Parental Drug Abuse:
An Important Issue for Professionals Working With Children

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**Introduction**

Parental drug and alcohol abuse is an important issue, particularly for professionals working with children. Below is a discussion of some key issues related to parental drug abuse, in addition to some discussion on effective prevention and intervention techniques.

**Maternal Drug Use and Prenatal Development**

**Cigarettes**

 Since 1964, the Surgeon General has been advising against smoking cigarettes. Cigarettes are well know to have a myriad of health consequences (most notably cancer) and are the number one preventable cause of death in the United States. These serious health consequences extend to fetuses when mothers smoke during pregnancy.

 **Prenatal Impacts**

Smoking during pregnancy can cause tissue damage to the lung and brain of the fetus. In addition, prenatal smoking is correlated with the occurrence of cleft lips, and miscarriage. The lack of oxygen reaching the fetus could cause premature birth and low birth weight (Shoff & Yang, 2013). Smoking during pregnancy is also associated in with respiratory illness, obesity, diabetes, and cancer in the child (Pickett & Wakschlag, 2015). In addition, prenatal smoking can alter the formation, structure, and functionality of the brain. The child may be born with withdrawal symptoms (Eckblad, Korkeeila, & Lehtonen, 2015).

 Health complications continue for the newborn if the baby is exposed to secondhand smoke. For example, sudden infant death syndrome (SIDS) is three times more likely to occur if the child is frequently exposed to secondhand smoke. In addition, the child might develop weaker lungs (Schoff & Yang, 2013).

 **Risk Factors**

According to the 2011 Pregnancy Risk Assessment and Monitoring System (PRAMS), about 10% of women reported smoking during the last three months of pregnancy. Many women who smoke heavily during pregnancy live in stressful circumstances: they come from low socioeconomic statuses (SES), have low levels of education, are unemployed, single, often have other children, have depressive symptoms, and do not receive prenatal care until later than recommended (Shoff & Yang, 2013).

 There are also racial differences in the women who tend to smoke during pregnancy. Mexican American women, for example, were found to be almost three times more likely to quit smoking during pregnancy, compared with Caucasian Americans. African American women are less likely to quit smoking than Caucasians.

 **Prevention and Treatment**

 Social capital has been found to be a protective factor in maternal smoking during pregnancy (Shoff & Yang, 2013). Thus, teaching social capital to students and paving the way for upward social mobility could help prevent smoking. The Keep a Clear Mind (KACM) program is another effective preventative intervention against tobacco, alcohol and other drugs (NREPP, 2016).

 In working with the mother, there are pregnancy smoking cessation options. Some women choose a nicotine replacement program to quit during pregnancy. These programs, however, may not be effective because they could actually expose the fetus to higher levels of nicotine (Pickett & Wakschlag, 2015). The pregnant women could also receive psychosocial therapy, to gain coping skills and access to resources to help them quit smoking. Psychosocial therapy has been found to help women quit smoking and decrease the risk of low birthrate and premature births (Chamberlain et. al., 2013).

**Fetal Alcohol Syndrome (FAS)**

 Fetal alcohol exposure is the leading known cause of developmental disability and birth defect in the United States. FAS is a chronic condition experienced by individuals exposed to alcohol in the womb. Abnormalities include growth deficits, neurobehavioral disorders caused by alcohol’s impact on the central nervous system, and facial abnormalities. Individuals with FAS often have small eyelid openings, an upturned nose, a long upper lip, and a smaller head. FAS could be caused by maternal consumption of any amount of alcohol anytime during pregnancy. FAS, thus, could be caused by misinformation given to pregnant women about the risks of alcohol consumption. An important preventative measure is to disseminate information about the risks of drinking during pregnancy (NOFAS, 2007).

 Children with FAS are often developmentally delayed and may have difficulties with impulse control, memory, understanding social cues, balance, coordination, and are at an increased risk to be diagnosed with a learning disability NOFAS, 2007). FAS is can be treated with antidepressants, stimulants, neuroleptics, and anti-anxiety drugs. In addition, Behavior and Education Therapy has been found to be an effective treatment. This therapy might include friendship training, executive function training, parent-child interaction therapy, and parenting training (NREPP, 2016).

**Parental Alcoholism and Addiction**

Parental drug and alcohol use and abuse impacts multiple facets of a child’s life. Their family life is impacted, as is their social lives. They are put at an increased risk for additional adverse life experiences. Below is a discussion on Children of Addicts (COA’s).

**Family and School Life**

 COA’s often have a difficult family life. The behavior of their parents is often confusing and their parents may be either very affectionate or cold and dismissive. COA’s often blame themselves for their parent’s alcohol abuse and they often worry about their parents. These children often become parentified and may have to provide care for their parents (AAETS, n.d.). In addition, these children are at an increased risk for being abused or neglected (Lander, Howsare, & Bryne, 2013).

 COA’s also often struggle socially. These children may over rely on friendships, for example. Because of their sense of responsibility in their relationships with their parents, COA’s may become overly emotionally responsible in relationships and take on adult roles with others (Lander, Howsare, & Bryne 2013).

At school, these children sometimes delve into extracurricular activities and academics, making them frequently difficult to identify. Other COA’s, on the other hand, struggle at school. They are at an increased risk to be diagnosed with a learning disability, to repeat grades, and to drop out (AAETS, n.d.). These children may specifically struggle with the academic skills of abstraction and conceptual reasoning (NACoA, 2001).

**Risk Factors**

 COA’s are at an increased risk for physical and mental health difficulties and are three to four more times more likely to abuse alcohol or drugs themselves. They are also at an increased risk for sexual abuse. This could be in part because their lack of control in their relationship with their parents leads them to have an external locus of control, making them at an increased risk for choosing partners and friendsips with harmful behavior patterns (AAETS, n.d.).

**Addiction, Child Abuse, and Attachment**

As mentioned briefly above that parental alcoholism is associated with child neglect and maltreatment; 40-80 percent of child abuse cases involve caregiver substance abuse and COA’s are three times more likely to be physically, sexually, or emotionally abused and four times more likely to be neglected than their peers (National Council on Child Abuse and Family Violence). This is concerning, considering that 14% of children under two, 12% of children 6-11, and 10% of children 12-17 have at least one parent addicted to drugs or alcohol (Elements of Behavioral Health, n.d.). These rates of abuse lead to childhood trauma, neural damage, and attachment difficulties, putting them at an increased risk for mental illness and/or substance abuse.

**Protective Factors**

 Some COA’s may emotionally distance themselves from their alcoholic parents (such as the children who become submersed in academics and extracurricular activities). This is called adaptive distancing and it is associated with resilience and better adaptability. Children who adaptively distance are better equipped to understand that they are not the cause of the parent’s drinking and are less likely to become codependent with their alcoholic parent. It is positive to note that the majority of COA’s find long-term success and that three out of four COA’s do not develop an addiction (Bernard, 2004).

**Working with COA’s**

 Much of the important work with COA’s is geared at increasing the protective factors. Skill building interventions, for example, can help build resilience and assist children in developing self-care and emotional regulation skills, along with awareness of avenues to seek help. Other skills to cultivate include developing autonomy, social skills, appropriate helping skills, appropriate interpretations of experiences, ways to stay positive, and developing a relationship with an adult not involved in addiction (NACoA, 2001).

 In addition, one should provide COA’s with accurate, age appropriate information on alcoholism. They should be taught the ‘Seven C’s’: “I didn’t **cause** it, I can’t **cure** it, I can’t **control** it, I can help take **care** of myself by: **communicating** my feelings, making healthy **choices,** and **celebrating** me” (NACoA, 2001).

 Finally, COA’s should be connected with resources. Adolescents could be connected to the local Alateen groups, for social support and education on addiction. In addition, students could be connected with developmentally appropriate literature and movies on alcoholism and addiction (NACoA, 2001). A great resource for activity ideas is this website: <http://www.nacoa.org/pdfs/EDkit_web_06.pdf>

**Conclusion**

As demonstrated, parental alcohol and drug abuse is an important issue. It impacts child development on the physical, emotional, and cognitive level. Working to increase preventative measures and ensuring that one is using evidence-based modalities when working with those impacted is very important.

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