DOCUMENT RESUME

ED 336 204 PS 019 922

AUTHOR	Bauer, Anne M.; And Others
TITLE	Parenting Children Who Have Been Prenatally Exposed to Drugs or Alcohol: A Handbook for Foster and Adoptive Parents.
SPONS AGENCY	Cincinnati Univ., Ohio.
PUB DATE	90
NOTE	73p.
PUB TYPE	Guides - Non-Classroom Use (055) -- Information Analyses (070) -- Reports - Research/Technical (143)
EDRS PRICE	MF01/PC03 Plus Postage.
DESCRIPTORS	*Alcohol Abuse; *At Risk Persons; Birth Weight; Child Development; *Child Rearing; Cocaine; *Drug Abuse; Foster Family; Interpersonal Competence; Language Skills; Parent Child Relationship; *Prenatal Influences; Special Education; Stress Variables; *Young Children
IDENTIFIERS	*Child Behavior; Fetal Alcohol Syndrome

ABSTRACT

This manual provides an overview of the early child development of normal children with low birthweight who have been exposed to drugs before birth. The research on children exposed to cocaine and alcohol during the prenatal period is reviewed, as are the results of studies showing deficiencies in language and social development of drug-exposed children. Ways for foster parents to help children with these deficiencies are suggested. Issues relating to the parenting of drug-exposed children concern stress, burnout, and child and parent characteristics. Suggestions for parenting stressful children involve diet and exercise, relaxation techniques, social support systems, and time management. A discussion of behavior management of drug-exposed children addresses the ultimate goal of children's self-management; the reasons children do what they do; and the special problems of children who have been maltreated. The referral process for special education, the categories of special education children, special education services, and ways of helping a child in special education are described for parents with school-age children. A glossary of technical terms is included. An appendix describes a study that examined the effects of crack babies on the child welfare system. (76 footnotes; 108 references) (BC)

Parenting Children who have been Prenatally Exposed to Drugs or Alcohol: A Handbook for Foster and Adoptive Parents[1]

Anne M. Bauer

Pamelazita W. Buschbacher

Gwendolyn E. Ellis

Judithann Whelley

The University of Cincinnati

[1]This manual was developed through the support of Summer Faculty Research Fellowship funding for Dr. Bauer and University Program Activities Committee (University of Cincinnati) funding for research assistants and other costs.

To the Reader

Parenting children who have been prenatally exposed to drugs or alcohol is labor intensive. Yet the foster and adoptive parents of the children whom we studied generously gave of their time, experience, and personal perceptions to help not only the children whom they were parenting, but all children and parents dealing with prenatal drug and alcohol exposure. We thank them, because without them, there would be no handbook. The parents, who spoke so openly and candidly, are a remarkable group of people. We also thank Jennifer Danko, Jerri Lilly, Terri Freshley, and Cheryl Reber of Hamilton County Department of Human Services, who helped us identify and contact participants.

Whenever such complex issues as prenatal alcohol and drug exposure are discussed, some technical terms must be used. We have provided a glossary to help the reader with our meaning for these terms. Also, throughout the document, we use the term "baby" to describe children younger than 24 months (two years) of age. By primary caregiver, we mean whomever is assuming the primary care of that child be it biological or substitute parent, grandparent, sibling, extended family member, or family friend. In addition, by substitute caregiver, we mean the adoptive or foster parent who is assuming the parenting role with the child. We also describe the children as "drug or alcohol exposed", though we recognize that for many of the children involved, drug and alcohol were both used by the biological mother.

Some of the information included in this document may seem overwhelming or pessimistic. We urge the reader to accept, as we have, Christine Lubinski's[1] contention that in order to help, we must look away from the isolated, negative view of damaged children to an approach and a model for helping the children and heir families.

We also must thank our own children and families for their patience and understanding as we interviewed parents, organized data, and worked on this document. Families are the reasons we have developed these materials, and we appreciate the impact that the participants of this research and our own families have on our lives.

Annie Bauer
Pam Buschbacher
Gwen Ellis
Judy Whelley

---

[1] Lubinski, C. (1990). Addressing the impact on women, children, and families. Paper presented at "Babie and Cocaine", Alexandria, VA: LRP Productions.

Contents

The Importance of the Early Years: Child Development and Children who are at Risk for Learning Problems

The Importance of the Early Years

In 1969, Bowlby[2] wrote that a baby's survival is best ensured when he or she maintains contact and closeness with a person to whom they can attach. In child development, the most significant factor during the first year of any child's life is the baby's relationship with the primary caregiver. The child's first attempts to communicate emerge from the ways in which the caregiver and the child interact. With very young babies, the caregiver makes the child's behavior meaningful. For example, a newborn baby cries. The child's caregiver goes to the child and says, "Oh, you're hungry" and feeds the child. What was actually the child's automatic response to discomfort has now been given meaning as a signal that the child is hungry. The child learns that he or she cries, then he or she is fed. What was once an automatic response to a hungry tummy becomes a way of communicating a need.[3]

This personal dialogue between the primary caregiver and the baby continues for about twelve months. Then, when the child is around one year old, the primary caregiver redirects the child away from their personal system of communication towards a system which other persons can understand. As this redirection takes place, the child develops a more recognizable form of communication we call language. The development of a secure relationships with the primary caregiver during the first year of life is the most important developmental task of the infant. The

---

[2] Bowlby, J. (1969). Attachment and loss, Vol. I: Attachment. New York: Basic Books.

[3] Dore, J. (1986). The development of conversational competence. In R. L. Schiefelbusch, (Eds.), Language corpetence: Assessment and intervention, (pp. 3-60). San Diego, CA: College Hill Press.

baby must learn to see him or herself as acceptable and loveable. If the baby does not learn this, he or she may remain preoccupied with attachment concerns and less able to adapt to learning environments.[4]

Sameroff[5] discuss what he refers to as a transactional model of child development. This model is helpful in discussing children who have entered into substitute care. In this way of looking at child development, simple cause-and-effect explanations don't work. Rather, Sameroff suggests that we have to analyze the ways in which the child's environment responded to the particular child's characteristics at a particular point in time.

Cicchetti and Rizley[6] discuss two broad categories of characteristics of the early learning environment of young children in disruptive early environments. They describe "potentiating factors", which increase the probability that the child will have problems developing. Potentiating factors may be biological (such as being premature or low birth weight), psychological (being a child with a difficult temperament), or environmental (parent neglect). The other category, "compensatory factors" decrease the probability that the child will have developmental problems. Compensatory factors include a parent's history of good parenting, secure family relationships, or grandparents or other family members who help in caring for the child.

In discussing child development, Cicchetti[7] describes a series of issues that children must begin to address successfully at a certain point of their lives in order to be effective learners and well-adjusted individuals. These issues aren't tasks which are achieved and then form stepping stones to the

---

[4] Sameroff, A. (1975). Transactional models in early social relations. Human Development, 18, 65-79.

[5] Sameroff, 1975.

[6] Cicchetti, D. & Rizley, R. (1981). Developmental perspectives on the etiology, intergenerational transmission, and sequelae of child maltreatment. New Directions for Child Development, 11, 31-55.

[7] Cicchetti, D. (1989). Perspectives from developmental psychopathology. In D. Cicchetti & V. Carlson (Eds.), Child maltreatment (pp. 377-431). Cambridge, England: Cambridge University Press.

next task. Rather, these issues continue to change and grow through the child's lifetime. For example, during the first year of life, the most essential issue for the child to begin to address successfully is attachment. Between twelve and thirty months, the child must begin to establish his or her independence, exploring the environment, regulating emotions, problem solving, dealing with frustrations, and developing communicative skills. This independence issue is quite apparent in typical children experiencing the "terrible twos," during which time they are exploring everything, trying out "no", and dealing with emotions. This "contrary" period is actually a positive sign that the child is beginning to recognize his or her individuality.

Between thirty months and seven years of age, the primary issue is to establish peer relationships. During this time, children develop a sense of pride in their achievements, develop emotional bonds with peers, self-regulate their own behavior, and become aware of social roles. Finally, between seven and twelve-years-of-age, children must integrate all these issues of attachment, independence, and peer relationships, forming social networks, assuming responsibilities, and becoming aware of their own internal psychological processes.

Milestones for Low Birth Weight and Premature Children

So far we've been describing challenges to development among typical children in what we sometimes would call a "normal" setting. Unfortunately, many of the children in substitute care would not be considered typical children, nor have they always lived in "normal" settings. As we'll discuss later, many of the children who have been drug or alcohol exposed are low-birth weight or premature children. In describing the challenges confronting these children, it is perhaps easiest to begin with the most obvious signs that children aren't developing as quickly or the same way as other children, those developmental milestones we all look for in babies. Max Sugar[8] conducted extensive studies of children who were born prematurely or had low birth weight. The following chart may be helpful in assessing a premature or low-birth-weight child's development.

---

[8] Sugar, M. (1982). The premature in context. New York: SP Medical & Scientific.

Low Birth Weight and Full Term Babies
Differences in Development

Milestone	Low Birth Weight	Full Term
	(in weeks)	
Smile, during exam	17	11
Following persons or bright moving objects	17	16
Recognition of mother's voice	14	9
Recognition of mother's face	16	14
	(in months)	
Stranger anxiety	10	9
Sitting	8	6
Crawling	11	6
Walking	14	11
Teething	10	7

Low-birth-weight babies continue to be challenged as they grow older. In one study, premature and low-birth-weight babies had delayed mental growth and motor skills as late as three to seven years of age. Compared to average birth weight children of the same age, nine year old very low birth weight children scored significantly lower on tests that measure general intelligence. In addition, the children had marked problems in mathematics, beyond those demonstrated by other at-risk populations.

Attachment and Developmentally Challenged Children

Children who have been prenatally exposed to drugs and alcohol are developmentally challenged. For these babies, difficulties in responding to stimulation might disrupt the caregiver-infant attachment process. Blacher and Meyers[9] suggest that the more severely challenged children may never achieve the

[9] Blacher, J. & Meyers, C. E. (1983). A review of attachment formation and disorder of handicapped children. American Journal of Mental Deficiency, 87, 359-371.

full reciprocity in social interactions that is necessary to truly attach to another human being. They feel that this difficulty in forming attachments shouldn't really be surprising, given the problems a severely challenged baby may have in making sense about the primary caregiver's signals. The key parenting behavior which has been associated with the development of better social responses in babies who have severe problems with development is a sensitive and flexible response to the babies movements and cues. Specific comforting techniques, including swaddling and holding may be helpful in working with these babies.

Babies who have been neglected in their very early lives have difficulty with the "movement language" which other babies show. These babies don't reach out for people and toys, don't use their motor skills to seek pleasure or try to get people's attention in positive ways. This is because among young children, the ways in which parents respond to distress, hunger, and feeding sets the stage either for rewarding the babies' signals. Rewarding the baby's attention with attention leads to the baby's experiencing interactions as positive, pleasurable events. If the baby's attempts to connect with other individuals are ignored, the baby will decrease their attempts to get attention in positive ways.

Cox[10] describes several factors that seem to influence the child's development in response to separation from the primary care giver:

* The quality of the maternal bond - the response depends on the strength of the first six months of attachment

* The age of the child - children have the most serious reactions when they are between six months and four years of age

* The length of the separation

* The environment in which the child is placed. Stability, affection, active involvement, and stimulation reduces the stress of separation for the child.

* Whether or not the child is familiar with the new caregiver prior to living with him or her; also remaining with siblings reduces the child's stress.

---

[10] Cox, M. (1984). Interruption in parenting: The incarcerated mother. Topics in Clinical Nursing, October, 49-59.

On a More Optimistic Notes

With the information we now have about child development, one begins to wonder if any children who have had disruptions during their early years will "make it." In 1989, Werner[11] completed a thirty year study of 698 babies who received protective services of some kind, on the Hawaiian island of Kauai. He found that some children did indeed "make it," and there were several patterns among these children. The children whom he called "resilient children":

* Had the sort of temperament that made people respond to them in a positive way
* Enjoyed social interaction
* Had a close bond with at least one caregiver from whom they received positive attention during the first years of life.

Substitute caregivers have the unique opportunity to provide that close bond.

---

[11] Werner, E. (1989). Children of the garden island. Scientific American, 106-111.

What Do the Researchers Say?

The costs of babies exposed to drugs and alcohol is staggering. It is estimated that the cost of one developmentally delayed child from birth to eighteen-years-of-age is approximately $720,000. By the year 2000, there may be between one half and two million drug and alcohol exposed children. In most cities the increasing majority of child welfare cases are drug related, with increased child abandonment, increased violence, and the need for services and placements for special needs children.[12]

Substance abuse has a serious impact on children in two ways. First, children are born with neurological problems because their mothers used drugs and alcohol. Drugs and alcohol cross the placenta and reach the baby, causing birth defects, small birth size, neurological problems, and drug or alcohol dependence.[13] The second way is that these children frequently live in a confusing family environment, either remaining with biological parents who are pre-occupied with drugs and alcohol or entering a series of foster care situations.[14] The problems caused by drugs involving birth defects, growth problems, and neurological problems depend on the type of substance abuse.

In this section, we'll discuss drug abuse, with an emphasis on cocaine abuse, and alcohol abuse separately. Because family problems are the same regardless the type of substance abused,

---

[12] Coletti, S. D. (1990). Testimony of Op0eration Par for United States Senate Subcommittee on Children, Family Drugs, and Alcoholism.

[13] Chasnoff, I. J. (1988a). Drug use in pregnancy: Parameters of risk. The Pediatric Clinics of North America, 35, 1403-1412.

[14] Weston, D. R., Ivins, B., Zuckerman, B., Jones, C., & Lopez, R. (1989). Drug exposed babies: Research and clinical issues. Zero to Three, 9 (5), 1-7.

and we'll discuss them first.

Families Involved in Substance Abuse

When families are involved in substance abuse, two things happen to children. First, the interactions which usually take place between parents and young children may not occur. Second, parents involved in substance abuse do not necessarily have the same priorities as other parents. Their primary concern is to get and use their substance of choice, not to care for their children. As a result, the child's needs are neglected. Children living with substance abusing parents are living in unstable, often dangerous environments, cared for inconsistently by parents who themselves have psychological and physical problems because of the substance abuse.[15]

When mothers are engaged in substance abuse, they may demonstrate mental disorders, such as seizures, paranoid and suicidal thoughts, violent or aggressive behaviors, harming self or others due to delusions, and problems in motor coordination. These can pose dangers to a child. In addition, the effects of drug exposure is intensified because mothers may have a "drug of choice" which they mix with alcohol, cigarettes, and other drugs, as well as being exposed to hepatitis and AIDS, both related to drug use.[16]

Doing research with families who are involved in substance abuse is difficult. Many families are engrossed in illicit activities. Getting information is challenging because the families typically have disorganized daily lives and are preoccupied with the activities of addiction.[17]

There are basically two groups of children who are most seriously injured by drug and alcohol abuse: those prenatally exposed to cocaine, usually in the form of alkaloidal cocaine (crack) and those prenatally exposed to alcohol.

---

[15] Howard, J., Beckwith, L., Rodning, C., & Kropenske, V. (1989). The development of young children of substance abusing parents: Insights from seven years of intervention and research. Zero to Three, 9 (5), 8-12.

[16] Weston, et. al, 1989.

[17] Howard, et. al, 1989.

Children Prenatally Exposed to Cocaine

"Crack" cocaine first became widely available during 1985.[18] Cocaine has emerged as the "first substance of abuse" because it doesn't need to be injected, is easy to get, and is relatively inexpensive.[19] Crack cocaine, sold in the form of small, creamy-colored chunks which look like rock salt, leads to a five to 15 minute "high" in less than ten seconds, and has a far more powerful effect than powdered cocaine.[20] Crack use results in an intense, but brief, feeling of competence, which is then replaced by an irritable, restless, depressed state. Cocaine use is frequently part of polydrug abuse, and is not restricted to those usually perceived as "drug addicts." Cocaine users report more sexually transmitted diseases, and greater use of alcohol, cigarettes, marijuana, opiates, and other drugs during pregnancy.

If a woman uses cocaine one or two days prior to delivery, it can still be detected in the urine of her newborn baby for as long as 96 hours after birth. In contrast, in adults, cocaine is only apparent in the urine for up to 60 hours. This slower metabolism is due to the newborn have a less mature liver than his or her mother.[21] Though the exact risk of cocaine exposure to an individual human pregnancy is unknown, professionals working with women who may become pregnant are urged to tell patients about the possibility of risks to the fetus and watch the

---

[18] Rist, M (1990). The shadow children. The American School Board Journal (January, 1990), 19-24.

[19] Keith, L. G., MacGregor, S., Friedell, S., Rosner, M., Chasnoff, I.J., & Sciarra, J. J. (1989). Substance abuse in pregnant women: Recent experience at the perinatal center for chemical dependence of Northwestern Memorial Hospital. Obstetrics and Gynecology, 73, 715-723.

[20] Gold, M. S. (1987). Crack abuse: Its implications and outcomes. Resident and Staff Physician, 33 (8), 3-6.

[21] van de Bor, M., Walther, F. J., Sims, M. E. (1990). Increased cerebral blood flow velocity in infants of mothers who abuse cocaine. Pediatrics, 85, 733-736.

pregnancy carefully.[22]

The most frequently reported characteristic of cocaine exposed babies is low birth weight, which is also called prenatal growth retardation.[23] Children who are born small have been found to be mentally and physically delayed as long as three to seven years after birth.[24]

Dan Griffith suggests that both the mother and the infant have behavioral characteristics which limit their ability to contribute to a healthy mother/infant relationship. Most cocaine exposed babies are fragile, disorganized infants who spend the majority of time sleeping or crying. These children have low threshholds for overstimulation, and avoid the human face. These babies have difficulty entering and maintaining a "quiet, alert" state which is necessary for parent-child interaction and learning.[25]

---

[22] Hoyme, H. E., Jones, K. L, Dixon, S., Jewett, T., Hanson, J. W., Robinson, L. K., Msall, M. E., & Allanson, J. E. (1990). Prenatal cocaine exposure and fetal vascular disruption. Pediatrics, 85, 743-747.

[23] Bingol, N., Fuchs, M., Diaz, V., Stone, R. K., & Gromisch, D. S.(1987). Teratogenicity of cocaine in humans. Journal of Pediatrics, 110, 93-96.; Farrar, H. C. & Kearns, G. L. (1989). Cocaine: Clinical pharmacology and toxicology. The Journal of Pediatrics, 115, 665-675.; Frank, D. A., Zuckerman, B. S., Amaro, H., Aboagye, K., Baucher, H., Cabral, H., Fried, L., Hingson, R., Kayne, H., Levenson, S., Parkern, S., Reece, H., & Vinci, R. (1988). Cocaine use during pregnancy: Prevalence and correlates. Pediatrics, 82, 888-895.

[24] Harvey, D., Prince, J., Burton, J., Parkinson., D., Campbell S. (1982). Abilities of children who were small for gestational age babies. Pediatrics, 69, 296-300.

[25] Griffith, D. R. (1990). The effects of perinatal drug exposure on child development: Implications for early intervention and education. Paper presented at "Babie and Cocaine", Alexandria, VA: LRP Productions.

Cocaine exposed babies have been found to demonstrate several neurological problems.[26] They may be jittery, and are poor in interacting with others and in organizing stimuli.[27] Cocaine-exposed babies feel stiff when their arms or legs are moved and demonstrate excessively extended postures. Tremors, especially in their arms and hands, occur when they reach for objects. As they grow older, these children maintain their primitive reflexes. These primitive reflexes are important because they have to be replaced by more mature movement patterns as development occurs. Maintaining these reflexes makes the development of body image difficult for cocaine exposed babies.[28]

Children who have been prenatally exposed to cocaine also may demonstrate a wide variety of birth defects, such as microcephaly[29] and malformations of arms or legs.[30] In one study, seven of the ten babies demonstrated defects in their arms or leg, such as absence of arms below the elbow, missing fingers or toes, or missing forearm bones.[31] Because of increased blood flow to the brain, babies exposed to cocaine are at a greater risk of brain hemorrhage after birth.[32] There appears to be a wide variety of both birth defects and symptoms as well as a varied time during which the children's symptoms appear.

Cocaine exposed children are less responsive to their mothers and difficult to engage in play or console when they are

---

[26] Chasnoff, I. J. (1988a). Drug use in pregnancy: Parameters of risk. The Pediatric Clinics of North America, 35, 1403-1412.

[27] Chasnoff, I. J., Burns, N. J., Schnoll, S. H., & Burns, K. A. (1985). Cocaine use in pregnancy. New England Journal of Medicine, 313, 666-669.; Hadeed, A. J., & Siegel, S. R. (1989). Maternal cocaine use during pregnancy: Effect on the newborn infant. Pediatrics, 84, 205-210.

[28] Schneider, J., & Chasnoff, I. J. (1987). Cocaine abuse during pregnancy: Its effects on infant motor development: a clinical perspective. Topics in Acute Care and Trauma Rehabilitation, 2, 59-73.

[29] Hadeed & Siegel, 1989.

[30] Bingol, et al., 1987.

[31] Hoyme, et al., 1990.

[32] van de Bor, et al., 1990.

distressed.[33] In addition, they have unexpected swings in their emotional responses. These babies cannot experience the normal processes of mother-child attachment, which are so important to the early relationship between infant and mother, and, in fact, all social interactions as they grow older.[34]

Children prenatally exposed to cocaine have been found to score in the low average range on developmental scales and tests.[35] The most problems occur when the children are playing, and have to organize, initiate, and independently follow through on play activities. Rather than playing pretend, these children scattered, batted, and picked up and put down toys. This sort of play is usually seen among much younger children.

Perhaps the most frightening results were reported when a test known as cranial ultrasonography was used to contrast cocaine exposed and drug-free yet ill children.[36] The type, location, and distribution of brain damage in cocaine exposed children suggest that symptoms of that brain damage may not be seen in infancy or early childhood. Rather, brain damage may become evident only after the first year, when more complex visual-motor and social skills are required of the preschool- and school age child. Even among the drug exposed babies who appear normal, there is a serious concern for abnormal neurological, cognitive, and behavioral development as they approach school age. This research implies that children could be placed in foster or adoptive homes as fairly "normal" babies, and demonstrate serious problems and challenges to the family as they grow older.

Children Prenatally Exposed to Alcohol

The effects of prenatal exposure to alcohol were first described in 1973. Before this time, most health professionals attributed the learning and developmental problems often found in

---

[33] Howard, et al., 1989.

[34] Chasnoff, I. J. (1988b). Newborn infants with drug withdrawal symptoms. Pediatrics in Review, 9, 273-277.

[35] Howard, et al., 1989.

[36] Dixon, S. D. & Bejar, R. (1989). Echoencephalographic findings in neonates associated with maternal cocaine and methamphetamine use: Incidence and clinical correlates. Journal of Pediatrics, 115, 770-778.

children of alcoholics to a chaotic homelife and poor parenting. However, children raised in consistent, nurturing foster homes also demonstrated behavioral problems.[37]

In 1980, the Fetal Alcohol Study Group of the Research Society on Alcoholism's minimal criteria for the diagnosis of fetal alcohol syndrome was presented. Diagnosis is recommended when the patient has symptoms in each of these categories:

1. Prenatal and/or postnatal growth retardation: weight, length, and/or head size below the 10th percentile when corrected for gestational age;

2. Central nervous system involvement: signs of neurological problems, developmental delays, or intellectual impairment;

3. Common facial characteristics with at least two of these three symptoms: (a) microcephaly (small heads) (b) micro-ophthalmia (small eye slots) and/or small spaces between the margins of the eyelids; c) poorly developed middle between the upper lip and the nose, thin upper lip, or flattening of the jaw area.[38]

Abel[39] suggests that if only one or two of these characteristics are present and the mother is suspected of alcohol use during pregnancy, then a diagnosis of "possible fetal alcohol effects" may be made. Cooper[40] suggests that "possible fetal alcohol effects" broadens the view of alcohol effects on the fetus, emphasizing that alcohol may not only cause the fetal alcohol syndrome but may be associated with a wide range of problems. It is these fetal alcohol effect children who are far more numerous than fetal alcohol syndrome children, are less likely to be identified, and represent a more widespread challenge to teachers, health care professionals, and foster and adoptive parents than fetal alcohol syndrome children, whose problems are more apparent. Three to five children of every

---

[37] Jones, K. L. & Smith, D. W. (1973). Recognition of the fetal alcohol syndrome in early infancy. Lancet, 2, 999-1001.

[38] Rosett, H. L., & Weiner, L. (1984). Alcohol and the fetus. New York: Oxford University Press.

[39] Abel, E. L. (1984). Prenatal effects of alcohol. Drug and Alcohol Dependence, 14, 1-10.

[40] Cooper, S. (1987). The fetal alcohol syndrome. The Journal of Child Psychology and Psychiatry and Allied Professionals, 28, 223-227.

thousand are born with fetal alcohol effects.[41]

Children suspected of fetal alcohol effects or fetal alcohol syndrome demonstrate a broad range of IQ scores. There is a relationship between intellectual functioning and facial symptoms: children with more severe facial symptoms and slower growth seem to demonstrate more brain damage.[42] As young as eight months of age, babies with prenatal alcohol exposure demonstrated lower weight, length, and head circumference, minor physical anomalies, and feeding difficulties.[43]

The most common problem associated with prenatal exposure to alcohol is growth retardation. The baby's length is more severely affected than weight.[44] Of perhaps greater concern, however, is that most of these children seem to demonstrate persistent hyperactivity and distractibility, which cause serious problems in school.[45] These children display a variety of school problems reflecting their brain damage. Research studies to date have shown that these children do not "outgrow" their hyperactivity and impulsivity.[46]

---

[41] Nadel, M. (1985). Offspring with fetal alcohol effects: Intervention and identification. Alcoholism Treatment Quarterly, 2 (1), 105-116.

[42] Streissguth, A. P., Herman, C. S. & Smith, D. W. (1978). Intelligence, behavior, and dysmorphogenesis in the fetal alcohol syndrome: A report on 20 patients. Journal of Pediatrics, 92, 262-267.

[43] Day, N. L., Richardson, G., Robles, N., Sambamoorthi, U., Taylor, P, Scher, M., Stoffer, D., Jasperse, D. & Cornelius, M. (1990). Effect of prenatal alcohol exposure on growth and morphology of offspring at eight months of age. Pediatrics, 85, 748-752.

[44] Rosset & Weiner, 1984.

[45] Spohr, H. L., & Steinhausen, H. C. (1987). Follow-up studies of children with fetal alcohol syndrome. Neuropediatrics, 18, 13-17.

[46] Cooper, 1987.

In a series of carefully controlled research studies, Ann Streissguth and her associates[47] documented the behavioral problems which are present in children prenatally exposed to alcohol. They found as little as 1.5 ounces of alcohol per day was significantly related to an average loss of 10 IQ points. In their longitudinal studies (they have followed some children's development for as long as ten years), which controlled for birth order, the biological mother's education, nutrition, use of caffeine, alcohol, and nicotine, they found that at four years of age, the children they followed had significantly poorer attention and orientation, and longer reaction times than non-exposed children. By school age, careful analysis revealed that these children demonstrated a pattern of problems including memory, problem solving, focusing and maintaining attention, and regulating their impulsivity. Though auditory, spatial, and verbal memory problems were found, impulsivity was the most significant characteristic reported by classroom teachers.

In a sample of primarily middle class, majority culture mothers who reported occasional "social drinking" before they knew they were pregnant, this alcohol use was significantly related to lowered IQ, academic achievement, difficulties in classroom behavior, and problems in attention and in seeing a task or activity through to completion.[48] These children's fetal alcohol effects included poor short-term memory, impulsivity,

---

[47] Streissguth, A. P., Barr, H.M., Sampson, P. D., Darby, B. L. & Martin, D. C. (1989). IQ at age four in relation to maternal alcohol use and smoking during pregnancy. Developmental Psychology, 25, 3-11.; Streissguth, A. P., Bookstein, F. L., Sampson, P. D. & Barr, H. M. (1987). Neurobehavioral effects of prenatal alcohol: PLS analysis of neuropsychologic tests. Neurotoxicology and Teratology, 11, 492-507.; Streissguth, A. P., Clarren, S. K., & Jones, K. L. (1985). Natural history of the fetal alcohol syndrome: A ten-year follow-up of eleven patients. Lancet (Part 2), 47, 422-431.; Streissguth, A. P., Herman, C. S. & Smith, D. W. (1978). Intelligence, behavior, and dysmorphogenesis in the fetal alcohol syndrome: A report on 20 patients. Journal of Pediatrics, 92, 262-267.;Streissguth, A. P., Martin, C. D., Barr, H. M., Sandman, B. M., Kirchner, G. L., Darby, B. L. (1984). Intrauterine alcohol and nicotine exposure: Attention and reaction time in four-year old children. Developmental Psychology, 20, 533-541.; Sampson, P. D., Streissguth, A. P., Barr, H. M. & Bookstein, F. L. (1989). Neurobehavioral effects of prenatal Alcohol: Part II. Partial Least Squares Analysis. Neurotoxicology and Teratology, 11, 477-491

[48] Sampson et al., 1989.

problems with mathematics, and difficulties paying attention. These children demonstrate fine motor problems, such as tremulousness, weak and primitive grasp, poor finger articulation, delay in establishing hand dominance as well as their hyperactivity.[49] A significant number of children who were diagnosed with fetal alcohol exposure in the 1970's are having learning problems, behavioral problems, and attention deficits in the 1980's and well into the 90's, as problems do not decrease as the child grow older.[50]

Children who were prenatally exposed to alcohol were also found to demonstrate specific behavioral and language disorders. These children may be all right in their nonverbal communication, yet have difficulty in verbal language skills. They have been found to repeat familiar routines, themes of play, and topics over and over again. These children were also reported to apparently block on some concepts which teachers claimed they knew. The children were anxious, had poor peer relationships, and played immaturely or inappropriately. The language of these children was unusual, with adequate articulation, but poor knowledge of the rules of dialogue, reduced sentence length, a failure to appreciate the communicative function of language, and little appropriate spontaneous language. The children were hypervigilant, distractible even in normal levels of auditory and visual stimulation, and behaviorally disorganized.[51]

School poses a particular challenge to these children. Aside from their hyperactivity, few problems were noted; none were described as rebellious, antisocial, or negative.[52]

---

[49] Streissguth, A. P. (1976). Psychologic handicaps in children with the fetal alcohol syndrome. Annals of the New York Academy of Sciences, 273, 140-145.

[50] Van Dyke, D. C., & Fox, A. A. (1990). Fetal drug exposure and its possible implications for learning in the preschool and school-age population. Journal of Learning Disabilities, 23 (3), 160-163.

[51] Shaywitz, S. E., Caparulo, B. K. & Hodgson, E. S. (1981). Developmental language disability as a consequence of prenatal exposure to ethanol. Pediatrics, 68, 850-855.

[52] Streissguth, A. P., Herman, C. S. & Smith, D. W. (1978). Intelligence, behavior, and dysmorphogenesis in the fetal alcohol syndrome: A report on 20 patients. Journal of Pediatrics, 92, 262-267.

Considerable difficulty with both classroom management and learning regarding these children were noted. Younger children were found to be cooperative and friendly, yet difficult to work with due to their hyperactivity. Though the hyperactivity slightly decreased in some of the children as they grew older, they retained their difficulties in focusing their attention.[53]

Behavioral and learning difficulties may be the most significant yet most frequently overlooked problems in children exposed to alcohol. Though the children in one study had IQ's well within the normal range, all experienced school failure. Hyperactivity, usually treated through medication, was present in all but one student. Students were described as being unable to function without one-to-one or small group instruction. Statements by school personnel such as "cannot sit still" and "seems to have the skills yet is not learning" were noted in all of the students records. By third grade, all of the students in one study were recommended for special education services.[54]

Other medical disorders were also apparent in these children. In their ten year follow-up, problems with poor dental alignment, malocclusion, and cleft palate, eye problems ranging from strabismus to severe nearsightedness, heart murmurs, and skeletal problems such as scoliosis and dislocated hips. Chronic otitis media and permanent hearing loss, which also have serious impact on language learning, were noted in over half of the subjects.[55]

Summary

With the continued use growth of crack, cocaine, and polydrug use, there will be an increase in the number of children with behavioral problems, learning problems, and attention deficit disorders in foster and substitute care. Children of substance abusing parents are living in unstable, often dangerous environments, cared for inconsistently by parents engaged in

---

[53] Streissguth, A. P., Clarren, S. K., & Jones, K. L. (1985). Natural history of the fetal alcohol syndrome: A ten-year follow-up of eleven patients. Lancet (Part 2), 47, 422-431.

[54] Shaywitz, S. E., Cohen, D. J. & Shaywitz, B. A. (1980). Behavior and learning difficulties in children of normal intelligence born to alcoholic mothers. The Journal of Pediatrics, 96, 978-982.

[55] Streissguth, Clarren, & Jones, 1985.

substance abuse. The developmental effects of the many problems confronting children prenatally exposed to drugs and alcohol and living in substance-abusing families will have an increasing impact on the eduction, medical, social welfare, and justice systems.

In schools, changes will need to be made to meet these children's needs. Administrators should anticipate a low teacher-child ratio to meet the special needs of these children. In order to plan for stability and security, children should be assigned to teachers for more than one year, rather than moving them each year. This would imply that ensuring as few changes as possible in foster placements. In planning for the psychosocial needs and security of these children, teacher may need to cross traditional role boundaries, developing warm and strong relationships to assist the children in developing attachments.[56]

Jeptha Greer, executive officer of the Council for Exceptional Children, reflects that the most recent challenge of children with multiple needs was that of the rubella epidemic; comparatively, she suggests we are facing a tidal wave of children with multiple needs related to drug and alcohol exposure. Social service agencies and schools need to be braced to deal with these children.[57]

---

[56] Rist, 1990.

[57] Greer, J. (1990). The drug babies. Exceptional Children, 56, 382-387.

What We've Learned About the Development of Children who have been Prenatally Exposed to Drugs and Alcohol

As we discussed in the section on early child development, the child's primary caregiver makes the baby's initial movements and automatic responses meaningful. In this way, the baby learns to signal caregivers, and that communication works, that is, that he or she is capable of giving someone a message that is understood and results in the baby getting something he or she wants. At these early stages it is very difficult to separate language and social skills.

Dore [58]describes the way in which the child's first words emerge of the dialogue between the baby and primary caregiver, in which the child's behavior is made meaningful by the parent. Then, at about one year of age, the mother redirects the child to language, a system which others can understand and use. These redirections become the child's first words.

Dore describes a sequence through which babies develop their first words. first, they make a sound, giving a signal along with their actions. They, they begin to develop a small group of signs, that men several different sets of action patterns. As babies mature, they begin to develop words which are more similar to those which adults use. In this stage, children move to become more specific about terms, more general in groupings which mean the word (for example from "ball" for just his ball to all balls), reorganization (for example, from "dog" for all animals to including "dog", "cat", etc.) and detachment (words are no longer paired with the action). In the final stage of developing words, the child can say one word to indicate a different idea (for example, pointing to shoes and saying "Dada", meaning the shoes belong to "Dada.")

During preschool, the child begins to develop more complex language. The child begins to learn social scripts, which he or she uses to anticipate the way a certain event will go. Language has moved from a personal to an interpersonal way of communicating.

---

[58] Dore, 1986.

Before a child can use language effectively, he or she needs to develop regular back-and-forth turntaking habits. In babies, these "baby games" are essential in both building relationships and later language learning. The caregiver, in this stage, is actually a play partner, helping the baby become socially outgoing and responsive. The caregiver plays baby games such as "peek a boo," "so big," "clap hands," and "pat-a-cake." The child's words emerge from a variety of nonverbal communications and a larger base of this social interactive behavior. The caregiver's interactions and communications can genuinely influence the child's communication, especially if he or she makes an effort to match the child's communicative attempts and generally become more sensitive partners.

Among children who are mentally retarded, language and social development may be both slower and different from other children. Even when they were using the same length of phrases of nonhandicapped, younger children, the mentally handicapped children had less sophisticated language. Children may be slower in producing language, slower in both producing and understanding language, or develop language which is similar to nonhandicapped children with the same mental development. In children who are mentally retarded, the child's level of mental functioning may not be his or her level of language functioning.[59]

In our study conducted through the assistance of Hamilton County Department of Human Services, and support from the University of Cincinnati, the foster and adoptive parents of fourteen drug and/or alcohol exposed children aged eight months to six years of age were interviewed to gather information regarding the children's language development. The Receptive-Expressive Emergent Language Scale was used for this purpose.

The Receptive-Expressive Emergent Language Scale (REEL) is an individually administered parent-interview scale which aims to assess the newborn to three-year-old child in understanding language and expressing thoughts and feelings through speech. Three receptive and three expressive language items are grouped with specific ages delineated. In that the rate of development changes as the child grows older, the monthly intervals for groups of items are progressively larger for two and three year olds.

There was a great deal of variation among the children in

---

[59] Rondal, J. A. (1989). Parent-child interaction and the process of language acquisition in severe mental retardation. Beyond the obvious. In K. Marfo, (Ed.), Parent-child interaction and developmental disabilities (pp. 114-125). New York: Praeger.

their receptive, expressive, and total language scores. Only one child was less than one standard deviation below average in the total language quotient. The scores of the eight children, aged eight to seventeen months, who were included in this study are listed below:

Child	Receptive Quotient	Expressive Quotient	Language Quotient
1	38	92	69
3	18	18	18
4	25	13	19
7	73	73	73
8	85	55	78
9	67	89	78
11	94	94	94
13	50	67	58
Average	56.25	62.625	60.875

In typical children, the average receptive, expressive, and language quotient is 100. All but one of the children showed a serious problem (two standard deviations below the mean in one of the areas included in this study. Five had serious problems in receptive language, four had problems in expressive quotient. Even though no pattern seemed to emerge in the kinds of language problems the children demonstrated on this test, serious problems were common. Because this scale is a broad measure rather than specific skills test, more specific patterns related to the children's language development are difficult to discern.

Social Skills

The Social Skills Rating System Parent Preschool form was also administered in an interview format with the parents of four of the children. This 55 item scale includes 38 prosocial behaviors rated on dimensions of frequency and importance, and 17 problem behaviors rated only on frequency. Four factors have been identified for preschool children: Cooperation, Assertion, Social Initiation, and Self-Control. Problem behaviors are described as internalizing (such as acts lonely, appears sad or depressed) and externalizing (such as fights, bullies, disturbs others). Both a standard score and percentile rank are computed for the prosocial and problem behaviors.

Parents reported great variability in their behavior. Three of the children demonstrated fewer positive social skills than their age peers, especially in the area of responsibility. However, only one child showed significantly greater externalizing behaviors (such as fighting, tantrums, arguing,

fidgeting) and internalizing behaviors (such as acting sad or depressed, appearing lonely).

More descriptive information regarding the children's social skills were gleaned from the parents' interviews. The most frequently reported problems involved attending, with comments such as "he has trouble paying attention to what people say," "he seems to wander around as if lost" and "he doesn't always seem to understand what people say to him." Other behaviors reported seemed to involve activity level, with comments such as "fidgity", "agressive, hits and bites", "impulsive." Both of these sets of characteristics appear consistent with the findings of the research presented earlier.

Helping Children who have been Prenatally Exposed to Drugs and Alcohol Develop Language and Social Skills

Throughout this booklet we have emphasized the role of the primary caregiver in the child's early development. This role is essential in the social and language development of the young child. We now look at helping children learn to interact in a more natural way. In this more natural approach to helping children develop language and social skills, the primary caregiver first helps the child become a social play partner. After the child is able to play these "baby games," the caregiver helps the child become a communicator, someone who understands that he or she can give another person a signal which they understand. Parents then help children learn to talk by building new meanings and topics. Finally, the child needs help to learn to converse in order to enter school and social groups outside of the family.

Parents are usually experienced in helping their children learn to talk and converse. They are usually less experienced, however, with children who need help in learning the more basic idea of communicating. McDonald and Gillette[60] describe the following ways to help children at these basic levels.

Social Play

Before a child will learn to communicate, he or she needs to develop regular back-and-forth turntaking habits. Turntaking is involved in infant relationship building and later in language learning. At this level, the primary caregiver become play partners in the child's. The caregiver should appreciate that the quality and form of their interactions are more important goals, at first, than language and communication. Goals include becoming socially initiative and responsive, playing with others,

---

[60] MacDonald, J. D., & Gillette, Y. (1988). Communicating partners: A conversational model for building parent-child relationships with handicapped children. In K. Marfo, (Ed.), Parent-child interaction and developmental disabilities (pp. 220-239). New York: Praeger.

and learning the basic rule of give-and-take. In order to help the baby develop turntaking, the primary caregiver should avoid doing and saying too much. Acting as a "teacher" is not important; instead, the primary caregiver should participate in all the typical baby games, but perhaps both more frequently and for a longer period of time.

Primary caregivers can help children at this age by playing baby games such as "peek-a-boo", "clap hands", "How big is the boy (girl)?" or "Patty-cake". Frequent, spontaneous contacts with the baby are important. At first, what the baby is doing is less important than the fact that the child is having many contacts with another person. As you continue "playing" with the baby, the child will learn to stay in longer and more complex interactions.

Communication

The baby's first words emerge from this base of interactive behavior and nonverbal exchanges between the primary caregiver and the child. When children are beginning to use words, parents sometimes fall into the trap of only accepting words as communication, and pushing the child to use new words. This might decrease the child's motivation to try out new words. Also, because the child is saying words, the primary caregiver may overshadow the child in the amount of talking going on. However, once parents realize that their interactions and communications can genuinely influence the child's communication, they can become more sensitive partners.

At this "first words" stage of the child's development, the primary caregiver should continue to engage the baby regularly in play, with no demands to perform. This will make just interacting with people rewarding. The primary caregivers should talk in ways that describe the child's current experience and that provide words for his or her nonverbal communications. As the child begins to communicate more, the primary caregiver should remember to balance the sides of the conversation.

Girolametto[61] cautions persons interacting with children with disabilities. In her research, she found that the mothers of developmentally challenged children were less likely to respond in meaningful ways, and tend to dominate their

---

[61] Girolametto, L. E. (1989). Developing dialogue skills: The effects of a conversational model of language intervention. In K. Marfo, (Ed.), Parent-child interaction and developmental disabilities (pp. 145-116). New York: Praeger.

interactions with the children. She suggests that parents should follow the child's lead in what to talk about. Opportunities for the child's attempts to communicate to be naturally rewarded should be planned.

Mahoney[62] has fourteen suggestions for enhancing the language and social development of young children:

1. Play together frequently.
2. Get into the child's world, matching his or her level rather than trying to have the child match yours.
3. Make the turns in the conversation or game simple.
4. Keep the child an equal partner in the conversation.
5. Read the child's behavior.
6. Keep in mind how the child is developing in making judgments about his or her behavior.
7. Be responsive to the child. Talk to him or her whenever he or she is nearby. Comment on his or her behavior.
8. Make the interaction enjoyable. Have fun!
9. Decrease your control of the child's behavior.
10. Match the child's interests.
11. Gradually increase the length of the gameplaying or interaction periods.
12. Match the child's behavioral style. Active children like activity, calming children calm.
13. Keep track how the child is developing in other areas.
14. Match your demands to the child's developmental level.

Remember that using a responsive, nondemanding style fits in with what we know about achievement motivation. Children may develop their feelings of being able to control their environment.

---

[62] Mahoney, G. (1989). Enhancing the developmental competence of handicapped infants. In K. Marfo, (Ed.), Parent-child interaction and developmental disabilities (pp. 203-219). New York: Praeger.

Children are also naturally more attentive to their own interests. In addition, the acceptance which is shown in these interactions increases the child's self-esteem.

In summary, helping children learn to communicate is a "child centered" process. With these hypervigilant children, that is, children who are hesitent to let down their guard and interact, the adult does draw attention to topics for communicating. You've probably found yourself drawing the child's attention by saying "look," "listen," or "oh-oh" when something appears or happens. As the child develops, you can begin to shift from baby games, to interacting around toys, and then to interacting around books.

What We've Learned About Parenting Children Who Have Been Prenatally Exposed to Drugs and Alcohol

Stress and Parenting

Parenting any child is a challenge. When that child has been prenatally exposed to drugs or alcohol, the challenges multiply. These children may be immature physically and socially, which has been found to be stressful because of the unusual caregiving demands of immature children on their caregivers. The more severe the child's problems, the more stress is generated. In addition, greater developmental problems may decrease the child's positive reactions to the caregiver, decreasing attachment between the child and the primary caregiver.[63]

In the United States, parents are viewed as being highly responsible for their children and how they behave. When children do not look, act, or perform the way the community feels they should, judgments are made about the parents and their parenting skills. Miller and his associates suggest that parents of developmentally children are balancing many roles, parent, caregiver, and teacher, to name a few. In order to manage stress, parents concentrate on a primary role, and concentrate on one set of responsibilities at a time. Parents who are dealing with the stress of parenting a child with special needs must be willing to compromise standards in one of their roles. [64]

---

[63] Beckman, P. J. & Pokorni, J. L. (1988). A longitudinal study of families of preterm infants: Changes in stress and support over the first two years. The Journal of Special Education, 22 (1), 55-65.

[64] Miller, B . C. & Myers-Walls, J. A. (1983). Parenthood: Stresses and coping strategies. In H. McCubbin & C. R. Figley (Eds.), Stress and the family, Volume I: Coping with normative transitions (pp. 54 - 73). New York: Brunner/Mazel.

Several child characteristics have been related to greater parenting stress. Children with more behavior problems and lower achievement have been found to generate greater parenting stress. Among substitute caregivers, the quality of attachment between the caregiver and child could well relate to the early burnout of caregivers.[65] In severely handicapped children, the full exchange between caregiver and child that is necessary for attaining the highest level of attachment may be not be present, making social interaction with the child one sided.[66] As one special educator once stated, interacting with these children is like playing tennis with someone who is not a very good player. You keep hitting the ball directly to them, but you don't know if they are going to get it, or if they do get it, which direction their response will take.

Burnout and Parenting Developmentally Challenged Children

Burnout is a negative adaptation to stress. Just because a substitute caregiver is under stress, does not mean that the individual will give up parenting or even be dissatisfied with his or her role.[67] Individuals may report feelings of burnout and still continue their roles, be relatively happy with their work, and perhaps even perform well.

Burnout is primarily a product of an individual's perceived ability to do his or her job well. People who enter human services are motivated to do something good for other people. For these individuals, including substitute caregivers, being

---

[65] Bendell, R. D., Stone, W., Field, T., & Goldstein, S. (1990). Children's effects on parenting stress in a low income minority population. Topics in Early Childhood Special Education, 8 (4), 58-71.

[66] Girolametto, L. E. (1989). Developing dialogue skills: The effects of a conversational model of language intervention. In K. Marfo, (Ed.), Parent-child interaction and developmental disabilities (pp. 145-116). New York: Praeger.

[67] Chess, W. A. & Jayaratne, S. (1983). Job satisfaction and burnout in social work. In B. A. Farber, (Ed.), Stress and burnout in the human service professions, (pp. 129 - 141). New York: Pergamon.

helpful is a state which is seen as important. Farber[68] describes how burnout can occur among persons involved in the human services, including substitute caregivers. Substitute caregivers may suffer from conflicts within their roles, with a lack of clarity regarding a person's rights, responsibilities, methods, goals, status, and accountability. This issue is apparent among foster parents in that they are to attach to the child yet not take over the role as the child's parent, and in adoptive parents during preplacement where the are and are not quite the child's parents. In addition, substitute caregivers, in their motivation to do something good for children, may find it hard to say "no," taking in more children, who are more challenging than they can really care for without increased stress. Substitute caregivers may also experience role overload, simply having too much to do.

When they are experiencing burnout, individuals feel that no matter how hard they work, there are no payoffs in terms of accomplishment, recognition, advancement, or appreciation. Substitute caregivers may experience a feeling that they are expected to do more than they can. Also, foster parents may work very hard with an individual child who may return to his or her biological parents, regress, and re-enter foster care. However, in a study related to life stress, Thompson found that individuals who find positive meaning in events are far better able to deal with stress than others. In this way, substitute caregivers, with their strong motivation to help others, have an advantage over the biological parents of children who are developmentally challenged.

Substitute caregivers, especially foster and adoptive parents, however, have a particular stressor in their relationship with the children who they are parenting. Substitute caregivers are frequently parenting children they don't know, children who have no biological relationship to them. In this way, substitute caregivers are unable to recognize the children's behavior patterns, attribute them to a family member, and make a best guess about "how the child will turn out." For example, if a young child is stubborn "just like his dad," caregivers with biological relationships have a sense that "dad turned out okay" and the child will also progress through these phases.

What Parents Told Us about Stress and Parenting Children who have been Prenatally Exposed to Drugs and Alcohol

---

[68] Farber, B. A. (1983). Introduction: A critical perspective on burnout. In B. A. Farber, (Ed.), Stress and burnout in the human service professions, (pp. 1-20). New York: Pergamon.

The impact of maternal drug and alcohol use on infants is significant. Because of the types of disabilities these children may experience, and the sometime chaotic lifestyles of families involved in substance abuse, these children are more likely to be abused and neglected and enter substitute care. Although these children, with their developmental challenges, are almost expected to be difficult to parent, one primary source of information regarding how it feels to parent these children, their substitute caregivers, had been overlooked.

In our study conducted through the assistance of Hamilton County Department of Human Services, the foster and adoptive parents of fourteen drug and/or alcohol exposed children aged eight months to six years of age, were interviewed. Through the Parenting Stress Inventory (Abadin, 1983), the stress generated by providing care for these children was assessed.

The Parenting Stress Index (PSI, Abadin, 1983) is a self-report instrument which is designed to measure the relative amount of stress in the parent-child interaction system which may indicate a risk status for the child's later adjustment. The Index consists of a Child Domain of six subscales with 47 items and a Parent domain of seven subscales with 54 items. A Total Stress Score is obtained by adding the child and parent domain. Interpretive guidelines are provided for score ranges and cutting scores are suggested for making recommendations for professional help.

In addition to the Parenting Stress Index, the foster and adoptive parents were interviewed concerning the children, with open ended questions such as:

* Do you have any specific concerns about this child?

* What is this child's greatest strength? What is the greatest weakness?

Child Characteristics Domain Results

Child Characteristics Domain Scores. Of the fourteen children, nine received significantly high scores in the Child Characteristics Domain. These high scores are associated with children who display qualities which make it difficult for parents to fulfill their parenting roles. For parents of handicapped children (including mentally retarded, hyperactive, cerebral palsied, emotionally disturbed, and learning disabled) the Child Characteristics Domain Score is usually elevated. The most extreme scores are usually found in children who are behaviorally disordered or hyperactive.

Child Adaptability/Plasticity Scores. Seven of the thirteen children received high scores in this area. Children with high scores in this area are difficult to parent in that the child has problems adjusting to changes. These children may continue one activity beyond the time that it is appropriate, have problems changes activities without becoming emotionally upset, overreact to changes in routines, avoid strangers, or become difficult to calm once they are upset.

In this area, the foster or adoptive parents of over half of the children responded in the following ways to these items:

* Foster or adoptive parents of thirteen of the children agreed or strongly agreed with the statement "My child reacts very strongly when something happens that my child doesn't like."

* Foster or adoptive parents of eight of the children agreed or strongly agreed that "My child gets upset easily over the smallest thing."

Acceptability of Child to Parent. Twelve of the fourteen children received high scores in this area. High scores occur in this area when the child does not match the parents' hoped for child.

Foster or adoptive parents of over half of the children responded in the following ways to these items:

* Foster or adoptive parents of ten of the children agreed or strongly agreed that "My child does a few things which bother me a great deal."

* Foster or adoptive parents of eight of the children agreed or strongly agreed to the statements that "My child does not like to be cuddled or touched very much" and "My child doesn't seem to learn as quickly as most children."

Child Demandingness/Degree of Bother. Seven of the thirteen children demonstrated high scores in this area. Children with high scores place many demands on the parent. These demands may include crying, physically hanging on the parent, frequently asking for help, or many minor behavior problems. These children may have difficulty developing independence and show separation anxiety and lack of involvement with peers. In children older than four, high scores on this score usually indicate problems with compliance.

In this area, foster or adoptive parents of over half of the

children responded in the following ways to these items:

* Foster or adoptive parents of nine of the children agreed or strongly agreed to the statement "There are some things my child does that really bother me a lot" and "My child makes more demands on me than most children."

* Foster or adoptive parents of eight of the children agreed or strongly agreed to the statement "My child turned out to be more of a problem than I had expected" and "My child seems to be much harder to care for than most."

Child Mood. Ten of the children had high scores in child mood. Children with high scores in this area are usually unhappy, and frequently cry. High scores have also been found among children who have experienced parental absence and/or non-availability due to alcoholism or substance abuse.

In this area, the foster or adoptive parents of over half of the children responded in the following ways to these items:

* Foster or adoptive parents of nine of the children responded "My child cries and fusses much more than I expected or it seems almost constant."

* Foster or adoptive parents of eight of the children agreed or strongly agreed to the item "I feel that my child is very moody and easily upset."

Child Distractibility/Hyperactivity. Eight of the children demonstrated high scores in this area. Children with high scores in this area are frequently later diagnosed as Attention Deficit Disorder with Hyperactivity (DSMIII 314.01). These children are overactive, restless, distractible, have short attention spans, don't seem to listen, and fail to finish things they start.

Within this area, foster or adoptive parents of over half of the children reported in this way on the following items:

* Foster or adoptive parents of all of the children agreed or strongly agreed that "When my child wants something, my child usually keeps trying to get it."

* Foster or adoptive parents of twelve of the children disagreed or strongly disagreed that "My child can be easily distracted from wanting something."

* Foster or adoptive parents of ten of the children agreed or strongly agreed that "Compared to most, my child has more difficulty concentrating and paying

attention."

* Foster or adoptive parents of nine of the children agreed or strongly agreed that "My child is so active that it exhausts me."

* Foster or adoptive parents of seven of the children agreed or strongly agreed that "My child appears disorganized and is easily distracted" and "My child is much more active than I expected."

* Foster or adoptive parents of seven of the children disagreed or strongly disagreed to the statement that "My child will often stay occupied with a toy for more than 10 minutes."

Child Reinforces Parent. Five children received high scores in this area. High scores in this area indicate that the child fails to produce good feelings by the parent about him or herself.

Parent Characteristics Domain

Scores within the average range in the Parent Characteristics Domain suggest a health parent-child system, as related to dimensions of the parent's functioning. The foster or adoptive parent of only one child demonstrated a score in the high range, and that score was high by only one point.

In view of the subscales of the Parent Characteristics Domain, the foster or adoptive parents of all the children scored within the average range in parent depression, restriction imposed by the parenting role, relations with spouse, and parent health.

Foster or adoptive parents of six of the thirteen children scored in the high range on the parent attachment scale. However, this score, related to a sense of emotional bonding, is probably related to the role of foster parent, and the emotional insulation necessary to fulfill this role as children enter and leave the home. Two families scored in the high range related to sense of competence, and one in terms of social isolation, but again these scores were only high by one or two points.

Foster and Adoptive Parent Concerns and Children's Characteristics

Some consistent concerns emerged from interviews with foster and adoptive parents. The foster and adoptive parents reported stress about the future of the children. This revolved around

either the child's lack of social judgement and activity level, leading to concerns about delinquency, or when the child's behavior would improve to such an extent that they would not require the intensive caregiver parents are providing. In addition, foster and adoptive parents reported stress over unusual sleep patterns, problems with speech and language, and the medically frail nature of some of the children. These parent-reports are consistent with other research literature findings.

Parenting Stressful Children

We've seen that children who have been prenatally exposed to drugs and alcohol can indeed be stressful children. In this section, we will briefly describe ten strategies to help you manage stress. In no way are we providing all the information you need in order to successfully participate in these activities. Rather, we are presenting enough information to increase your awareness of these activities, so that you can seek out further information.

Diet and Exercise

Raschke and her associates[69] have described ways to decrease stress through diet and exercise. They suggest that persons in stressful positions avoid artificial additives, flavorings, and colorings. In addition, avoiding excessive use of alcoholic beverages, coffee, and cigarettes may reduce stress. Quick weight loss programs also generate greater stress; decreasing your intake of saturated fat, processed sugar, cholesterol, and salt may be helpful. Finally, daily exercise in some form can be helpful in reducing stress.

Relaxation Techniques

There are several relaxation techniques that can be helpful

---

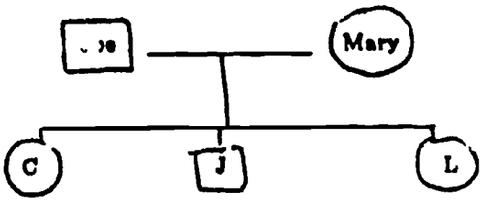
[69] Raschke, D., Dedrick, C., DeVries, A. (1988). Coping with stress. Teaching Exceptional Children, 21 (1), 11-14.

dealing with stress. One simple technique is to sit very quietly with your feet up and eyes closed, listening to soft music. You may need to have another individual "run interference" while you take your fifteen minutes of peace.

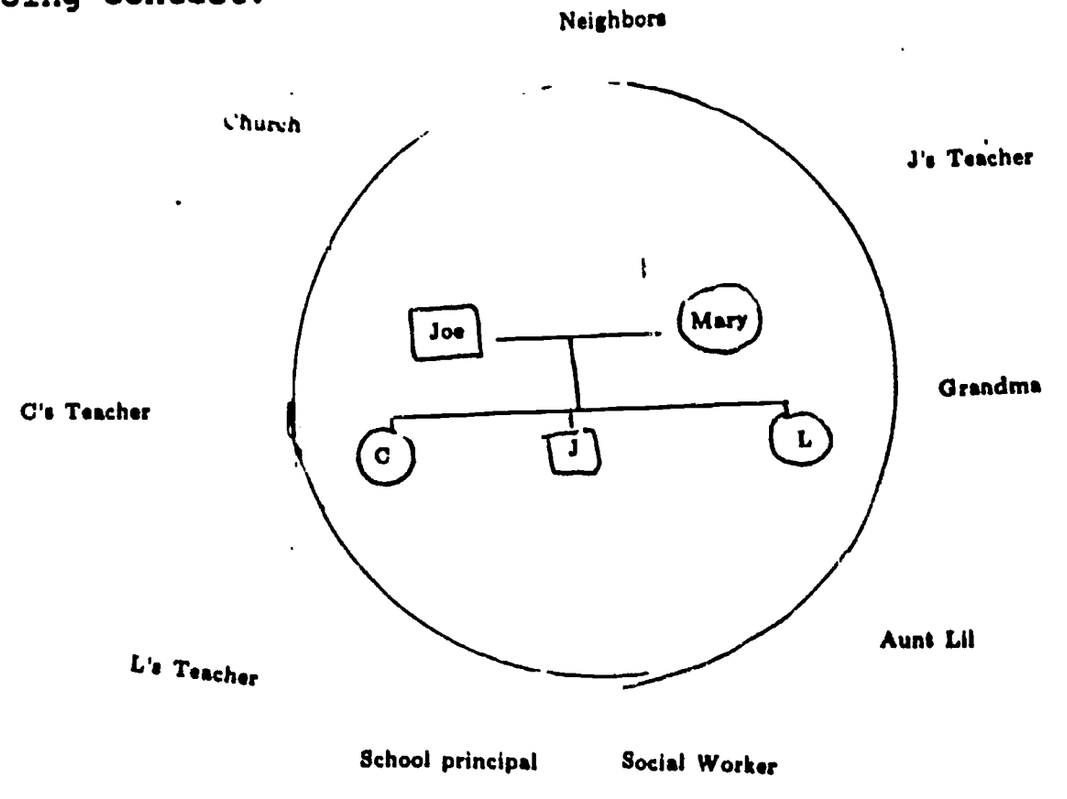
Another useful relaxation technique is called "thought halting." In thought halting you listen to an inner voice that yells "stop" while visualizing a stop sign. You then can take several deep breaths or sit as still as possible for several minutes. Both of these techniques can be coupled with thematic imagery, which is closing your eyes and imaging yourself on the beach, laying on a cloud, or sitting in a warm tub.

Social Support Systems

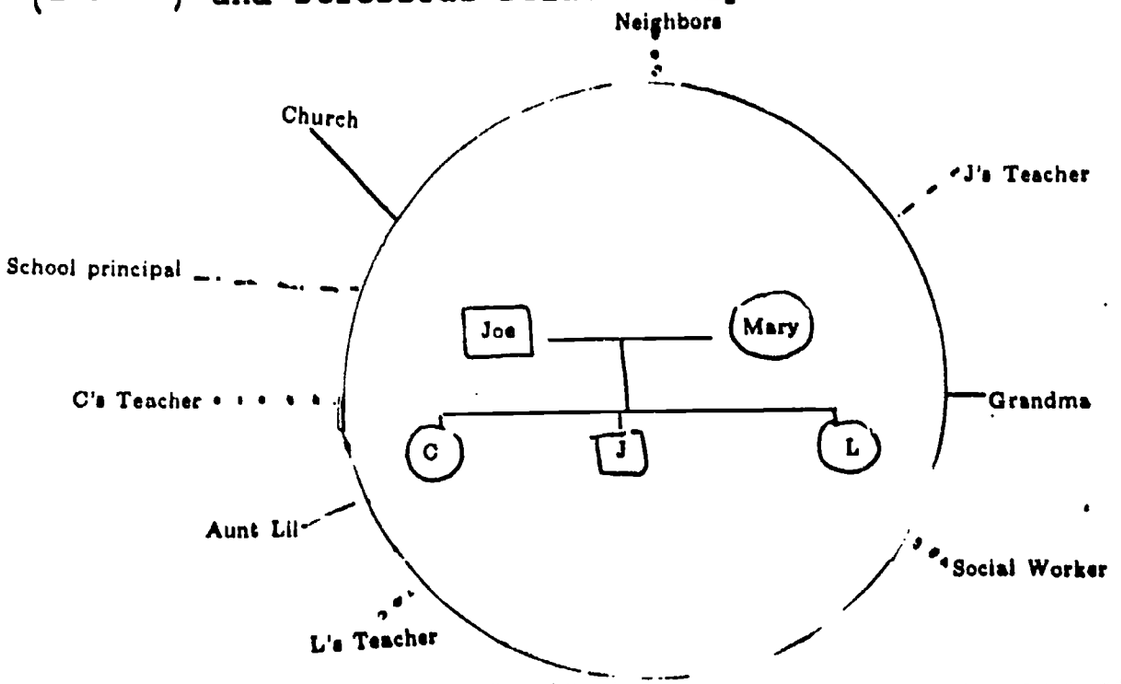
Social support systems have been related to better coping in families in stress. In order to use the supports you have available to you, it may be necessary to first identify them. One way to identify your social supports is through a technique called an ecogram. In an ecogram, you first draw your immediate family, using squares for males and circles for females:



Next you add all of the individuals with whom you have ongoing contact:



Finally you mark the kinds of relationships you have with each of those individuals. Strong relationships are marked with solid lines (_____), questionable relationships with dashes (- - -) and stressful relationships with dotted lines (....).



By studying your family's ecogram, you can see who is helpful and who is stressful. This can give you further insight as to who to call upon and who to work with on relationships. Social supports are essential, but using the same individuals too frequently can be challenging for your supporters themselves. Through looking to a variety of people for support, you can develop a network with backups for your closest supporters.

Goal Settings and Time Management

Anyone who parents frequently feels as if everyone wants a piece of him or her. The number of things to do can at times be overwhelming. There are several strategies, though, that can help you manage the stress of simply having so much to do. The first of these is goal setting. In goal setting you decide the things that you definitely want to accomplish that day and realistically look at what you'll need to do to reach that goal. By setting and accomplishing goals, you have a sense of having done something.

Time management is related to goal setting. It is frequently useful to make a list, ordering the items of the list from most to least important, and checking off jobs as they are completed. A quiet area, which is your "turf", respected by other family members, can be helpful. In addition, IBM's old adage, "if you touch it, do it" can help you decrease the amount

of time you spend thinking about the overwhelming amount of things you need to do, and increase your sense of accomplishment.

In terms of time management, it may be helpful for you to compartmentalize the roles you play. It may be helpful to designate when you are acting as substitute caregiver, rather than spouse, rather than biological parent. At the times in which you are fulfilling one role, try to "turn off the thoughts" related to the other role.

Positive Strokes

Everyone enjoys positive strokes. There are several ways in which you can give them to yourself. First, with positive self-talk, you can make positive comments to yourself. These can be real through "GTM's" (good to myself's), such as simply taking the time for yourself for a long, hot soak, eating that candy bar, or buying that new tape, because you deserve it. Also, by catching the kids being good, you can increase you sense of positive worth and impact on their lives.

Making a Plan for Coping

Another way to help you cope with the stresses of parenting children prenatally exposed to drugs and alcohol is to make a plan for coping. These are the steps to forming such a plan:[70]

1. Determine the real meaning what is happening. For example, a child has entered your home who is crying throughout the night, making it very difficult for all family members to sleep. The real meaning of what is happening has nothing to do with your parenting skills. There is probably little you can do to make the child stop or to make your other family members sleep.

2. Make a decision about how much you can do to work with the situation.

3. Use the stress management techniques described above.

4. Evaluate how well you are doing in coping with the

---

[70] Zeitlin, S., & Williams, G. G. (1988). Developing family resources for adaptive coping. Journal of the Division for Early Childhood, 12 (2), 137-146.

situation.

We recognize that you have a tough job. By taking care of yourself and increasing your personal awareness of how tough that job is, you may be able to do it longer and in a more rewarding way.

Managing the Behavior of Children Prenatally Exposed to Drugs and Alcohol

Persons who have parented children recognize that there is no "cookbook" for managing children's behavior. Everything that we say and do with children has an impact on their behavior. As Shea defines it, behavior management is "all those actions (and conscious inactions) educators engage in to enhance the probability that children, individually and in groups, will develop effective behaviors that are personally self-fulfilling, productive, and socially acceptable." This way of looking at working with children is a little different than "making children behave." In this broad way of looking at behavior management, we must remember:

* all our actions serve as models for our children; children truly learn what they live

* having children control themselves rather than controlling children is the goal

* behaviors which may not be socially appropriate may have been important survival skills in the child's other placements

* children respond to expectations; if we expect them to act out, they will probably oblige us

* children need the opportunity to make mistakes to learn natural consequences

In helping children who have been prenatally exposed to drugs and alcohol, there are several principles to follow:

* Be aware of the child's needs. We have learned that children who were prenatally exposed to drugs and alcohol have difficulty recognizing the effects of their behavior, are very active and distractible, need very specific, concrete directions, and are developmentally delayed.

* Anticipate the child's behavior. After living with a child for even a brief period of time, we can begin to

anticipate the child's behavior. If the child is very active, you can expect that sitting during a church service is going to be a challenge. By anticipating behavior, you can provide the child with limits before a very disruptive behavior occurs.

* Plan ahead. A plan, and a backup plan to deal with the "what if's" is necessary when dealing with children who have the behavioral needs of children who have been prenatally exposed to drugs and alcohol. Though you may plan to use a treat bought from the vending machines at the doctor's office as a reward for quietly waiting, have something tucked in your purse or pocket in case the machine isn't working.

* Encourage the child to be productively occupied. Children are experts at filling their time with activities. However, unless we provide some structure, those activities may not be the ones we prefer.

* Praise appropriate behavior. Children who have been prenatally exposed to drugs and alcohol need to learn to find relationships with individuals rewarding.

In this section, we will discuss strategies which address some of the behavioral issues reported by parents. These strategies are most appropriate for two of the most common behaviors reported: impulsive behavior and poor social judgment.

Behavior Management for Self-Management

Keeping in mind our goal of self management changes the ways in which we tackle children's behavior. One of the most effective ways of working towards self-management, especially with children prenatally exposed to drugs and alcohol who may have problems relating their behavior to the effects of their behavior, is the use of natural consequences. In natural consequences, the results of the child's behavior are the naturally occurring results. For example, if you spend all morning playing with your shoes, and you can't go outside until you have your shoes on, then you simply have less time to play. If you play with your pop and spill it, you clean it up, and don't have more. The National Association for the Education of Young Children[71] suggests the one of the biggest causes of discipline problems may be the issue of the caregiver's need to

[71] National Association for the Education of Young Children, (1988). The difficult child, Young Children (July), 60-68.

control. Rather, we should trust children to make a nearly constant effort to learn the complex social patterns we constantly teach, by controlling the situation, not the child.

There are several basic learning principles that can help with behavior management:

* Children learn to behave in a certain way because of what happens after that behavior. In children who have been prenatally exposed to drugs and alcohol, however, who may have difficulty making the connection between their behavior and the result, you may need to be even more consistent and persistent that with other children.

* When children are first learning something, they need to be praised or rewarded every time the new behavior occurs.

* Whenever you do something to have a child behave in a certain way, you need to have a plan for how you are going to remove the supports so children begin to act on their own.

* Generalization (doing a positive behavior in more than one place or for more than one person) must be considered. We've all had the frustrating experience of a child acting a certain way for one person and not another.

* The reward which you use must be considered valuable by the child. You can't assume all children like stickers or M&M's or a trip to the store.

* Punishment should be avoided because:
    1. it only suppresses rather than decreasing the behavior
    2. it doesn't let the child know what he or she is supposed to do
    3. aggression by the punisher presents the child with an inappropriate model
    4. punishment may increase the child's fear, tension, stress, or withdrawal
    5. punishment may increase the child's avoidance of adults

In addition to these basic principles, we have begun to realize the importance behind the reasons for a child's behavior.

Why Children Do the Things They Do

In helping children with developmental disabilities learn to manage their own behavior, its important to consider why children do the things they do. Anne Donnellan[72] suggests that we always make "the least dangerous assumption" when we're dealing with children. The least dangerous assumption we can make is that they are acting in a way which seems most productive to them. Though they may do things we don't prefer, children behave in ways which are their best efforts to meet their needs.

There are four basic reasons why children do the things they do:

* the behavior gets them attention.
* the behavior places them in control of the situation.
* they have not yet learned other ways to behave
* they are not mature enough or ready to behave in other ways

In discussing children who have been prenatally exposed to drugs and alcohol, we are primarily talking about children who have not yet learned other ways to behave or who are not mature enough or ready to behave in other ways. Because of the difficulty these children have in connecting their behavior to the effect their behavior has on the environment, they have difficulty learning more productive behaviors. In addition, with their neurological problems, maturity is a consistent problem.

With the complex problems confronting children who have been prenatally exposed to drugs and alcohol, punishment is inappropriate. They simply may not understand why they are being punished. Rather, some techniques which help you teach the child more appropriate ways of behaving should be used.

One way of teaching children an appropriate behavior is called contingent observation. Porterfield, Herbert-Jackson, and Risley[73] suggest that contingent observation is an effective way of teaching social skills such as sharing. These steps would be used for contingent observation:

---

[72] Donellan, A. M. (1984). The criterion of the least dangerous assumption. Behavioral Disorders 9 (2), 141-150.

[73] Porterfield, J. K, Herbert-Jackson, E., & Risley, T. R. (1976). Contingent observation: An effective and acceptable procedure for reducing disruptive behavior of young children in a group setting. Journal of Applied Behavioral Analysis, 9, 55-64.

1. Tell the child the inappropriate behavior (In this house we don't take toys from other children)

2. Tell the child the behavior you desire (In this house we ask for the toys we want)

3. Move the child away from the other children playing, and have him or her sit without any toys (Sit here and watch how the other child ask for the toys they want)

4. When the child has been watching quietly for a little less than one minute, ask the child if he or she is ready to go back to play.

5. If the child indicates yes, he or she rejoins the group. If the child indicates no, or gives no response, he or she is told "Sit here and watch the children until you think you can ask for the toy you want"

6. The child sits for another 30 sec. to 1 minute, and repeats step 4.

7. When the child returns to the group, positive attention is given for the appropriate behavior (Great! You asked for the toy you wanted!)

8. If the child cries or disrupts the group for a few minutes, or if the child refuses to sit quietly, he or she is taken to a quiet place for no more than one minute for each year of the child's age (totalling no more than five minutes.)

Another strategy for children who have not developed appropriate behaviors involves being very precise in the behavior expected and required by the situation. Sanders and Glynn provide a technique for helping children with unusual situations, such as waiting in a doctor's office:

1. Prepare the child by describing the expected behavior. Describe where you are going and how long it will take. (We are going to the doctor's office. There will be many people waiting. You will need to look at books or play quietly with toys for what seems like a long time.)

2. When you arrive, involve the child in an activity and make sure the child has something to do; remind the child you have a treat available.

3. Interact with the child and praise him or her every so

often.

4. If a disruptive behavior occurs, gain the child's attention immediately.

5. Describe the problem and state the correct behavior (We don't yell in the doctor's office. We wait quietly and look at books.)

6. If the child obeys, continue interacting with the child and praising him or her.

7. If the problem continues, say (No. We wait quietly and look at books.)

8. If the child does not obey immediately, provide a backup consequence (Remove from play or book area or "you will get a treat if you wait quietly.")

Specific Problems of Children who have been Maltreated

As we mentioned earlier, children who live in families engaged in substance abuse have a strong chance at being maltreated. Maltreatment in itself generates a range of behaviors which may add another layer to the behavioral challenges of children who have been prenatally exposed to drugs and alcohol. Pat Crittenden[74] has explored each of the three kinds of maltreatment, effects on children, and ways of working with them.

Children who have been abused. Children who have been physically or emotionally abused usually develop social interactions in one of two patterns: compliance or defiance. These children are experts at reading their caregivers current emotional state. Compliant abused children have learned to both predict and manage adult behavior, through surface "pleasing" behaviors. Defiant abused children can predict adult anger, but have not yet figured out how to manage it. So, they react with anger and aggression. Compliant abused children are often seen as devious, as only "skin deep," and when punishment is used, become even more manipulative. Defiant abused children, when punished, simply become more aggressive and angry.

Compliant abused children rarely experience joy in discovering new things or satisfaction with achievement. They must encouraged to try new things, and praised. Defiant abused

---

[74] Crittenden, P. (1989). Teaching maltreated children in the pre-school. Topics in Early Childhood Special Education, 9 (2), 16-32.

children have difficulty accepting direction from others, and have battles with authority. Defiant abused children understand conflict, and frequently enter into power struggles with caregivers. Behavior management which encourages self-management is essential for both these groups of children. A structured, predictable environment is needed, where limits are enforced through natural consequences. It is necessary to emphasize that loss of privileges or activities through natural consequences is not the caregiver's fault, but a result of the child's actions.

Children who have been neglected. Neglected children may treat people like objects. These children have little understanding of adult behavior, and fail to understand the relationship of punishment to behavior. They have learned that adults are unlikely to respond under any conditions, and that, therefore, they can safely be ignored or used as tools to get things.

Children who have been neglected have a difficult time attending to stimulation. In environments, such as playrooms, which excite other children, children who have been neglected flit from one thing to another. These children need repetition and structure. They have not learned that caregivers interfere with their behavior, and may need the "broken record" technique of interfering neutrally and repeating the same simple rule again and again. For example, if the child is throwing toys, the caregiver would interfere with "In this house we don't throw. We play with toys" and model playing with the toys appropriately. As soon as the child throws again, repeat the rule and model. At that point you may choose to remove the child for a very brief period (30 seconds to one minute) before saying the rule again and letter them have the toys. A structured, predictable environment is needed, with a great deal of individual attention. Caregivers should be aware of how emotionally needy these children are.

Marginally maltreated children have lived in families in which there are substantiated reports of mixed abuse and neglect that is too mild to result in removal of the children at the first intervention of Human Services. These children are very needy, and seek a great deal of attention. They continue disruptive behavior as long as it gets them the attention they desire. The are distractible and delayed, but don't have the serious problems seen in abused or neglected children. They are anxious and have low self-concept. They don't attempt things for fear of failing. These children need ongoing, positive adult attention. Ignoring behavior is not appropriate for these children because they will increase the level of behavior being ignored until it may be dangers. Limits should be clear, and following limits should be rewarded.

Summary

Some key thoughts concerning the behavior of children who have been prenatally exposed to drugs and alcohol include:

* Many of these children are very active and impulsive. They may not think before they act. The child may not be able to respond to questions about why they did something.

* Many of these children are able to do something one day, and appear to forget the next. This problem is as frustrating to them as it is to you.

* The aim of any behavior management is self-management. This is a particular challenge for children who have been prenatally exposed to drugs and alcohol and are hyperactive, impulsive, and have poor social judgment. These children seem to require even more consistent, clear communication about limits and natural consequences when those behavioral limits are crossed.

Once They're in School. . .

Margaret Rist[75] reminds us that schools are just beginning to see children prenatally exposed to drugs and alcohol in their classrooms. Though the children who will be or are in regular education also need support, this section will provide information regarding those children who receive services in special education. Working with children in special education, with the complex paperwork, specific rules and guidelines, and confusing categories, is frequently challenging to parents whose other children have attended regular education

How Does a Child End Up in Special Education?

Children are usually evaluated for special education as a result of one of two processes: screening and referral. In screening, some sort of assessment is completed on the child to determine if additional testing is necessary. In referral, the child is identified by parents, primary caregivers, doctors, or community agency personnel, as potentially having a problem and needing further testing.

Referring children for special education is a complicated process. First, the teacher (or parent or caregiver) completes some sort of referral form. This form may ask information about how the child developed, illnesses, or any remarkable events in the child's life. If a teacher is completing the referral, he or she must describe all of the activities which he or she used to try to meet the child's needs. If parents or caregivers or completing the referral, a reason for the referral should be carefully written. A parent's referral usually goes immediately to a team which studies and evaluates the child. This team will call the parent and have a conference in order to get the parent's permission to test the child.

---

[75] Rist, M (1990). The shadow children. The American School Board Journal (January, 1990), 19-24.

The teacher's referral usually goes to the school principal or supervisor. After reviewing it, the principal either forwards the referral to the school's referral committee, or returns it to the teacher. After reviewing the referral, the committee schedules a conferences with the principal, the individuals acting for the child as parents, and teacher. The purposes of this conference are to determine if testing is the next step for the student. Parents may refuse to consent to the testing.

If testing is the next step for the student, a diagnostic evaluation takes place. Both formal tests (structure procedures with specific guidelines for administration, scoring, or administration) and informal ways (interviews, checklists, rating scales) are used to evaluate the child. Diagnostic and evaluation team members have two responsibilities: to develop a case study report and to write an individualized education plan. The case study report includes reports on all the testing results and the child's history. This report concludes with a decision as to whether the child meets the criteria of the different special education categories. If the child meets the criteria of any of the categories, he or she is eligible for special education. The criteria for these categories is described in the next section.

The second document, the Individualized Education Plan (IEP) is completed if the child meets the criteria for one of the categories of special education services. If the student is eligible, the team writes educational goals and objectives, decides what kinds of services the child needs, and recommends a placement for the child.

Parents and those who are acting as the child's parents are active decision makers during the IEP process. In dealing with schools, Theresa Early[76] suggests that you tell yourself:

* My experience of my child is important. I am an expert on how I experience my child.

* My child has a right to an appropriate education and school personnel have a responsibility to provide it.

* No matter how much conflict there is between the school and me, my child needs an education. Its important for me to keep in mind that I have to be able to work with

---

[76] Early, T. J. (1989). What you need to know about your child with an emotional disability and the individualized educational plan (IEP). Lawrence, KA: University of Kansas School of Social Welfare.

the school.

The IEP is a report that includes a statement of the child current level of functioning, annual goals, short term objectives to meet those goals, a statement of the amount of time the child spends with children who are not in special education, and all the services which the child will be provided. It is reviewed by the parent and special educators at least once a year. Without an IEP, a child cannot be in special education.

What Are the Different Categories of Special Education Children?

Public Law 94-142, the law which required all children to have a free, public, appropriate education, no matter their disability, defines the following categories of special education children. The federal definition of the category is also included:

* Mental retardation: significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period (before 18 years of age).

* Specific learning disabilities: a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, which may manifest itself in an imperfect ability to listen, think, speak, read, write, spell, or to do mathematical calculations. The term includes such conditions as perceptual handicaps, brain injury, minimal brain disfunction, dyslexia, and developmental aphasia. The term does not include children who have learning problems which are primarily the result of visual, hearing, or motor handicaps, of mental retardation, of emotional disturbance, or of environmental, cultural or economic disadvantage.

* Seriously emotionally disturbed: a condition exhibiting one or more of the following characteristics for a long period of time and to a marked degree, which adversely affects educational performance: (a) an inability to learn which cannot be explained by intellectual, sensory, and health factors; (b) an inability to build or maintain satisfactory interpersonal relationships with peers and teacher; (c) inappropriate types of feelings under normal circumstances; (d) a general pervasive mood of unhappiness or depressions; or (e) a tendency to develop physical symptoms or fears associated with personal or school problems.

* Speech and/or language impaired: a communicative

disorder such as impaired articulation, language or voice disorder, and fluency disorders (such as stuttering), which adversely affects a child's educational performance.

* Deaf: having a hearing impairment which is so severe that the child is impaired in processing linguistic information through hearing, with or without amplification, which adversely affects educational performance. Hard of hearing: a hearing impairment, whether permanent or fluctuating, which adversely affects a child's educational performance but which is not included under the definition of deaf.

* Visually handicapped: a visual impairment which, even with correction, adversely affects a child's educational performance. The term includes both partially seeing and blind children.

* Orthopedically impaired: a severe skeletal deformity with adversely affects a child's educational performance.

* Other health impaired: having an autistic condition which is manifested by severe communication and other developmental and educational problems, or having limited strength, vitality, or alertness due to chronic or acute health problems such as a heart condition, tuberculosis, rheumatic fever, nephritis, asthma, sickle cell anemia, hemophilia, epilepsy, lead poisoning, leukemia, or diabetes, which adversely affects a child's educational performance.

* Multihandicapped: concomitant impairments as mentally retarded-blind, mentally retarded-orthopedically impaired, the combination of which causes such severe educational problems that they cannot be accommodated in special education programs solely for one of the impairments.

The definitions used in school districts for each of the categories depends on the state in which the district is located.

From what we know so far about children who have been prenatally exposed to drugs and alcohol, these children may learn at a slower rate and develop mentally to a lower level (mentally retarded), have specific learning disabilities, have behavior problems (seriously emotionally disturbed), have orthopedic handicaps, language problems, or be multihandicapped.

What Are Some of the Services Available in Special Education?

Children in special education are served in many places, and may receive many different services. They may be placed in resource rooms, where they only spend part of the day for special help, or attend special classrooms in the regular school either part or full time. Children with more serious disabilities may attend a special school. Very disabled children may receive help from a homebound teacher who comes to them five hours each week. In addition, these children may receive:

* Special transportation
* Speech, language, and communication therapy
* Audiology (hearing assessment and monitoring)
* Psychological services (ongoing testing)
* Physical or occupational therapy
* Medical and school health services
* Counseling and social work services

If these services are stated on the child's IEP, they must be provided by the school district free of charge.

How to Help a Child in Special Education

There are several things you can do to help a child in special education. Perhaps most importantly, you can exercise your rights. You have the right to:

* review all of the educational records kept on your child
* have the child evaluated by someone outside of the school district
* written notice that they are going to evaluate the child; you may or may not consent to the testing
* an impartial hearing if you disagree with the school district's decision
* equal participation in planning the programming for the child

For any child in special education, it is important to remember that the district is there to meet your child's needs, not to make your child fit.

Who Should Know What?

Children in substitute care, especially those who have been prenatally exposed to drugs and alcohol, have complex personal histories. Persons parenting these children are continually faced with a dilemma: How much should the school know? and What is really "none of their business?" In confronting this dilemma, it may be helpful to ask yourself these questions:

* Is the information necessary for the child's physical safety? (for example medication the child is on, whether the child has seizures, if there is any medical concern)

* Is the information necessary for the safety of others? (for example, is the child aggressive or destructive? Does he or she take risks?)

* Is the information necessary for the child's personal safety? (for example, are there restraining orders against biological family members?)

* Is the information necessary for the teacher to teach the child? (for example, is there a hearing loss? a visual problem? does the child have an attention problem?)

* Is the information necessary for the teacher to understand and deal with the child's behavior? (for example, a female child who has been sexually abused having difficulty relating to a male teacher, children who "duck" when fast movements occur around them, children who hide food).

* Would the information have an impact on his or her expectations for the child? (for example, biological parents and other siblings who are mentally retarded)

The amount of detail provided should be carefully considered. For example, where it may be helpful for a teacher to know that a child's father is incarcerated, the specific crime is irrelevant. There may also be times when some professionals need to know information and others do not. The school nurse may need to know some issues, where as the principal may not. If in doubt, remember the child's privacy, and consult your caseworker.

Glossary

abruptio placenta - early separation of the placenta from the wall of the uterus

adaptive behavior - the success with which an individual is independent and socially responsible in terms of his or her age and cultural group; includes maturity, learning, and social adjustment

ADD (attention deficit disorder) - a disorder with onset before seven years of age, continuing at least six months, marked by significant inattention and impulsivity

addicted - emotionally and/or physically dependent on a substance

ADHD (attention deficit hyperactivity disorder) - a disorder with onset before seven years of age, continuing at least six months, marked by significant inattention, impulsivity, and hyperactivity

alcohol exposed - documented use of any amount of alcohol by the mother during pregancy

anoxia - reduced oxygen content of the blood to a point where the functioning of brain tissue is affected

ataxic - a lack of physical coordination

attachment - the relationship that forms between the child and caregiver, usually during the first year of life, which influences the child's approach to intellectual, social, and emotional situations

bio-underclass - the group of children whose combined physical damage and socioeconomic disadvantaged could lead to a life of inferiority

cerebral palsy - a motor handicap which occurs before or during birth; problems include poor balance, awkward or unintentional movements, poor speech, and tight muschles

cocaine - cocaine hydrochloride; a stimulant which is typically sniffer; lowers anxiety and social inhibitions

cognitive deficit - limited function in some intellectual area

contingency awareness - an awareness that personal behavior has an effect on the environment or results in another person's actions

CP - see cerebral palsy

crack - alkaloidal cocaine, sold is mall, creamy-colored chunck which resemble rock-salt; usually smoked, crak lead to a reaction in less than te \ seconds

craniofacial abnormalities - differences in the formation of the skull and face; the typical craniofacial abnormalities include small head size, flattened philtrum, short, upturned nose; small eyes, think upper lip, and oversized jaw

DD - see developmental disability

developmental disability - a severe, ongoing disability caused by a mental and/or physical problem, which according to Ohio's definition (a) is found before the person is 22 years old, (b) is likely to continue, (c) reduces the person's effectiveness in self-care, language, learning, mobility, self-direction, indepependence, and (d) reflects the persons need for longrange special services

developmentally handicapped - Ohio's term for persons who are educable or trainable mentally retarded

discrimination - the ability to see and/or hear differences and similarities in the environment

drug babies - infants who have been drug and alcohol exposed or who are born drug or alcohol addicted

drug-exposed - documented use of any drug by the mother during pregnancy

DSM III R - Diagnostic and Statistical Manual of Mental Disorders - Third Edition, Revised - the manual used by psychologists and psychiatrists for diagnosis of psychiatric problems

dysmorphic - the process of malformations or creating problems in structure and formation

echolalia - repetition of a word, phrase, or sentence spoken by another person

enuresis - not toilet trained after the age when bladder control usually occurs (18 months during the day, 3 years at night)

epicanthal fold - a fold of skin on either side of the nost which sometimes covers part of the split between the eyelids

epilepsy - sometimes called convulsive disorders; a disorder marked by seizures; seizures may include losing consciousness, convulsive movements, or disturbed behavior

ethanol - alcohol

fetal alcohol effects - symptoms of neurological problems, facial characteristics, or growth retardation related to alcohol use during pregancy; symptoms are not as servere as in fetal alcohol syndrome, and problems may occur in only one area

fetal alcohol syndrome - a pattern of malformations and alcohol-related defects related to alcohol abuse during pregnancy; for diagnosis of fetal alcohol syndrome there are three patterns: neurological problems, facial characteristics, and growth retardation

hyperactive - activity above the normal level expected for an individual's age

IEP - Individual Education Program or Plan; a written description of the goals and objectives for a special education student which is collaboratively developed by the parents and school

IFSP - Individual Family Service Plan; for preschool special needs children; a written description of the resources to help a family meet their goals for their child's development, which is collaboratively developed by the parents and preschool-program

intelligence quotient - IQ - a number used to express the intelligence of a person when compared to peers

language disorder - problems associated with understanding and producing language

learning disability - "specific learning disability" in Ohio; children who have a problem in one or more of the psychological processes dealing with written or spoken language; the child have difficulties in learning, speaking, reading, writing, spelling, or doing arithmetic. Children who have visual, hearing, or movement problems, or who are mentally retarded or behaviorally disordered are excluded from this group.

low birth weight - children born weighing less than or equal to five pounds

MDI - mental development index; used with the Bayley Scales of Infant Development much the same way as IQ

mental age - the mental ability of a person, as measured on an intelligence test

mental retardation - general intellectual function and adaptive behavior significantly below that of others; must be identified before the individual is 18 years old

microcephaly - abnormal smallness of the head

morbidity - the rate of disease or physical problem in a population

morphology - the structure and formation of a being

neonate - newborn infant

otitis media - inflammation of the middle ear, usually involving trapped fluid

OT/PT - occupational therapy/physical therapy

palbebral fissures - the "slots" in which the eyes are located

perinatal - during birth

PE tube - a plastic tube inserted through the ear drum when there is entrapped fluid in the middle ear; PE stands for "pressure equalization"

phenylcyclidine hydrochloride (PCP) - a central nervous system active drug often refered to as "angel dust"

philtrum - the indentation in the midline of the upper lip

pragmatics - the use of language in communicating

premature infants - infants of birth weight less than five points or gestational age less than 36 weeks

preterm infants - see premature infants

ptosis - drooping of the upper eyelid

secondary drug usage - use of cigarettes or alcohol in addition to another drug

SIDS - sudden infant death syndrome

stage-salient issues - important age and stage-appropriate tasks which are critical to a child's development of social competence

teratogen - any substance than interferes with the normal development of a fetus

teratogenicity - the propoerty of a chemical or disease to cause malformation in a fetus

transactional model - a way of looking at child development in which any contact between the child and another individual or the environment is seem as a transaction in which each is changed by the other; for example, the baby is effecting those who take care of him or her just as he or she is effecting the people who care for him or her

very low birth weight - children born weighing less than or equal to 1500 g. (approximately 3 lbs. 4 oz.)

withdrawal - physical and socioemotional effects of discontinuing use of a substance on which an individual has become dependent

References

Abel, E. L. (1984). Prenatal effects of alcohol. Drug and Alcohol Dependence, 14, 1-10.

Backhaus, K. A. (1989). Training mental health practitioners to work with adoptive families who seek help. Child Welfare, 68 (1), 61-68.

Barnett, D. W., Hall, J. D. & Bramlett, R. K. (1990). Family factors in preschool assessment and intervention: A validity study of parenting stress and coping measures. Journal of School Psychology, 28, 13-20.

Barr, H. M., Streissguth, A. P., Darby, B. L., & Sampson, P. D. (1990). Prenatal exposure to alcohol, caffeine, tobacco, and aspirin: Effects on fine and gross motor performance in four year old children. Developmental psychology, 26, 339-348.

Baumeister, A. A., Kupstas, F., & Klindworth, L. M. (1990). New morbidity: Implications for prevention of childrens' disabilities. Exceptionality, 1, (1-16).

Beckman, P. J. & Pokorni, J. L. (1988). A longitudinal study of families of preterm infants: Changes in stress and support over the first two years. The Journal of Special Education, 22 (1), 55-65.

Bendell, R. D., Stone, W., Field, T., & Goldstein, S. (1990). Children's effects on parenting stress in a low income minority population. Topics in Early Childhood Special Education, 8 (4), 58-71.

Bingol, N., Fuchs, M., Diaz, V., Stone, R. K., & Gromisch, D. S.(1987). Teratogenicity of cocaine in humans. Journal of Pediatrics, 110, 93-96.

Blacher, J. & Meyers, C. E. (1983). A review of attachment formation and disorder of handicapped children. American Journal of Mental Deficiency,k 87, 359-371.

Bowlby, J. (1969). Attachment and loss, Vol. I: Attachment. New York: Basic Books.

Camarata, S. M., Hughes, C. A., & Ruhl, K. L. (1988). Mild/moderate behaviorally disordered students: A population at risk for language disorders. Language, Speech, and Hearing Services in the Schools, 19, 191-201.

Campbell, L., Clark, M., & Kirkpatrick, S. E. (1986). Stress management training for parents and their children undergoing cardiac catheterization. American Journal of Orthopsychiatry, 56, 234-243.

Chasnoff, I. J. (1985). Effects of maternal narcotic vs. nonnarcotic addiction on neonatal neurobehavior and infant development. In T. M. Pinkert, (Ed.), Current research on the consequences of maternal drug abuse (pp. 84-95). (NIDA Research Monography #59). Washington, DC: Department of Health and Human Services.

Chasnoff, I. J. (1988a). Drug use in pregnancy: Parameters of risk. The Pediatric Clinics of North America, 35, 1403-1412.

Chasnoff, I. J. (1988b). Newborn infants with drug withdrawal symptoms. Pediatrics in Review, 9, 273-277.

Chasnoff, I. J., Burns, N. J., Schnoll, S. H., & Burns, K. A. (1985). Cocaine use in pregnancy. New England Journal of Medicine, 313, 666-669.

Chess, W. A. & Jayaratne, S. (1983). Job satisfaction and burnout in social work. In B. A.

Cicchetti, D. (1989). Perspectives from developmental psychopathology. In D. Cicchetti & V. Carlson (Eds.), Child maltreatment (pp. 377-431). Cambridge, England: Cambridge University Press.

Cicchetti, D. & Rizley, R. (1981). Developmental perspectives on the etiology, intergenerational transmission, and sequelae of child maltreatment. New Directions for Child Development, 11, 31-55.

Cicchetti, D., & Toth, S. L. (1987). The application of a transactional risk model of intervention with multi-risk maltreating families. Zero to Three, 7 (5), 1-8.

Clarren, S. K., & Smith, D. W. (1978). The fetal alcohol syndrome. New England Journal of Medicine, 298, 1063-1067.

Coletti, S. D. (1990). Testimony of Op0eration Par for United States Senate Subcommittee on Children, Family Drugs, and Alcoholism.

Cooper, S. (1987). The fetal alcohol syndrome. The Journal of Child Psychology and Psychiatry and Allied Professionals, 28, 223-227.

Cox, M. (1984). Interruption in parenting: The incarcerated mother. Topics in Clinical Nursing, October, 49-59.

Crittenden, P. (1989). Teaching maltreated children in the pre-school. Topics in Early Childhood Special Education, 9 (2), 16-32.

Day, N. L., Richardson, G., Robles, N., Sambamoorthi, U., Taylor, P, Scher, M., Stoffer, D., Jasperse, D. & Cornelius, M. (1990). Effect of prenatal alcohol exposure on growth and morphology of offspring at eight months of age. Pediatrics, 85, 748-752.

Department of Health and Human Services, (1990). Crack babies. Washington, DC: Office of the Inspector General, Department of Health and Human Services.

Dixon, S. D. & Bejar, R. (1989). Echoencephalographic findings in neonates associated with maternal cocaine and methamphetamine use: Incidence and clinical correlates. Journal of Pediatrics, 115, 770-778.

Donellan, A. M. (1984). The criterion of the least dangerous assumption. Behavioral Disorders 9 (2), 141-150.

Dore, J. (1986). The development of conversational competence. In R. L. Schiefelbusch, (Eds.), Language competence: Assessment and intervention, (pp. 3-60). San Diego, CA: College Hill Press.

Dubowitz, H., Newberger, C. M., Melnicoe, L. H., & Newberger, E. H. (1988). The changing American family. The Pediatric Clinics of North American, 35. 1291-1311.

Early, T. J. (1989). What you need to know about your child with an emotional disability and the individualized educational plan (IEP). Lawrence, KA: University of Kansas School of Social Welfare.

Farber, (Ed.), Stress and burnout in the human service professions, (pp. 129 - 141). New York: Pergamon.

Farber, B. A. (1983). Introduction: A critical perspective on burnout. In B. A. Farber, (Ed.), Stress and burnout in the human service professions, (pp. 1-20). New York: Pergamon.

Farrar, H. C. & Kearns, G. L. (1989). Cocaine: Clinical pharmacology and toxicology. The Journal of Pediatrics, 115, 665-675.

Fox, M. & Arcuri, K. (1980). Cognitive and academic function in foster children. Child Welfare, 59, 411-496.

Frank, D. A., Zuckerman, B. S., Amaro, H., Aboagye, K., Baucher, H., Cabral, H., Fried, L., Hingson, R., Kayne, H., Levenson, S., Parkern, S., Reece, H., & Vinci, R. (1988). Cocaine use during pregnancy: Prevalence and correlates. Pediatrics, 82, 888-895.

Fried, P. A. & Watkinson, B. (1990). 36 and 48 month neurobehaviral follow-up of children prenatally exposed to marijuana, cigarettes, and alcoho. Journal of Developmental and Behavioral Pediatrics, 11, 49-58.

Freudenberger, H. J. (1983). Burnout: Contemporary issues, trends, and concerns. In B. A.

Farber, (Ed.), Stress and burnout in the human service professions, (pp.23 -28). New York: Pergamon.

Girolametto, L. E. (1989). Developing dialogue skills: The effects of a conversational model of language intervention. In K. Marfo, (Ed.), Parent-child interaction and developmental disabilities (pp. 145-116). New York: Praeger.

Glidden, L. M. (1985). Adopting mentally handicapped children: Family characteristics. Adoption and Fostering, 9 3), 53-56.

Glidden, L. M., & Pursely, J. T. (1989). Longitudinal comparisons of families who have adopted children with mental retardation. American Journal on Mental Retardation, 94 (3), 272-277.

Gold, M. S. (1987). Crack abuse: Its implications and outcomes. Resident and Staff Physician, 33 (8), 3-6.

Greer, J. (1990). The drug babies. Exceptional Children, 56, 382-387.

Griffith, D. R. (1990). The effects of perinatal drug exposure on child development: Implications for early intervention and education. Paper presented at "Babie and Cocaine", Alexandria, VA: LRP Productions.

Hadeed, A. J., & Siegel, S. R. (1989). Maternal cocaine use during pregnancy: Effect on the newborn infant. Pediatrics, 84, 205-210.

Harrison, W. D. (1983). A social competence model of burnout. In B. A. Farber, (Ed.), Stress and burnout in the human service professions, (pp. 29 - 45). New York: Pergamon.

Harvey, D., Prince, J., Burton, J., Parkinson., D., Campbell S. (1982). Abilities of children who were small for gestational age babies. Pediatrics, 69, 296-300.

Hochstadt, N. J., Jaudes, P. K., Zimo, D. A., & Schachter, J. (1987). The medical and psychosocial needs of children entering foster care. Child Abuse and Neglect, 11, 53-62.

Howard, J., Beckwith, L., Rodning, C., & Kropenske, V. (1989). The development of young children of substance abusing parents: Insights from seven years of intervention and research. Zero to Three, 9 (5), 8-12.

Hoyme, H. E., Jones, K. L, Dixon, S., Jewett, T., Hanson, J. W., Robinson, L. K., Msall, M. E., & Allanson, J. E. (1990). Prenatal cocaine exposure and fetal vascular disruption. Pediatrics, 85, 743-747.

Jones, K. L. & Smith, D. W. (1973). Recognition of the fetal alcohol syndrome in early infancy. Lancet, 2, 999-1001.

Keith, L. G., MacGregor, S., Friedell, S., Rosner, M., Chasnoff, I.J., & Sciarra, J. J. (1989). Substance abuse in pregnant women: Recent experience at the perinatal center for chemical dependence of Northwestern Memorial Hospital. Obstetrics and Gynecology, 73, 715-723.

Klein, N. K., Hack, M., & Breslau, N. (1989). Children who were very low virth weight: Development and academic achievement at nine years of age. Journal of Developmental and Behavioral Pediatrics, 10, 32-37.

Kroll, J. (1990). Testimony of North American Council on Adoptable Children for United States Senate Subcommittee on Children, Family Drugs, and Alcoholism.

Kysela, G. M., McDonald, L., Reddon, J., & Gobeil-Dwyer, F. (1989). STress and supports to families with a handicapped child. In K. Marfo, (Ed.), Parent-child interaction and developmental disabilities (pp. 273-289). New York: Praeger.

Le Blanc, P., Parekh, A. J., Naso, B., & Glass, L. (1987). Effects of intrauterine exposure to alkaloidal cocaine ("crack"). American Journal of Diseases of Children, 141, 937-938.

Levine, M. D. (1987). Developmental variation and learning disorders. Cambridge, MA: Educators Publishing Service, Inc.

Love, A. J., & Thompson, M. G. (1988). Language disorders and attention deficit disorders in young children referred psychiatric services: Analysis of prevalence and a conceptual synthesis. American Journal of Orthopsychiatry, 58 (1), 52-64.

Lubinski, C. (1990). Addressing the impact on women, children, and families. Paper presented at "Babie and Cocaine", Alexandria, VA: LRP Productions.

MacDonald, J. D., & Gillette, Y. (1988). Communicating partners: A conversational model for building parent-child relationships with handicapped children. In K. Marfo, (Ed.), Parent-child interaction and developmental disabilities (pp. 220-239). New York: Praeger.

Mahoney, G. (1989). Enhancing the developmental competence of handicapped infants. In K. Marfo, (Ed.), Parent-child interaction and developmental disabilities (pp. 203-219). New York: Praeger.

McDonough, K. M. (1989). Analysis of the expressive language characteristics of emotionally handicapped students in social interactions. Behavioral Disorders, 14 (2), 127-139.

McIntrye, A. & Keesler, T. Y^. (1986). Psychological disorders among foster children. Journal of Clinical Child Psychocology, 15, 297-303.

McKenna, M. A. J. (1990, May 29). "They challenge us every day": Schools alarmed, frustrated as 'crack babies' grow up. The Cincinnati Enquirer, p. A1, A6.

Miller, B . C. & Myers-Walls, J. A. (1983). Parenthood: Stresses and coping strategies. In H. McCubbin & C. R. Figley (Eds.), Stress and the family, Volume I: Coping with normative transitions (pp. 54 - 73). New York: Brunner/Mazel.

Murray, J. B. (1987). Psychophysiological effects of methylphenidate (Ritalin). Psvhological Reports, 61, 315-336.

Nadel, M. (1985). Offspring with fetal alcohol effects: Intervention and identification. Alcoholism Treatment Quarterly, 2 (1), 105-116.

National Association for the Education of Young Children, (1988). The difficult child. Young Children (July), 60-68.

National Council on Disability, (1990). HHS releases report on crack babies. Focus, Spring, 1,8.

Ohio Task Force on Drug-Exposed Infants, (1990). Final Report. Columbus, OH: Office of the Governor.

Parker, S., Greer, S. & Zuckerman, B. (1988). Double jeopardy: The impact of poverty on early child development. Pediatric Clinics of North American 35, 1227-1241.

Plant, M. L. & Plant, M. A. (1987). Family alcohol problems among pregnant women: Links with matenbral sustance use and birth abnormalities. Drug and Alcohol Dependence, 20, 213-219.

Pelham, W. E., Burnett, K., Harper, G. W., Milich, R., Murphy, D. A., Clinton, C., & Thiele, C. (1990). Methylphenidate and baseball playing in ADHD children: Who's on first? Journal of Consulting and Clinical Psychology, 58, 130-133.

Phillips, D. K., Henderson, g. I., & Schenker, S. (1989). Pathogenesis of fetal alcohol syndrome. Alcohol Health and Research World, 13, 219-297.

Porterfield, J. K, Herbert-Jackson, E., & Risley, T. R. (1976). Contingent observation: An effective and acceptable procedure for reducing disruptive behavior of young children ir a group setting. Journal of Applied Behavioral Analysis, 9, 55-64.

Prizant, B. M., Audet, L. R., Burke, G. M., Hummel, L. J., Maher, S. R. & Theadore, G. (1990). Communication disorders and emotional/behavioral disorders in children and adolescents. Journal of Speech and Hearing Disorders, 55, 179-192.

Raschke, D., Dedrick, C., DeVries, A. (1988). Coping with stress. Teaching Exceptional Children, 21 (1), 11-14.

Rist, M (1990). The shadow children. The American School Board Journal (January, 1990), 19-24.

Rodning, C., Beckwith, L., & Howard, J. (1989). Characteristics of attachment organization and play orientation in prenatally drug-exposed toddlers. Development and

Psychopathology, 1, 277-289.

Rondal, J. A. (1989). Parent-child interaction and the process of language acquisition in severe mental retardation. Beyond the obvious. In K. Marfo, (Ed.), Parent-child interaction and developmental disabilities (pp. 114-125). New York: Praeger.

Rosett, H. L., & Weiner, L. (1984). Alcohol and the fetus. New York: Oxford University Press.

Sameroff, A. (1975). Transactional models in early social relations. Human Development, 18, 65-79.

Sampson, P. D., Streissguth, A. P., Barr, H. M. & Bookstein, F. L. (1989). Neurobehavioral effects of prenatal Alcohol: Part II. Partial Least Squares Analysis. Neurotoxicology and Teratology, 11, 477-491

Schneider, J., & Chasnoff, I. J. (1987). Cocaine abuse during pregnancy: Its effects on infant motor development: a clinical perspective. Topics in Acute Care and Trauma Rehabilitation, 2, 59-73.

Schor, E. L. (1988). Foster care. The Pediatric Clinics of North America, 35 (6), 1241-1252.

Shaywitz, S. E., Caparulo, B. K. & Hodgson, E. S. (1981). Developmental language disability as a consequence of prenatal exposure to ethanol. Pediatrics, 68, 850-855.

Shaywitz, S. E., Cohen, D. J. & Shaywitz, B. A. (1980). Behavior and learning difficulties in children of normal intelligence born to alcoholic mothers. The Journal of Pediatrics, 96, 978-982.

Shea, T. M. (1978). Teaching children and youth with behavioral disorders. St. Louis: C. V. Mosby.

Spohr, H. L., & Steinhausen, H. C. (1987). Follow-up studies of children with fetal alcohol syndrome. Neuropediatrics, 18, 13-17.

Streissguth, A. P. (1977). Maternal drinking and the outcome of pregnancy: Implications for child mental health. American Journal of Orthopsychiatry, 47, 422-431.

Stinnet, T. A., Oehler, J., Stinnet, J., & Stout, L. J. (1989). Abilities of the "Social Skills Rating System - Teacher versions to discriminate behavior disordered, emotionally disturbed, and handicapped students. School Pschology Review, 18 (4), 526-535.

Streissguth, A. P. (1976). Psychologic handicaps in children with the fetal alcohol syndrome. Annals of the New York Academy of Sciences, 273, 140-145.

Streissguth, A. P., Barr, H.M., Sampson, P. D., Darby, B. L. & Martin, D. C. (1989). IQ at age four in relation to maternal alcohol use and smoking during pregnancy. Developmental Psychology, 25, 3-11.

Streissguth, A. P., Bookstein, F. L., Sampson, P. D. & Barr, H. M. (1987). Neurobehavioral effects of prenatal alcohol: PLS analysis of neuropsychologic tests. Neurotoxicology and Teratology, 11, 492-507.

Streissguth, A. P., Clarren, S. K., & Jones, K. L. (1985). Natural history of the fetal alcohol syndrome: A ten-year follow-up of eleven patients. Lancet (Part 2), 47, 422-431.

Streissguth, A. P., Herman, C. S. & Smith, D. W. (1978). Intelligence, behavior, and dysmorphogenesis in the fetal alcohol syndrome: A report on 20 patients. Journal of Pediatrics, 92, 262-267.

Streissguth, A. P., Martin, C. D., Barr, H. M., Sandman, B. M., Kirchner, G. L., Darby, B. L. (1984). Intrauterine alcohol and nicotine exposure: Attention and reaction time in four-year old children. Developmental Psychology, 20, 533-541.

Sugar, M. (1982). The premature in context. New York: SP Medical & Scientific.

Tallal, P., Dukette, D., & Curtiss, S. (1989). Behavioral/emotional profiles of preschool language-impaired children. Development and Psychopathology, 1, 51-67.

Thompson, S. C. (1985). Finding positive menaing in a stressful event and coping. Basic and Applied Social Psychology, 6 (4), 279-295.

van de Bor, M., Walther, F. J., Sims, M. E. (1990). Increased cerebral blood flow velocity in infants of mothers who abuse cocaine. Pediatrics, 85, 733-736.

Van Dyke, D. C., & Fox, A. A. (1990). Fetal drug exposure and its possible implications for learning in the preschool and school-age population. Journal of Learning Disabilities, 23 (3), 160-163.

Werner, E. (1989). Children of the garden island. Scientific American, 106-111.

Weston, D. R., Ivins, B., Zuckerman, B., Jones, C., & Lopez, R. (1989). Drug exposed babies: Research and clinical issues. Zero to Three, 9 (5), 1-7.

Zeitlin, S., & Williams, G. G. (1988). Developing family resources for adaptive coping. Journal of the Division for Early Childhood, 12 (2), 137-146.

Zuckerman, B. (1985). Developmental consequences of maternal drug use during pregnancy. In T. M. Pinkert, (Ed.), Current research on the consequences of maternal drug abuse (NIDA Research Monography #59) (pp. 96-106). Washington, DC: Department of Health and Human Services.

Department of Health and Human Services, Office of the Inspector General.

Crack babies. (1990).

EXECUTIVE SUMMARY

PURPOSE

This report examines how crack babies are affecting the child welfare system in several major cities.

BACKGROUND

Crack is cocaine in a smokeable form. The National Institute on Drug Abuse (NIDA) estimates that over 5 million women of child bearing age are using illegal substances; for 1 million this means cocaine. The President's National Drug Control Strategy report estimates that 100,000 cocaine exposed babies are born each year.

Prenatal cocaine exposure can lead to premature birth, low birthweight, birth defects, and respiratory and neurological problems. Crack babies have a significantly higher rate of Sudden Infant Death Syndrome (SIDS) than babies not prenatally drug exposed. While experts believe that many crack babies will suffer developmental disabilities, the full range of long term effects of prenatal cocaine exposure are not known.

When crack babies are identified, local child welfare agencies are usually notified to provide protective services, social services, or foster care. However, these agencies are often unable to meet the needs of crack babies and their mothers.

While some State and local governments have done studies on aspects of the crack baby problem, little data is currently available at the national level. Several studies are underway at the Federal level to gain insight into this problem.

METHODOLOGY

We conducted on-site interviews in 12 metropolitan areas during the last quarter of 1989. Respondents included child welfare administrators and caseworkers, hospital social services staff, private agency representatives, foster parents, State and local officials, and nation. experts.

We also reviewed numerous studies and public documents on this subject.

FINDINGS

We're Only Seeing Part Of The Problem.

- Eight cities identified 8,974 crack baby cases in 1989: the cost of hospital delivery and perinatal care, and foster care through age 5 could approximate $500 million

METHODOLOGY

We conducted on-site interviews with over 200 respondents in 12 metropolitan areas during the last quarter of 1989. The sites included: Chicago, Fort Wayne, Los Angeles, Miami, New York City, Newark, Oakland, Philadelphia, Phoenix, San Francisco, Tacoma, and Washington, D.C. We selected these sites to give a perspective on how cities of varying size and location were being affected by crack baby births.

Respondents included child welfare administrators and caseworkers, hospital social services staff, private agency representatives, foster parents, and State and local officials. We also interviewed a number of national experts.

We also reviewed numerous studies and public documents on this subject.

THE CHILD WELFARE SYSTEM STRUGGLES TO COPE.

:k baby cases are complicated and time-consuming.

In most cities visited, an increasing majority of child welfare cases are drug related. The New York City mayor's task force reported a 72 percent increase in child abuse due to drug dependency, primarily crack, from 1985 to 1988.

State officials contend that crack baby cases are more complex than other child welfare cases. One official said, "Crack users represent a different kind of [protective services] case—there is a lot more abandonment and violence."

Drug use can supercede all other aspects of the lives of crack addicted mothers. In the words of one caseworker, working with the mothers "is like beating your head against a brick wall...because you are dealing with someone who has no control over her life. She's worried about her next hit."

Caseworkers can spend days tracking mothers who give false addresses to hospitals and then abandon their babies. Other time-consuming activities include finding emergency placements, foster care, parental drug treatment, and services necessary for special needs children.

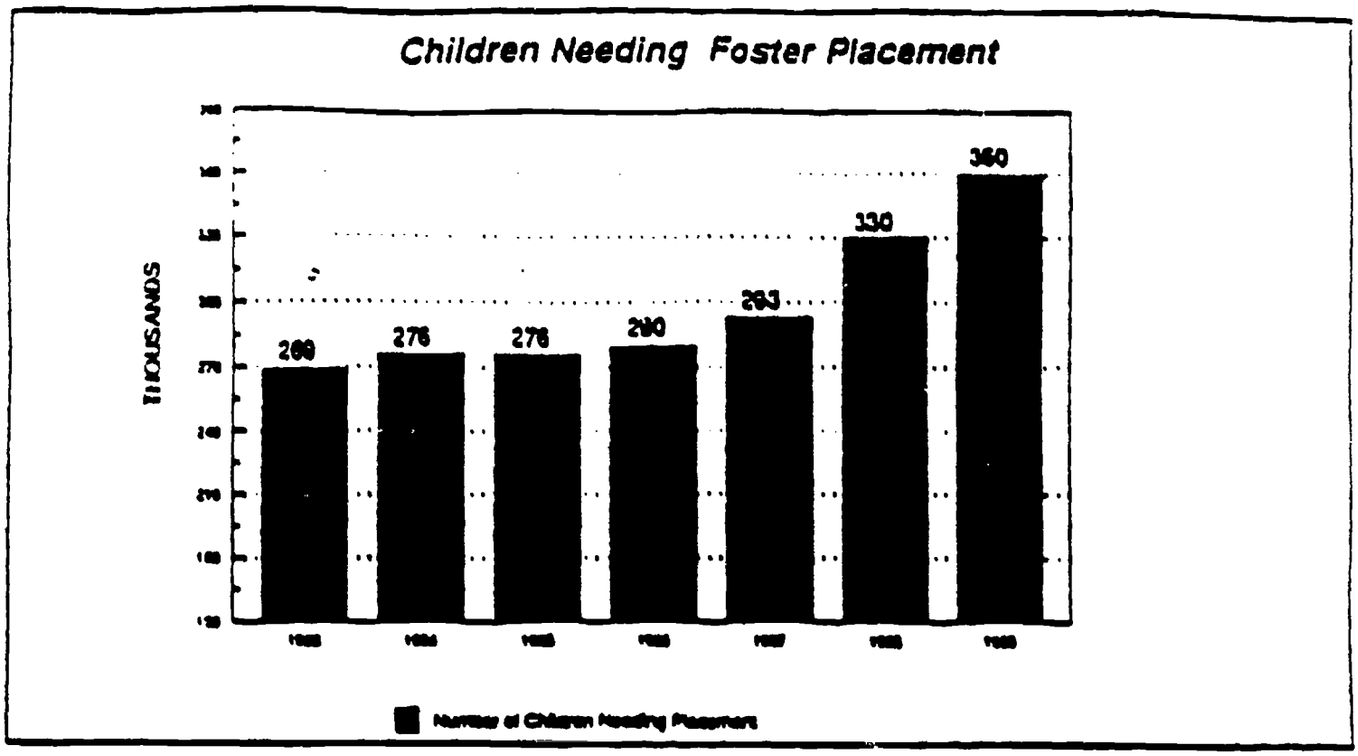
Child welfare casework is a dangerous job, according to several respondents. Caseworker home evaluations can require entering hostile situations, unescorted and without radio contact. "Police don't go into some of these places," said one respondent. Personal danger, stress, and relatively low pay contribute to caseworker burnout or resignation. One city official reported half of the staff had been working less than 1 year. In another city, the average tenure of a child protective worker is 2 years.

Some child welfare officials point out that high turnover results in staff who lack long term experience or training. They say this problem creates a lack of continuity of service and complicates legal proceedings as several caseworkers may work on a case over the years.

We found large caseloads of child welfare workers in many cities. One typical child welfare agency official reported an average caseload of 49 children for foster care and 161 for protective services. The lowest reported caseload was in New York City with 20 children for family service caseworkers and 40 for protective services.[5]

Prenatal exposure to drugs is not treated as child abuse.

Babies who test positive for controlled substances are not always reported to child welfare officials. The actions taken depend on how a State defines child abuse or neglect. These terms are not interchangeable and the distinction can be significant.



Respondents speculated that the increase of children in foster care is due to increased parental drug abuse, but this cannot be confirmed. Data to demonstrate this connection is not collected nationwide by child welfare agencies.

Shortages of black foster parents and homes that accept infants are reported. Respondents in five cities report a particular shortage of homes for infants with special needs. In one State that prohibits interracial placements, we were told the babies are predominantly black, but there is a shortage of black foster parents. To deal with the demand, some agencies put more children in each foster home, shift children between homes, separate siblings, and place children in group homes.

Low reimbursement was the most commonly cited reason for a shortage of foster parents. Respondents say reimbursements are too low to attract full-time foster parents, especially for medically needy babies.

Also, rate schedules are complex and lack uniformity. Variables affecting rates include the child's age and health, the placement agency, and the services or products that qualify for reimbursement. For example, one city has eight categories of reimbursement for infants who do not require consistent medical attention. For infants who do require consistent medical care, there are four categories. Within each category, child welfare has the flexibility to determine the exact reimbursement rate. Overall, reimbursement ranges from $3,233 to $30,730 annually.

Respondents told us repeatedly that foster parents need training and support services. They said there is a correlation between such training and a foster parent's willingness to continue.

RECOMMENDATIONS

We agree with respondents that the problems of crack babies are inseparable from the larger issue of prenatal exposure to all drugs and alcohol. The recommendations that follow are intended to address this broader issue.

STATE AND LOCAL RESPONSIBILITIES

1. *Encourage outreach and community involvement.* State and local governments should conduct aggressive outreach programs to provide prenatal care for at risk pregnant women. These efforts must emphasize the dangers of prenatal drug or alcohol exposure. Community and religious groups should be involved in identifying and helping mothers and children at risk. It is important to work with local black and Hispanic leaders.

2. *Reduce placement barriers.* State and local agencies should reduce barriers to placing drug exposed infants into foster care and adoptive homes. This includes reviewing and revising existing laws and policies on abandonment, termination of parental rights, and interracial placement. Courts should establish "fast track" procedures to expedite child welfare cases involving drug abuse.

3. *Develop guidelines and training.* States should develop guidelines for child welfare agencies to follow in responding to drug exposure cases and training caseworkers to handle such cases. Guidelines should cover risk assessment, family reunification, and termination of parental rights. Caseworkers should be trained in identifying substance abuse behaviors, recording drug histories, and documenting evidence for court.

4. *Establish reporting and tracking systems.* States should establish criteria for reporting prenatal drug exposure as child abuse. Existing State child abuse reporting and tracking systems should be expanded and computerized.

5. *Expand interagency mechanisms.* State and local governments should develop initiatives such as task forces to coordinate services and integrate funds. These initiatives should involve courts and prosecutors to review policies and expedite legal proceedings involving drug-exposed babies and their families.

DEPARTMENT OF HEALTH AND HUMAN SERVICES RESPONSIBILITIES

Office of Human Development Services

1. *Disseminate effective practices.* The Office of Human Development Services (HDS) should identify practices, programs, and laws or regulations considered effective in dealing with drug-exposed baby cases and disseminate this information to State and local governments.