Impact of Pre- and Postnatal Parental Substance Use on Child Development

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Presentation Objectives

Participants will…
• Be able to identify primary characteristics of prenatal and postnatal substance exposure to alcohol and other drugs, and the long-term effects of this exposure on the developmental spectrum for children.
• Learn about how parental substance abuse can impact child behavior and family relations.
• Gain more knowledge about evidence-based assessment and treatment strategies for children exposed to parental substance abuse.

Scope of the Problem

(NSDLIH Report, 2009)

8.3 million (11.9%) of U.S. children =
Number of U.S. children living with a parent who was abusing or dependent on drugs or alcohol in the last year

- 7.3 million (10.3%) = Alcohol
- 2.1 million (3.0%) = Illicit drugs
Exposure by Age
(NSDUH Report, 2009)

% of Children Living with 1 or Both Parents with Substance Dependence or Abuse, by Child Age: 2002-2007

13.9
9.9

Child Maltreatment in the United States of America
As of 2012

Neglect
Physical Abuse
Sexual Abuse
Psychological Maltreatment
Medical Neglect
Other/Unknown

Substantiated Maltreatment by Age

Child Maltreatment, 2012
DHHS, ACF, ACYF

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Substance Abuse and Child Maltreatment

- Parental substance use is a concern in over 50% of child welfare families (U.S. Department of Health and Human Services, 2007)
- Most prevalent cause for child welfare involvement is parental neglect (includes use of drugs or alcohol that interferes with parenting abilities), with 64% of all cases citing this cause (USDHHS, 2007)
- Over ½ of the U.S. child-bearing age population report having used illicit drugs in their lifetime (SAMSHA, 2007)

Current Substance Use Among Pregnant Women Aged 15-44, by Age, 2008-2009 Combined

Impact of Prenatal Exposure

- Can affect existing and developing structures
- Different systems are impacted at different stages of development.
- Damage due to alcohol exposure is permanent.
- Discriminating effects of specific illicit substances is difficult given poly-substance use among users
- Some harmful effects of some drugs can be reversed with good postnatal nutrition and care.

Wells (2009); Smith et al. (2007)
Common Effects of Prenatal Exposure Across Substances

- Fetal growth retardation (i.e., weight, length, head circumference)
- Premature delivery
- Tremors/Jitteriness
- Irritability
- Feeding and sleep problems
- Social, physical, and school adjustment problems.
- Cognitive, speech/language, motor, and behavior problems

Wells (2009)

Fetal Alcohol Spectrum Disorder / Fetal Alcohol Syndrome

- FASD is estimated in 0.20% - 2.00% per 1,000 live births (CDC, 1993, 1995, 1997, 2002)
- FAS is estimated between 2,000 and 8,000 babies per year (May & Gossage, 2001)
- FAS can only be diagnosed by a physician

Diagnosis of FAS/FASD: 4-Digit Diagnostic Code

- CDC Criteria (2004)
  - Growth deficiency
  - FAS facial phenotype
  - CNS abnormalities
  - Prenatal alcohol exposure

(CDC/NCBDDD Scientific Working Group, 2004)

http://depts.washington.edu/fasdpn/
Common FASD Behaviors

- **Newborns:**
  - Easily startled
  - Difficult to comfort

- **Early Childhood:**
  - Poor habituation
  - Poor visual focus
  - Mild developmental delays
  - Distractibility and hyperactivity
  - Difficulty adapting to change
  - Difficulty following directions

Common FASD Behaviors

- **Middle Childhood**
  - Difficulty predicting and/or understanding consequences
  - Concrete thinking
  - Poor comprehension of social rules and/or expectations
  - Appearance of capability without actual ability to perform
  - Potential emerging discrepancy between comprehension skills and expressive language
  - Hyperactivity, impulsivity
  - Memory deficits

Common FASD Behaviors

- **Adolescence**
  - Poor adaptive functioning
  - Lying and stealing
  - Faulty logic
  - Low self-image and motivation
  - Academic achievement lower than expected
  - Inappropriate sexual behavior
  - Lack of time awareness accentuated
  - Relationship difficulties
  - Unreliable with money
  - Mental health problems (e.g., depression, anxiety, etc.)
Cocaine and Child Development

- Abnormally developed or missing extremities
- Withdrawal and related effects can last up to 6 months
- Increased risk for stroke and/or seizures in the first 6 months
- Increased risk for Sudden Infant Death Syndrome (SIDS)
- Poor self-regulation, difficult to console
- High-pitched and excessive crying
- Abnormalities in sleeping and respiration
- Hypertonia
- Voracious sucking

Schuetze, Eiden, & Coles (2007)

Effects of Cocaine, cont’d

- Infancy:
  - Difficulty with body regulation and stress reactivity
  - Decreased interaction
  - Low threshold for frustration and tactile stimulation

Schuetze, Eiden, & Coles (2007)

Effects of Cocaine, cont’d

- Childhood and Adolescence:
  - Delayed language development
  - Impaired abstract reasoning
  - Poor attention, concentration, and memory
  - Difficulty organizing and sequencing tasks
  - Learning and behavior problems
  - Difficult and violent behavior

Schuetze, Eiden, & Coles (2007)
Meth and Child Development

- **Neonatal:**
  - Separation of the placenta
  - Cardiac anomalies
  - Cranial abnormalities
  - Altered neonatal behavioral patterns (e.g., abnormal reflexes and extreme irritability)

Meth and Child Development

- **Long-term difficulties:**
  - Stunted growth
  - Tremors
  - Poor feeding habits
  - Disturbed sleep patterns
  - Hypotonia
  - Increased risk for SIDS

Marijuana and Child Development

- Sleep disturbances in sleep cycling and sleep patterns (can last up to age 3)
- Poor habituation to stimuli and visual responsiveness
- Abnormally fast heart rate, poor feeding, and irritability
- Decreases in height, weight, and head circumference – Do not appear to last over time.
Opiates and Child Development

- Neonatal Abstinence Syndrome (NAS)
  - Withdrawal signs begin to show within one to three days of life; however, signs may take as long as seven to ten days with methadone exposure.
  - Convulsions
  - Tremors/jitteriness, hypertonia, unprovoked muscle jerks.
  - May be inconsolable, more irritable, more easily aroused.
  - Potential for persistent or projectile vomiting over 12-hour period, as well as multiple episodes of explosive diarrhea
  - Abnormally fast heart rate, fever, weight loss of >10%, and water loss in the stools

  Bailey, Campagna, & Derr (2008)

Direct Exposure After Birth

- Breast milk
- Breathing in chemicals when drugs are manufactured or used
- Ingesting substances
  - Accidentally
  - Intentionally: Amusement or Sedation

  Grant (2006)

Substance Abuse and Parenting

- Interferes with decision making
- Less sensitive and responsible
- Emotionally and physically unavailable
- Lowers threshold of aggression
- Interferes with the formation of secure attachments

  Smith et al., (2007); Young, Baks, & Otero (2007)
  - 2.7x & 4.2x greater risk for abuse and neglect, respectively

Substance Abuse and Parenting

- Parental substance abuse places children at increased risk of trauma exposure

Sprang, Staton-Tindall, & Clark (2008)

Post-Traumatic Stress Disorder DSM 5

- **B** - Intrusion Symptoms
  - Recurrent involuntary (intrusive thoughts/images)
  - Dissociative reactions/flashbacks
  - Recurrent distressing dreams (in kids don’t need trauma content)
  - Trauma re-enactment play (kids)
  - Distress to cues (internal/external)
  - 1 or 2 of these

- **C** - Avoidance
  - Avoid memories, thoughts/feelings of event (internal reminders)
  - Avoid (or try to) people/places/objects/situations (external reminders)
  - 1 or both of these

- **D** - Negative Cognitions or Mood
  - Inability to remember aspects of trauma
  - Persistent/ exaggerated neg. beliefs of self, etc.
  - Distorted thoughts re: cause or outcomes
  - Persistent negative emotional state
  - Diminished activities
  - Interests
  - Detached/estranged
  - Can’t experience positive emotions
  - 2 or more of these

Drug Endangered Children and PTSD

- 83.7% DEC (vs. 52.6% of non-DEC) exposed to a trauma
  - DEC statistically HIGHER on ALL traumatic events
- 59.9% DEC (vs. 27.3% non-DEC) more likely to have an adverse response to a traumatic event 2.33 times more likely
- DEC more likely to be re-victimized
  - 3.37 times more likely
  - 49.2% DEC (vs. 25.1% non-DEC)

Based on Sprang, Staton-Tindall, & Clark (2008)
Effects on Thinking

- Self-blame
- Able to and responsible for controlling parent's use
- Parent's feelings for them
- Family secrecy and isolation
- Family role confusion

Emotional Effects

- Fear & Worry
  - About parent
  - Parental violence, instability, neglect
  - Exposure to volatile, dangerous situations and people
  - Consequences of missing school, moving, etc.
  - About keeping family secrets
  - About family needs - shelter, food, finances, transportation, etc.

- Sadness & Loss
  - Loss of relationships
  - Loss of home, school, community, etc.
  - Sadness about instability, turmoil, secrecy
  - Sadness about having to grow up so quickly

Emotional Effects

- Anger at...
  - Parent(s) for addiction, absence, neglect, abuse
  - Others for not seeing their parent's addiction and intervening
  - The “system” for taking them away from their parents
  - Self for inability to make things right
Emotional Effects

- Self-focused
  - Guilt, shame
  - Responsibility
  - Unwanted, rejected, and unimportant
- Difficulty managing feelings

Behavioral Effects

- Role reversal with parent(s) – “Parentified”
- Isolation, secrecy, hesitation to accept outside help
- Oppositionality, rule-breaking
- Poor coping
- Aggression
- Bullying
- Poor social and relationship skills
- Self-Harm
- Substance Abuse
- Delinquency
- Sexual behavior

EARLY INTERVENTION!!!

THE SOONER THE CHILD RECEIVES
THE HELP S/HE NEEDS,
THE BETTER CHANCE
FOR POSITIVE and SUSTAINABLE
OUTCOMES.
Assessment of Prenatal Exposure to Substance Abuse
- Medical; possibly genetic testing
- Comprehensive developmental evaluation
  - Cognitive/IQ
  - Speech/language
  - Motor
  - Medical/physical development
  - Behavioral
  - Psychosocial via interview of caregiver

Assessment of Environmental Exposure to Substance Abuse
- Medical
- Psychosocial via interview of caregiver (and sometimes child)
- Cognitive (e.g., Wechsler, Kaufman, etc.)
- Developmental screening (e.g., Early Screening Profiles)
- Behavioral measures
  - Behavior Assessment Scale for Children (BASC)
  - Child Behavior Checklist (CBCL)
  - UCLA PTSD Index for DSM-IV / DSM 5
  - Trauma Symptom Checklist for Children (TSCC)
  - Trauma Symptom Checklist for Young Children (TSCYC)

Potential Treatment Recommendations
- Medical
- Speech/language services
- Occupational/physical therapy
- School services (e.g., IEP, special education)
- Individual/family therapy
- Behavioral parent training
- Education and advocacy
- Permanency and safety planning
- Collaboration among all providers
Key Points in Providing Services

- Engagement of caregiver and other key adults
- Identification and re-evaluation of child's needs
- Early intervention
- Consistency
- Predictability
- Follow through
- Creativity

Child Trauma Treatment

- Recommended components:
  - Psychoeducation
  - Stress management techniques
  - Direct exploration of the trauma
  - Exploring/correcting inaccurate attributions
  - Inclusion of caregiver
  - Behavioral Parent Training

Trauma-Focused – Cognitive Behavioral Therapy

- Developers:
  - Judith A. Cohen, M.D.
  - Anthony P. Mannarino, Ph.D.
  - Esther Deblinger, Ph.D.
- Designed for children ages 5 to 18 who have been exposed to trauma or have traumatic grief
TF-CBT Treatment Structure

- Average 12 – 18 sessions
- 1 to 1 ½ hour weekly sessions
- Each session is divided into individual child and caregiver sessions
  - The length of the child and caregiver portions may vary by topic
- Similar topics in most caregiver and child sessions
- Combined parent-child time in some to many sessions

TF-CBT Training

- Web-based learning
- Learn at own pace
- Concise explanations
- Video demonstrations
- Clinical scripts
- Cultural considerations
- Clinical challenges
- Resources
- Links
- Free of charge

http://tfcbt.musc.edu/

TF-CBT COMPONENTS

- PRACTICE
  - Psychoeducation and Parenting Skills
  - Relaxation
  - Affective Modulation
  - Cognitive Coping
  - Trauma Narrative & Cognitive Processing
  - In Vivo Desensitization
  - Conjoint Parent-Child Sessions
  - Enhancing Future Safety and Development
**Children’s Program at Betty Ford Center – Jerry Moe, MA**

The 7 Cs

- I don’t need it.
- I can’t control it.
- Help two sides of myself.
- Communicating feelings.
- Having good behaviors and celebrating them.

**Strengthening Families Program**

- Developer: Karol Kumpfer, Ph.D.
- Designed for children ages 6-11 years old whose parents are in substance abuse treatment and reunification is active
- Length of treatment is 14 sessions
- Main components
  - Parent Training
  - Children’s Skill Training
  - Family Skills Training

**Parent-Child Interaction Therapy**

- Developer: Sheila Eyberg
- Designed for children ages 3 to 7 with oppositional behavior
- Effective with children who have been physically abused
- Length of treatment is 14-16 sessions
- Improve parent-child relationship and child compliance with parent directives
- Therapist coaches caregiver through the use of a one-way mirror and a bug-in-the-ear device

http://pcit.phhp.ufl.edu/
Substance Abuse and Mental Health Service Administration

VISION: A life in the community for everyone.

MISSION: Building resilience and facilitating recovery.

www.samhsa.gov

NCTSN The National Child Traumatic Stress Network

To raise the standard of care and improve access to services for traumatized children, their families and communities throughout the United States.

www.nctsn.org

Additional Resources

- California Evidence Based Clearinghouse for Child Welfare
  Downloadable resources at: http://www.ca.Childwelfareclearinghouse.org/

- National Alliance for Drug Endangered Children:
  http://www.nationaldec.org/

- National Organization on Fetal Alcohol Syndrome:
  http://www.nofas.org/

- American Professional Society on the Abuse of Children.
  Multidisciplinary professional organization that publishes treatment resources:
  http://www.apsac.org/