements with children also influenced self-efficacy for recovering parents. Parents in recovery, particularly from injection drug use who lived with their children, showed improved sex-related HIV knowledge and self-efficacy to reduce sex-related HIV activities as opposed to those parents not living with their children. Gender factor coupled with living arrangement resulted in improved social and personal motivation to reduce HIV risk among fathers who lived with their children as opposed to those who did not (Copenhaver et al., 2010). Mothers showed an exact opposite pattern, thus indicating possible differences in motivation based on gender. The authors concluded that residing with children may affect parents recovering from injection drug use; personal motivation to reduce drug-related HIV risk was different for male and female parents (Copenhaver et al., 2010).

Support systems and family practices can influence PSE for parents recovering from SUD. Dysfunctional families often report disorganized family rituals or routines (Fife et al., 2011). Results indicated a significant inverse relationship between overall family rituals (religious and nonreligious rituals) and substance use such that minority women in the study who practiced more family rituals reported using fewer drugs (Fife et al., 2011). Participants who attended church regularly with their families were less likely to use drugs. Overall, mental health problems and its severity were predictors of MSE (Fife et al., 2011).

Community Factors
Community resources play a key role in creating an environment that fosters positive or negative health behaviors among groups of people. Support from community leaders and access to programs that support recovery efforts may improve PSE for recovering parents. The literature strongly identifies social support in the community as a significant factor for positive outcomes for parents recovering from SUD (Baldwin et al., 1999; Campbell-Grossman et al., 2005; Eliason & Skinstad, 1995; Groh et al., 2008; Montgomery et al., 2011; Wilke et al., 2005). Although the idea of social support can be positive in many cases, the social networks for substance users before recovery (pretreatment) are often harmful and can greatly hinder an individual’s recovery efforts (Groh, Jason, & Keys, 2008).

Alcoholics Anonymous (AA) is identified as one recovery-related social support within the community (Groh et al., 2008). Social support was categorized and discussed in terms of four dimensions: structural, functional, general, and specificity (recovery helping). Structural support was defined as the dimension of social support that includes the number

<p>| TABLE 1 Factors Influencing Parental Self-Efficacy (PSE) for Parents in Recovery From Substance Use Disorders (SUD) Using the Socioecological Model (SEM), Continued |
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<th>SEM Level</th>
<th>SEM Level Focus</th>
<th>Factors Influencing PSE</th>
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<tr>
<td>Community</td>
<td>Relationships among organizations, institutions, and informal networks within defined boundaries; community norms</td>
<td>• Neighborhood quality</td>
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<td>• Community resources</td>
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<td>• Community access to programs that support recovery efforts</td>
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<td>• Engagement of community leaders</td>
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<td>(Baldwin et al., 1999; Campbell-Grossman et al., 2005; Eliason &amp; Skinstad, 1995; Groh et al., 2008; Montgomery et al., 2011; Wilke et al., 2005)</td>
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<tr>
<td>Policy</td>
<td>Local, state, and national laws and policies</td>
<td>• Policy focus and funding on drug supply or drug demand reduction</td>
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<td>• Policy regarding parental SUD and child placement</td>
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<td>• Societal attitudes</td>
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<td>• Race and ethnicity bias</td>
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and different types of relationships available to an individual. Functional support addresses the extent to which support members provide meaningful assistance to each other (Groh et al., 2008). General support broadly promotes overall well-being and health, whereas specificity support is directly connected to certain functions to promote individual outcomes (recovery helping, substance use or abstinence; Groh et al., 2008). AA had the greatest impact on friend networks but had less influence on family member networks. Consequently, individuals with reported harmful community networks that supported substance use benefited the most from AA involvement (Groh et al., 2008).

**Organizational Resources**

Organizational collaboration (i.e., criminal justice system, health organizations, and child welfare services) has been found to support individual behavioral change among families affected by SUD. Green et al. (2008) explored organizational challenges by interviewing key representatives from three agencies working with families affected by SUD. Collaboration was shown to have at least three major beneficial functions: building shared value systems, improving communication, and providing a support team for parents affected by SUD. Each function leads to different kinds of benefits for families as well as providers.

Despite these benefits to families, providers within each system continued to struggle with effective collaborations because of deep mistrust and lack of understanding of other systems’ values, goals, and perspectives. Other barriers included client confidentiality, logistical and resource concerns, time pressures imposed by legislation, and staff turnover among treatment providers. Future implications were directed toward gathering the clients’ perspectives of benefits and barriers in collaborative networks and the need to determine the most effective collaborative networks for this population (Green et al., 2008).

**Policy**

National policy and funding associated with SUD, societal attitudes regarding parenting and addiction, and ethnicity may influence PSE for parents recovering from SUD. In this section, the influence of U.S. policy, public opinions, and ethnicity on PSE was explored for the recovering parent.

The U.S. government currently uses a program called Healthy People 2020 to support national and state efforts to improve the health of populations (Department of Health and Human Services, 2012). Two of the top 12 “leading health indicators” focus on behavioral health outcomes (SUD and mental health; Department of Health and Human Services, 2012). According to this program’s report, SUD is associated with many destructive social conditions affecting family finances, work performance, intimate partner violence, poor child outcomes, and crime. Both social attitudes and legal responses to SUD make it one of the most complex public health issues facing American society (Department of Health and Human Services, 2012).

Although the burden of SUD is recognized as a national problem, legislation has typically focused on law enforcement to address the issue. According to Fornili and Burda (2010), scientific evidence supports expanded health service delivery and evidenced-based interventions to prevent and treat SUD. However, drug control efforts have historically placed more emphasis on law enforcement and legal sanctions as viable methods of drug control as opposed to substance abuse treatment and prevention programs. This is evidenced by the percent of funding resources allocated in the national budget for each of those priorities (Fornili & Burda, 2010).

Societal attitudes about addiction and mothering may also influence PSE. A literature review conducted by Eliason and Skinstad (1995) explored societal myths about women as substance abusers and described barriers to effective parenting for women who experience addictions. The societal myths included the notion that all women abusing substances are poor and women of color, promiscuous, and incapable of caring for their children. The general devaluing of the role of motherhood was also identified as a barrier to successful parenting:

Since women are supposed to be good mothers, the actual skills and practices of mothering are devalued and largely made invisible. That is, unless the mother is thought to be a “bad woman.” Women who have made themselves visible by violation of societal expectations (prostitutes, alcohol/drug addicts, women who need public assistance…) are automatically assumed to lack any positive mothering skills. To be “deviant” from societal gender role expectations means to be a bad parent (Eliason & Skinstad, 1995, p. 86).

Race and ethnicity may influence MSE for mothers recovering from SUD. According to Carten (1996), crack cocaine had a devastating impact on mothers and women of child-bearing age particularly in urban communities in the United States in the 1980s. Crack cocaine use quickly escalated during this time, and the number of child protective services reports increased significantly. These reports were clustered around the city’s impoverished neighborhoods, and the majority involved families headed by single women of color (Carten, 1996). The adverse consequences of drug use are reported in greater numbers in the African American community than in other ethnic groups, although substance abuse is generally widespread (Eliason & Skinstad, 1995). Although SUD is not determined by gender, race, ethnicity, or SES, the problem tends to be less visible among middle- and higher-income parents as they generally give birth in private hospitals that rarely screen for illicit drug use (Carten, 1996; Eliason & Skinstad, 1995).

**DISCUSSION**

Parents with SUD are particularly vulnerable because of their priority health needs. As individual responsibility and perceived poor choices have historically been society’s rationale...
for SUD (Mechanic & Tanner, 2007), it is not surprising to see the high numbers of articles contributing intrapersonal factors to health behaviors for parents in recovery. Interventions designed to improve PSE should consider the biological, physical, and psychosocial challenges of these parents and develop interventions designed to promote protective factors that will improve PSE. Positive social support, ongoing sobriety, access to health care, religious and nonreligious rituals, and living arrangements with children have been identified as protective ecological factors that may positively affect PSE, thus improving parent and child outcomes.

Community support and parental access to tangible resources are critical for these vulnerable families. From an organizational perspective, interagency collaboration and seamless processes facilitate long-term behavioral changes associated with recovery and positive parenting outcomes. Social attitudes and government responses to SUD pose an additional challenge to this complex public health issue. Clinicians should advocate and inform policy at the national, state, and organizational levels about evidence-based interventions that improve health outcomes for these vulnerable parents.

As with any method of literature review, limitations exist. This search was primarily limited to available full-text articles. The method for determining relevant articles may have contributed to an exclusion of other clinically relevant articles applicable to both population and subject matter. Key phrases used in published articles in computer databases may have been inconsistently applied, thus yielding unrepresentative samples.

GAPS IN THE LITERATURE AND IMPLICATIONS FOR RESEARCH AND PRACTICE

There were no studies found that named factors contributing to PSE for parents in recovery from SUD. There were also few studies that linked contextual factors to parenting behaviors for the parent in recovery. Little research has been conducted that examines factors influencing paternal self-efficacy. Parents recovering from SUD experience complex challenges that should be examined contextually (Arria et al., 2010). As these parents are excessively prone to guilt and shame, more information is needed regarding the moderating effects of guilt and shame on PSE for the recovering parent.

The need for future research directed toward developing and testing interventions to improve PSE for recovering parents is strongly supported by the results of this review. The review highlights the importance of simultaneously addressing multiple ecological factors in future investigations. Further research should explore whether guilt and shame, as moderating variables, improve with length of sobriety or positive child outcomes. Providing parenting education regarding age-appropriate child development and care may improve PSE and parenting capability.

More research is needed that includes knowledge gathering about the benefits of health partnerships with faith-based and community support groups in fostering long-term recovery goals for these families. Access to organizational and community resources could foster long-term sobriety contributing to higher PSE and improved parenting behaviors. Clinicians need to be proactive in lobbying for national and state-level policies that reflect evidenced-based practice. Collaboration and advocacy will positively influence macrosystem factors that contribute to poor health behaviors, ongoing SUD, and poor parenting practices. As this literature review produced very little information regarding paternal self-efficacy, future research should be directed toward exploration of factors that affect paternal self-efficacy and interventions that will improve perceived efficacy for fathers recovering from SUD.

CONCLUSIONS AND LIMITATIONS

This review of literature provides some promising directions for research and practice utilizing the SEM to explore PSE for parents recovering from SUD. Researchers and clinicians must consider the important role of PSE when working with these parents. Protective factors such as social support, education, access to health care, religious and nonreligious family rituals, and sobriety maintenance should be incorporated into their long-term recovery plan. Researchers and healthcare providers need to shift from crisis intervention to health promotion and prevention when addressing the health and social issues of this vulnerable population.

This review of literature explores the many ecological factors affecting PSE for parents recovering from SUD. The goal is to develop multilevel interventions based on the SEM framework that will improve PSE over time. These interventions will need to be tested and evaluated for their effectiveness in improving behavioral patterns for recovering parents. Most importantly, researchers and health providers need to provide access to tangible resources (education, support, collaboration) at all levels of the SEM.

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REFERENCES


