Chronic Drug Users as Parents

Judy Howard
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by

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As a pediatrician who has specialized in child development, I have worked extensively with families of young children who have developmental disabilities.\(^1\) Within the population of children who are at risk for developmental problems, there is a stark disparity between youngsters being raised in chemically dependent families and those growing up in families where substance abuse is not an issue. The following two case examples highlight this divergence.

Case No. 1

Joey was born full term to a single mother in her mid-twenties. While the pregnancy was medically uncomplicated, it was not without stress because Joey's mother had been abandoned by his father. Joey's mother obtained prenatal health care. Nonetheless, Joey was born with Down Syndrome, exhibiting symptoms that included congenital heart disease which was surgically treated during his first year. Despite limited financial resources and minimal family support, Joey's mother worked collaboratively with involved professionals to secure ongoing health care, as well as home- and center-based early intervention services for her son. These services included educational programs as well as physical, occupational, and speech therapy. At age four, Joey is now enrolled in a normal preschool program. His mother continues to work as his advocate to ensure the best possible quality of life for Joey, both educationally and socially.

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1. I work with children who have developmental disabilities including Down Syndrome, cerebral palsy, and autism, as well as with families of children who were prenatally exposed to drugs or alcohol.
Case No. 2

Susie is the second child of a twenty-seven year-old single woman who has been a chronic heroin abuser for seven years. Susie’s mother had close relationships with her sister, also an addict, and her mother, an alcoholic. She obtained minimal prenatal care, and Susie was born underweight with a positive urine toxicology screen and feeding difficulties. Based on Susie’s medical fragility and her mother’s history of addiction, hospital personnel believed this was a high risk home situation and reported the case to child protective services (CPS) for further investigation. CPS recommended that Susie’s mother enroll in a methadone program. After agreeing to enter treatment, she was permitted to take Susie home with her. CPS also recommended that Susie’s mother participate in an infant and family services program specially designed for chemically dependent families. During the thirty months the family was enrolled in this program, program staff found Susie had language delays and was high risk for future learning difficulties. Also during this time, Susie’s mother’s addiction shifted from heroin to cocaine. Meanwhile, two reports of suspected child abuse or neglect were filed as a result of Susie’s mother abandoning her during binges and Susie’s failure to thrive. In spite of the efforts of physicians, social workers, public health nurses, and drug treatment counselors, Susie eventually was placed in foster care. Her mother openly acknowledged that, despite her love for her children, her addiction was her top priority.

These case examples underscore the unique challenges a parent’s chemical dependency presents to general and mental health care professionals working with the parent’s family.

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This Essay undertakes to provide a progressive overview of parental drug and alcohol abuse. Part I describes general trends in substance abuse, addressing: Estimated numbers of substance abusing adults and substance exposed children, the cost of health care services for infants born to substance abusing women, and medical complications related to prenatal substance exposure. Part II discusses the chemically dependent lifestyle, focusing on how substance abuse interferes with parenting functions, the intergenerational nature of chemical dependency, and the altered mental state associated with chronic drug use. The final Part focuses on the children of substance abusers and discusses newborn behaviors and developmental patterns of older children, and how both are influenced by biological and environmental factors.
I. General Trends in Substance Abuse

Prior to the 1960s, few types of illicit drugs were available in the marketplace. Until recently, the "typical" substance abuser was male.\(^2\) Cocaine had been widely used at the turn of the century but subsequently declined in popularity, and following World War II heroin became the most commonly abused drug in the United States.\(^3\) During the 1960s, as people attempted to break away from what was viewed as the conventional post-war lifestyle, many began to explore "instant pleasure-seeking with sex and drugs."\(^4\) Psychedelic and mood altering drugs became increasingly popular. By the time of the Woodstock festival, the media routinely featured reports on the widespread use of mind altering substances, and the entertainment industry had begun to portray drug use in movie plots and popular songs. In the 1970s, reports of chronic addiction and drug use as a means to escape life's problems became increasingly common, and polysubstance abuse became the norm.\(^5\) During the 1980s, increasing numbers of women began using drugs.\(^6\)

Last year, the United States General Accounting Office estimated that five million women of childbearing age used illicit drugs in this country in 1988.\(^7\) The number of substance affected children born each year is more difficult to determine, but the federal administration has estimated that nationwide 100,000 infants were prenatally exposed to cocaine in 1989.\(^8\) These figures do not incorporate data regarding the number of newborns prenatally exposed to heroin, phencyclidine (PCP), methamphetamine, or other substances of abuse. The percentage of drug involved births has been estimated at 7% in San Francisco, 7.5% in Washington, D.C., and as high as 10 to 15% in Milwaukee and 16% in Philadelphia.\(^9\) Statistics from individual hospitals are even more alarming. At Detroit's Hutzel Hospital from November 1988, to October 1989, 44.3% of 3010 newborns had a positive meconium drug screen for

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3. Id. at 6.
7. Id.
8. Id. at 4.
substances including cocaine, morphine (opiates), and marijuana. Thirty-one percent were positive for cocaine alone. At Mercy Catholic Medical Center in suburban Darby, Pennsylvania, researchers collected meconium from five hundred consecutively born newborns from February 1 to May 15, 1990. Of these, 11.8% of the infants tested positive for cocaine. In addition, researchers have estimated that in 1984 over 7000 children were born with Fetal Alcohol Syndrome resulting from maternal alcohol abuse during pregnancy.

In response to the growing number of children born to substance abusing women, national interest has recently shifted from adult users to the children of chemically dependent parents. Based on what is known today, we cannot project the long term cost to society for the general and mental health care or the special education services that many of these children may require. However, a recent study concluded that the cost of neonatal hospital care for infants whose mothers used cocaine during pregnancy was three to four times higher than for nondrug exposed infants. Further, costs for infants of polysubstance abusing mothers who used cocaine in addition to other illicit substances averaged $8450, as compared to $1283 for nonexposed infants. On the basis of their findings, these researchers estimate that $500 million annually will be needed to cover neonatal hospital expenses alone.

This startling threat to the new generation was not unforeseen. About fifteen years ago, a small group of researchers and clinicians began voicing many of the same concerns we are expressing today regarding the deleterious effects of drugs and alcohol upon family functioning. In 1976, the National Institute on Drug Abuse sponsored a symposium on comprehensive health care for addicted parents and their children. Several leading investigators who worked with chemically dependent families presented research findings that showed: a high rate of both in-

15. NATIONAL INST. ON DRUG ABUSE, SYMPOSIUM ON COMPREHENSIVE HEALTH CARE FOR ADDICTED FAMILIES & THEIR CHILDREN 20-21 (George Beschner & Richard Brotman eds., 1976).
fant mortality and low birth weight among children of substance abusers, a greater risk of obstetrical and medical complications in women who abuse drugs during pregnancy, and increased problems with ongoing parental responsibilities.

II. The Chemically Dependent Lifestyle

Much of what has been learned about chemically dependent parents is based upon clinical experience and research with families of lower socioeconomic status. Very few published studies describe large samples of middle- or upper-middle-class substance abusing parents. Though we know that the problem of alcohol and drug abuse crosses all social and economic boundaries, much remains to be learned about chemical dependency among families for whom access to resources and social supports is not a problem.

A. Parenting Functions

In the 1960s, when heroin was the most common substance of abuse, drug rehabilitation programs generally were designed to treat the physiological symptoms of withdrawal. It was rare for pediatricians or other professionals, such as public health nurses, pediatric nurse practitioners, or family practitioners, to consider the unique needs of parents who were addicted to drugs. However, in 1977 Josette Escamilla-Mondanaro published a graphic report on the clinical characteristics of sixty pregnant heroin addicts who had few social and economic supports but who sought prenatal care and drug treatment. The study addressed their relationships with husbands and significant others, the guilt these women felt following delivery, the unrealistic expectations many of them had of their babies, and the parenting relationships they developed with their growing children.\(^\text{16}\)

The study showed how the disorder of addiction can impair an individual's ability to engage in family planning activities. Most of the heroin addicted women described by Escamilla-Mondanaro—like many women today who abuse cocaine, methamphetamine, heroin, or other substances—did not plan their pregnancies. This is because many chemically dependent women experience interferences with menstruation and may miss periods. Many of these women believe they are unable to become pregnant.\(^\text{17}\) Consequently, many substance abusing women may

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not realize they have conceived until well into their pregnancy, thus lim-
iting available options for prenatal health care and family planning. Fi-
ally, the overriding priority and physiological need to procure drugs can
preempt efforts to make medical appointments and follow through with
health care recommendations.

Even when a chemically dependent woman who suddenly discovers
she is pregnant takes a strong interest in her pending motherhood and
appears to develop a bond with her unborn child, she may receive little
support from her husband or significant other, who also may be a sub-
stance abuser. As the Escamilla-Mondanaro study showed, some men
who are unable to cope with the responsibility of fatherhood may in-
crease their drug use and criminal activity, sometimes becoming incar-
cerated or hospitalized for overdose. However, even a chemically
dependent father who responds positively to the imminent birth of a
child may be physically, emotionally, or financially unable to provide for
his family.

In such situations, some women tolerate the fathers’ behavior by
fostering unrealistic expectations about the eventual relationship that will
develop once the baby is born. Many report that they believe their own
family members will behave more lovingly towards them during preg-
nancy and that their partners will seek employment in order to provide
appropriate housing for them and their child. Further, it is not uncom-
mon for chemically dependent women to believe that motherhood, in and
of itself, will diminish their craving for drugs. They may then believe
that parenthood, in and of itself, will help cure their addiction. Unfortu-
nately, these expectations are often unrealistic.

B. Childhood Patterns of Chemically Dependent Adults

The chemically dependent individual’s behaviors and feelings about
parenthood, pregnancy, and child-rearing do not exist in a vacuum. Health
professionals have increasingly come to realize the importance of
identifying the substance abuser’s personal history in order to develop
appropriate treatment plans. Significant background factors that influ-
ence parenting behaviors include: childhood experiences (including mul-

discussing reproductive risks of drug abuse and concluding that drug effects on reproduction
in populations may not be detected for many years).
19. Jack N. Carr, Drug Patterns Among Drug-Addicted Mothers: Incidence, Variance in
Use, and Effects on Children, 4 PEDIATRIC ANNALS 408, 408 (1975).
20. Id. at 416.
21. See Barbara C. Wallace, Chemical Dependency Treatment for the Pregnant Crack
multiple caregivers, and physical or sexual abuse); family values; parental use or abuse of drugs or alcohol; and educational background. The majority of young adults who abuse drugs and alcohol report family backgrounds involving parental substance abuse. We also have learned that many chemically dependent women also experienced physical, sexual, or emotional abuse as children. Information about the extent to which physical and sexual abuse have been experienced by the male addict population is more limited.

My colleagues and I are currently involved in a research demonstration project serving pregnant addicts and their offspring. This five year longitudinal study will include two hundred women and their children, with half of the group enrolled in a comprehensive home- and center-based perinatal program and half referred to existing community resources. The comprehensive treatment program includes bi-weekly home visits by a trained professional who serves as the case manager, transportation to prenatal and pediatric health care visits, and a weekly preschool program for toddlers. In addition, twice-weekly center-based drug treatment sessions are held addressing a range of topics, including the role of drugs in the women’s lives and how to decrease use, relationships, parenting skills, nutrition, hobbies, and physical fitness. A public health nurse accompanies the mother to all prenatal visits and supports her at the time of delivery if she so desires. The project’s goal is to determine whether these comprehensive support services, provided over a twenty-four month period, will make a difference by encouraging these mothers to remain drug-free and become more nurturing parents, and by improving the developmental outcome of their children.

Once a woman has made the decision to enroll in this program, we elicit information regarding her childhood, history of drug use, and current relationships with family members and significant others. This entry level information has yielded a remarkable picture of tragedy and sadness in almost one hundred women to date. Over 80% have histories of parental substance abuse, child physical abuse, or sexual abuse. Addition-

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Addict: Beyond the Criminal-Sanctions Perspective, 5 Psychol. Addictive Behav. 23 (1991).

22. Fawzy I. Fawzy et al., Generational Continuity in the Use of Substances: The Impact of Parental Substance Use on Adolescent Substance Use, 8 Addictive Behav. 109 (1983); Center of Alcohol Studies Library, Rutgers University, Children of Alcoholics (Alcohol Bibliography Series) (1983).

23. Judy Howard et al., The Development of Young Children of Substance-Abusing Parents: Insights from Seven Years of Intervention and Research, Zero to Three, June 1989, at 8, 8.

ally, the women report that very few of the general or mental health care professionals who have treated them have inquired about their childhood experiences. Our staff has found that these underlying issues can seriously complicate efforts to help these women become drug-free, nurturing parents.

C. Patterns of the Chemically Dependent During Adulthood

Individuals with abusive backgrounds tend to have low self esteem, which, in turn, negatively influences their educational achievements and interferes with the development of healthy social networks. For instance, the chemically dependent women whom we have served over the past eight years report fewer close friendships and more intense feelings of loneliness than nondrug abusing women. Furthermore, these women commonly acknowledge difficulties in learning and low motivation to complete high school diplomas or obtain college degrees. Many of these women question whether or not their learning difficulties in school are related to their own parents' use of alcohol or drugs at the time of conception or during pregnancy.

Many of these women never enter the "legitimate" work force or are unable to maintain long term employment. They tend to lack job skills and, in our experience, often report that their substance abuse activities interfere with regular employment. Mothers from less advantaged circumstances often resort to prostitution, stealing, or drug dealing in order to support their habits. Such illegal activities frequently result in periods of incarceration. Substance abusing women from more affluent backgrounds, on the other hand, may have access to trust funds or other financial resources and thus may not be as easily identified within the general population, since it is less likely that they will resort to illegal activities to fund their addiction.

D. The Altered Mental State Experienced by the Chemically Dependent

Addiction involves a pattern of compulsive behavior and lack of internal control that continues even in the face of adverse consequences. The current trend in substance abuse is polysubstance abuse, with the primary drugs of choice being cocaine, methamphetamine, heroin, and


26. Smith, supra note 5, at 118.
PCP. Each of these is frequently used in combination with alcohol or marijuana to help the user sleep or relax. In general, polysubstance abusers tend not to be primarily alcoholics who have added illicit drugs to their “repertoires.”

Abuse of these addictive compounds affects behavior and perception. Individuals who use cocaine or methamphetamine report increased alertness and elevated energy levels accompanied by decreased anxiety and social inhibitions. With chronic use, paranoia is not uncommon. Binge use of such stimulants is typical, but when a binge episode comes to an end, a “crash” ensues. During the “crash,” users commonly become unable to experience pleasure, take limited interest in their environments, and have very low energy levels. Stimulant users who experience sleep disturbances may turn to sedatives, opiates, marijuana, or alcohol to ease agitation and induce slumber.27

Unlike cocaine and methamphetamine, heroin is a depressant that produces a feeling of well being in the user, along with episodes of drowsiness. Heroin withdrawal symptoms are more violent than those associated with stimulants and may include strong muscle contractions, intense perspiration, writhing, and nausea.28 The heroin user experiences an intense desire to alleviate the symptoms of withdrawal through repeated administration of the drug. This differs significantly from the withdrawal or “crash” state associated with stimulants, during which the user experiences an intense craving to “sleep off” the acute drug effects. In either case, parents undergoing withdrawal or “crash” symptoms are unable to attend to their own well being, let alone that of their children. The complexities of day-to-day responsive parenting are incongruent with the altered mental state of chronic addicts.

The difficulties chronic addicts have in parenting are reflected in a report that examines the parental behaviors of amphetamine addicts towards their infants.29 Of the twenty-five children whose parents continued to use drugs throughout the pregnancy and after delivery, one third were removed from the care of their parents due to parental neglect, approximately 40% were hospitalized one or more times, and over 50% had developmental or emotional problems.30

27. Id. at 123-24.
29. Lars Billing et al., Occurrence of Abuse and Neglect of Children Born to Amphetamine Addicted Mothers, 3 Child Abuse and Neglect 205 (1979).
30. Id. at 209-11.
III. Children of Chemically Dependent Parents

Chemically dependent adults commonly fail to take necessary measures to ensure their own well being, and pregnant addicts are no exception. Lack of appropriate prenatal care, poor nutrition, venereal disease, hepatitis, AIDS, and the toxic effects of drugs and alcohol on the developing fetus have been associated with a variety of complications, including spontaneous abortion, stillbirth, preterm delivery, intrauterine growth retardation, and congenital infection. About a third of the children exposed to drugs or alcohol in utero are born preterm. This makes them biologically vulnerable in two areas. First, they may have complications related to prematurity, such as severe respiratory dysfunction, intracranial bleeds, visual handicaps, cerebral palsy, or learning problems. Second, they may have biological complications resulting from the effects of their mothers' prenatal drug use on the prenatal development of their organ systems, including the brain.

Those prenatally substance exposed infants who are born full-term (about 66% percent) are also at risk for developmental problems resulting from the effects of prenatal substance abuse. One of the most graphic reports of these complications describes a group of full-term infants who experienced uncomplicated deliveries but who had been exposed prenatally to cocaine, methamphetamine, heroin, or methadone. In approximately one third of these neonates, small infarctions (strokes) were detected upon cranial ultrasound examination. Other researchers have reported deviant electroencephalograms and interference with limb development and kidney structure.

Failure to thrive, usually due to medical or environmental factors, is another health disorder that is often observed in prenatally substance exposed infants. These children may show a marked deceleration in weight gain and may demonstrate poor developmental abilities. Some infants

33. Id. at 773; Tatiana M. Doberczak et al., Neonatal Neurologic and Electroencephalographic Effects of Intrauterine Cocaine Exposure, 113 J. PEDIATRICS 354, 355-56 (1988).
who have been exposed prenatally to drugs or alcohol demonstrate a pattern of poor sucking, swallowing difficulties, and distractibility that can interfere with adequate weight gain. In addition, environmental factors may come into play. For instance, children living in dysfunctional, chemically dependent families consistently may receive inadequate nutrition. Emotional neglect also can result in failure to thrive. Drug exposed infants who have not been adequately nurtured, like other babies who have suffered emotional neglect, may turn away when offered food.

A. Newborn Behaviors

Just as drugs impact the behaviors of the adult user, newborns who have been exposed to drugs and alcohol in utero also exhibit deviant responses to their environment. Early withdrawal syndrome has been documented extensively in infants prenatally exposed to heroin and the synthetic opiate methadone. These newborns typically are tremulous, irritable, hypertonic, and may have vomiting and diarrhea. They have poor motor control, do not attend well to visual stimuli, and show increased response to sound in the environment.

The "recreational drugs," cocaine and methamphetamine, once believed to have no effect on the developing fetus, now have been demonstrated to have definite negative effects on some infants chronically exposed to these substances in utero. Such infants often have decreased birth weight and small head circumference. Unlike the extremely irritable infant with prenatal exposure to heroin or methadone, cocaine exposed newborns frequently are lethargic and poorly responsive. They commonly have difficulty sucking and developing normal sleeping patterns, and they may also have rapid emotional state changes that can range from quiet sleep to irritable crying within an extremely brief span of time.

36. Geraldine S. Wilson et al., Early Development of Infants of Heroin-Addicted Mothers, 126 AM. J. DISEASES CHILDREN 457 (1973) (examining the effects of heroin on babies from 3-34 months old).
37. Id.
B. Developmental Patterns

Following the newborn period, prenatally substance exposed infants demonstrate a variety of developmental patterns ranging from “normalcy” to obvious delays in the areas of motor, cognitive, language, and personal/social development. During the first year of life, it is not uncommon to find problems in motor and language development. Beginning in the third year, minor motor difficulties may cause some prenatally substance exposed children to appear clumsy. At this time, professionals can conduct more detailed evaluations of problem solving skills, interpersonal interactions, attention to tasks, and other activities involving higher cortical function. Some children demonstrate hyperactivity, aggressive behavior, difficulty following directions, or problems with conversational expression. In the group of children my colleagues and I have studied, over 50% have developmental problems that are known precursors to learning and emotional difficulties.

The staff of “Family Resources,” a perinatal cocaine project for birth, foster, and adoptive families in New York City, has just finished evaluating forty children in their program. All of these children were placed directly into foster care upon hospital discharge. As a group, based on standardized developmental evaluations, these children appeared to be doing as well as their peers until they reached two years of age. At that point, their developmental scores on measures of language, interpersonal skills, and motor development began to decline. At three to four years of age, these children were doing less well than 96% of their peers in all areas of development, and less well than all of their peers in terms of socialization. These types of developmental patterns have been noted for many years. As early as 1976, one researcher noted that the quality of prenatally substance exposed children’s interactions with toys and with persons in their environments was different from that of children who were not prenatally exposed to drugs.


42. Id. at 9.

43. Id.

44. Lodge, supra note 40, at 81.
The interplay between biological risk factors and environmental factors cannot be ignored in evaluating the developmental abilities of prenatally substance exposed children. The disorganized drug lifestyle and the many social and health problems associated with addiction can interfere with a chemically dependent parent's ability to provide care and adequately supervise a child's daily activities. As noted above, parents who abuse drugs or alcohol suffer from periodic episodes of altered mental state and intense craving that can make them both emotionally and physically inaccessible to their children.45

Children who are raised in caring home environments and who have comfortable relationships with their parents or caregivers tend to be better socially adjusted later on in life.46 At UCLA, we recently completed a research project comparing the attachment behaviors of forty-one prenatally drug exposed children with those of twenty-eight children born to nondrug using parents. The two groups were similar in their socioeconomic status, ethnic background, family composition, and area of residence. All children received home-based intervention services designed to foster optimal development. The project's staff used standardized laboratory procedure47 to assess the children's attachment behavior to their caregivers. Project staff found that the children born to nondrug using mothers scored in the normal range, with 60% securely attached and 40% insecurely attached. Those children born to substance abusing mothers who had remained drug-free for one year after the children's births scored similarly to the nondrug exposed group, with 50% securely attached and 50% insecurely attached. In contrast, none of the substance exposed children living with their chemically dependent parents were securely attached.48

These findings are of particular concern because insecure attachment during toddlerhood can be a predictor of later problems with social and emotional development.49 Toddlerhood is a time when two evolving developmental traits emerge: trust and autonomy. In order to develop

45. See supra text accompanying notes 27-28.
47. See MARY D.S. AINSWORTH, SYSTEM FOR RATING MATERNAL-CARE BEHAVIOR (1976) (Educational Testing Service).
48. Carol Rodning et al., Quality of Attachment and Home Environments in Children Prenatally Exposed to PCP and Cocaine, 4 DEVELOPMENT & PSYCHOPATHOLOGY (special issue, forthcoming 1992) (manuscript at 22, on file with author).
autonomy (or an empowered sense of self), a young child must have developed trust in his or her adult caregivers. A stable, predictable, responsive environment fosters trust by providing a foundation from which a child can venture out into the world to experiment and develop a sense of independence. If a child does not have the opportunity to learn trust and to define a sense of self, meaningful and emotionally secure relationships with others will be much more difficult to establish.

No longitudinal studies examining the developmental outcomes of adult children of drug addicts have been published. However, reports describing the behavior of older children and teenagers being raised by parents in drug treatment have revealed behavioral and school adjustment problems. These youths tended to be more anxious, more insecure, and to have decreased attention spans. Their teachers reported more behavior problems, repeated grades, and absences. As adolescents, children of addicts were found to engage in more frequent and more serious delinquency. Finally, these children were found more likely to abuse drugs themselves and be in substance abuse treatment programs. However, whether these children were prenatally exposed to drugs has not been ascertained. If we extrapolate from the adult addicts we are working with, who frequently describe childhood backgrounds of parental substance abuse, we may infer that their children will repeat this cycle unless effective intervention is provided.

**Conclusion**

The two case scenarios at the beginning of this Essay highlight the issues involved in working with children who are biologically at high risk for deviant development. A pediatrician normally works collaboratively with parents to ensure appropriate evaluation of the problem at hand and to develop treatment strategies to achieve an optimal health and developmental outcome for their child. The desired outcome involves appropriate interpersonal behaviors, healthy self esteem, and opportunities to experience success. When a parent is chemically dependent, however, the pediatrician cannot be confident that parenting functions are not compromised. In fact, the parent becomes as much of a patient as the child. Because of the overriding need for drugs, the addicted parent may

be unable to act effectively as the child's advocate in working with professionals to secure needed health and educational services.

Previous research has demonstrated that a young child's need for a nurturing and emotionally stable environment cannot be neglected without adverse consequences.51 Yet, because of the nature of addiction and the current state of treatment methods, professionals cannot expect the majority of substance abusing parents to become and remain drug-free even after an extensive treatment course. In fact, in the three year research project my colleagues and I have just completed, only a small percentage of parents were able to become and remain drug-free.52 Furthermore, we were unable to predict precisely which parents would become drug-free during their time with us on the bases of childhood background, years of substance abuse, family support systems, and intensive twenty-four month participation in the home-based intervention services we provided.

Substance abuse treatment, parenting classes, and early educational problems would seem to be only some of the factors that contribute to success or recidivism. This puts not only the pediatrician, but also all professionals working with chemically dependent families, in a double bind. Who should be the focus of treatment—the parent or the young child? Furthermore, how can professionals from various disciplines coordinate their diverse methods of treatment for adult addicts and their children in order to ensure a cohesive family treatment plan? We cannot expect an addicted parent who is involved in drug treatment to provide ongoing advocacy and effective parenting for his or her child. Yet, this parent's young child needs a stable, nurturing environment in order to achieve optimal developmental outcome.

Recognizing that our expertise in working with chemically dependent families is in its infancy, we must devote our efforts to developing better ways to serve the needs of both addicted parents and their children. This can only be accomplished through an interdisciplinary model that is able to maintain an ongoing balance between the needs of the chemically dependent parent and those of the prenatally substance exposed child.


From a health care and drug treatment perspective, we need to develop programs that address addiction as a chronic, relapsing disorder that only very infrequently can be "cured" after a treatment period as brief as thirty to ninety days. The overall expectations for sobriety must be realistically based, so that we do not report failures in such a way as to imply that all participants should be successful over a brief treatment regimen. With this in mind, those professionals who address the needs of children (pediatricians, child care providers, educators, etc.) need to establish programs that shore up environmental supports for children in chemically dependent families. For instance, children of parents who are addicted, even if those parents are seeking treatment, would benefit from a long-term plan that would include provisions to ensure consistent, nurturing care from relative caregivers as available, community day programs, and after-school programs (including boys' and girls' clubs, recreational organizations, etc.).

As a rule, child welfare agencies and the legal system are intermittently involved with children of chemically dependent parents. Thus, they too need to be informed about the treatment needs of addicted parents, the course of recovery, and the children's ongoing need for stability and nurturing. Decisions about whether to remove children from chemically dependent families or to keep them with their addicted parents, as well as about court ordered reunification efforts, may be ineffective if they are not based on an understanding of addiction, reasonable expectations of drug and alcohol treatment programs for parents, and basic knowledge about child development, including the impact of disruptions and disorganization upon the young child.

Just as the pediatrician alone cannot effectively cope with the complex issues related to chemical addiction in families, neither can other professionals. Collaboration among health care providers, drug treatment counselors, mental health professionals, educators, child welfare agencies, and the legal system is essential if we are to provide the comprehensive and coordinated services these children and their families require. There can be no doubt that many will need these services over an extended period of time.