
INTRODUCTION TO
WORKING WITH CHILDREN OF PARENTS WITH
SUBSTANCE USE DISORDERS

Course Module

Developed by

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For the National Association for Children of Alcoholics

Content Area: HBSE and Practice

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Core Competencies for Social Workers in Working with Children and Families Affected by Parental Substance Use Disorders

Preamble

Substance use disorders (SUDs) create widespread problems impacting one in four children in the United States. Children of parents who have SUDs (hereby referred to as COAs) often experience both short-term and long-term effects in their mental and physical health, emotional and cognitive development, social adjustment, and spiritual and economic well-being. COAs are a vulnerable, at-risk population that requires the attention of the social work profession. Working with this population upholds the profession's core values of social justice, dignity and worth of the person, importance of human relationships, integrity and competence, and the ethical principles delineated in the Code of Ethics of the National Association of Social Workers (1999).

The strengths and needs of COAs are diverse, complex, and unique. Each individual is influenced by his or her stage of human development and level of individual ability, as well as by family functioning, social supports, and social context. Operating from a social justice perspective, social workers endeavor to empower people, and to alleviate oppression and economic inequity. Social workers also address problems in people's lives in the context of the social environment. Social work practice has the potential to have a profound influence on the lives of COAs.

Social workers practice in a variety of community and treatment settings and are ideally positioned to identify and address the effects of parental SUDs on children and their families. In order for social workers to work with COAs effectively, they need to have an understanding of the nature of SUDs and how they affect children in the context of the family system. In addition, social workers need to be aware of their personal values and experiences regarding SUDs, and to recognize the impact that these personal circumstances may have on their professional attitudes and actions. To work effectively with COAs, it is essential for social workers to possess the following core competencies.

Social Work Competencies

1. Understand substance use disorders (SUDs) including the causes, prevention, progression, consequences, and recovery.
2. Understand the biopsychosocial, cultural, and spiritual ramifications of SUDs as they impact on COAs and their families from neonatal development through all stages of life.
3. Understand the impact that SUDs have on parenting abilities and the consequences for children.
4. Understand the intersection of SUDs and other family, health, and social problems, including:
 - a. family violence (intimate partner violence and child maltreatment)
 - b. mental health disorders
 - c. physical health
 - d. crime (vulnerability to victimization and risk for criminality)
 - e. poverty, unemployment, and homelessness

- f. educational and vocational opportunities
 - g. social/cultural biases (including, but not limited to, race, ethnicity, class, sexual orientation, and disability)
5. Value the importance of early intervention and prevention of SUDs, and prevention of mental health and social problems for COAs and their families.
 6. Ability to engage COAs in a manner that is respectful and non-judgmental of their parents.
 7. Ability to screen and assess COAs using developmentally appropriate assessment tools and methods.
 8. Ability to identify, evaluate, and utilize existing research relevant to COAs and their families.
 9. Ability to use developmentally appropriate and empirically supported interventions with COAs and their families, and evaluate the effectiveness of the interventions being used.
 10. Understand the concept of resiliency and how risk factors can be diminished and protective factors can be facilitated in COAs.
 11. Ability to help children identify developmentally appropriate formal and informal supports in their lives, and work with them to enhance their resiliency and mitigate the impact of parental SUDs.
 12. Knowledge of how to access formal and informal community resources on behalf of COAs and their families.
 13. Ability to provide referrals for appropriate services and supports to COAs and their families.
 14. Knowledge of social policies pertinent to COAs and their families.
 15. Ability to advocate for individual clients, as well as to identify and advocate for appropriate policies to help COAs and their families.

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MODULE DESCRIPTION

This module is designed to introduce foundation level social work students to the experiences and challenges that children of substance abusing parents face. It also is intended to introduce students to assessment strategies that will enable them to recognize substance use problems in families and helping strategies that will enable them to provide appropriate interventions and referrals. The module includes information on definitions, prevalence, theoretical frameworks, and helping strategies. The module can be adapted to emphasize theory or practice depending on the course. The module provides students with knowledge and skills that will enable them to begin to acquire the core competencies that generalist social workers need for practice with children and families affected by parental substance use disorders.

MODULE LEARNING OBJECTIVES

Upon completion of this module students should be able to:

- Discuss the definitions of substance abuse and substance dependence.
- Describe pertinent models on the development of substance use disorders and their effects on families.
- Describe and discuss the effects on children of growing up in a family with a substance abusing parent(s).
- Recognize when substance abuse problems are present in a family.
- Describe helping strategies that may be useful (either for the family or the child) when addiction in the family is identified as a problem.

MODULE READINGS

Gruber, K.J., & Taylor, M.F. (2006). A family perspective for substance abuse: Implications from the literature. *Journal of Social Work Practice in the Addictions*, 6(1/2), 1-30.

Morehouse, E. R. (2000). Matching services and the needs of children of alcoholic parents: A spectrum of help. In S. Abbott (Ed.), *Children of alcoholics: Selected readings* (Vol. II, pp. 95-117). Rockville: National Association for Children of Alcoholics.

Peleg-Oren, N. & Teichman, M. (2006). Young children of parents with substance use disorders (SUD): A review of the literature and implications for social work practice. *Journal of Social Work Practice in the Addictions*, 6(1/2), 49-61.

Werner, E. E., & Johnson, J. L. (2000). The role of caring adults in the lives of children of alcoholics. In S. Abbott (Ed.), *Children of alcoholics: Selected readings* (Vol. II, pp. 119-141). Rockville, MD: National Association for Children of Alcoholics.

INSTRUCTIONAL METHODS

Estimated Time to Cover Module Objectives

Three hours (Can be lengthened or shortened depending on needs of course.)

Materials Needed

Chalkboard or Whiteboard

Chalk or Whiteboard Markers

LCD Projector (If video or slides are being used.)

Computer (If video or slides are being used.)

DVD or Video Player (If video is being used.)

Presentation/Lecture and Discussion

First Hour

Introduction

Substance use disorders are a widespread problem in the United States. Research shows that children of parents who have substance use disorders frequently experience challenges and problems associated with their parents' substance use. The impact on children ranges from minimal effects to serious and life long problems. Social workers frequently come into contact with children and families who have been affected by the substance use of others. It is important for social workers to have a basic understanding of substance use disorders and their effects on children to enable them to assess for substance use disorders in families and provide appropriate support and interventions to affected children.

Definitions

Substance Use Disorder

General classification for maladaptive patterns of use of alcohol or other drugs that result in significant distress or functional impairment (see American Psychiatric Association, 2000).

Substance Abuse

Persistent and repeated use of substances resulting in adverse consequences in an individual's life over a 12 month period. The individual continues to use substances even though he/she is experiencing problems in his/her life such as, failure to meet obligations at work, school, or home; using substances in a physically hazardous situation (driving under the influence); legal problems; and social or interpersonal problems (American Psychiatric Association, 2000).

Substance Dependence

Substance dependence is a more severe disorder than substance abuse. It is characterized by compulsive drug-taking behavior and possibly physiologic dependence. Physiologic dependence, as evidenced by tolerance and withdrawal, is neither necessary nor sufficient for a diagnosis of substance dependence to be given. Tolerance is exhibited by a need for a higher dose of the substance to achieve intoxication or the desired effect. Tolerance may also be exhibited by a diminished effect even though the dose is unchanged. Withdrawal symptoms occur when the blood or tissue concentration of a substance that has been used heavily over a prolonged period of time decreases. Withdrawal symptoms vary across drug classes, but generally are physiological, cognitive, and behavioral in nature. Individuals will attempt to reduce or avoid withdrawal symptoms by using the substance.

Compulsive behaviors include:

- Uses more of a substance than intended or uses it over a longer period of time than intended;
- Persistent desire or efforts to cut down or control use;
- Spends a lot of time focusing on the substance either obtaining it, using it, or recovering from its effects;
- Gives up important social, occupational, or recreational activities because of substance use;

- Continues to use the substance despite the serious effects that it is having on his/her life (American Psychiatric Association, 2000).

Prevalence of Substance Abuse and Substance Dependence

The National Survey on Drug Use and Health reports that in 2004 an estimated 22.5 million persons aged 12 or older (9.4 percent of the total population) were classified with substance dependence or substance abuse. Of these, 3.4 million were dependent on or abused both alcohol and illicit drugs, 3.9 million were dependent on or abused only illicit drugs, and 15.2 million were dependent on or abused only alcohol. Of the 7.3 million persons classified with dependence on or abuse of illicit drugs, 4.5 million were dependent on or abused marijuana, 1.6 million were dependent on or abused cocaine, and 1.4 million were dependent on or abused pain relievers (Substance Abuse and Mental Health Services Administration [SAMHSA], 2005).

Theories and Models

Several theories and models on the etiology and treatment of substance use disorders have been advanced. A full discussion of theoretical perspectives and models is beyond the scope of this introductory module. The focus here is on introducing the most widely used models in the United States that are pertinent to understanding the effects of parental substance use disorders on children. (See Miller & Hester, (2003) for an overview of models; McCrady & Epstein, (1999) for a comprehensive discussion of models and theories; and National Institute on Alcohol Abuse and Alcoholism [NIAAA], (2005a); McNeece & DiNitto, (2003); and Wood & Dunn, (2000) for a discussion of models and theoretical perspectives in the context of social work practice.)

Although the etiology of substance use disorders has been heavily debated over the years, it is now known that there are multiple and complex pathways that lead to the development of substance use disorders. Research shows that genetic, biological, familial, psychological, and social-cultural factors influence the development of substance use disorders. The degree to which each factor contributes to the development of addiction problems varies across individuals. The current understanding of the etiology of substance use disorders is congruent with the person-in-environment and systems perspectives of social work practice (see McNeece & DiNitto, 2003).

Disease Model

Addiction is most commonly accepted in the United States today as a chronic disease. In this view, alcohol and drug addiction is seen as a “primary disease” that is not secondary to another disorder or condition. Addiction is fundamentally a physical illness that is chronic, progressive, and (if left untreated) fatal. The afflicted individual eventually experiences problems in every aspect of their life (Sheehan & Owen, 1999). The disease has biological, psychological, social, and spiritual components to it. Early iterations of the disease model emphasized physiologic and genetic contributions to the development of the disease. The current disease model recognizes that genetic, psychological, and environmental factors influence the development of the disease (Hesselbrock, Hesselbrock, and Epstein, 1999).

The National Council on Alcoholism and Drug Dependence (NCADD) and the American Society of Addiction Medicine (ASAM) define alcoholism as:

A primary, chronic disease with genetic, psychosocial and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. It is characterized by continuous or periodic: impaired control over drinking, preoccupation with the drug alcohol, use of alcohol despite adverse consequences, and distortions in thinking, most notably denial (National Council on Alcoholism and Drug Dependence [NCADD], 2006).

The National Institute on Drug Abuse (NIDA) views addiction as a brain disease. Drug usage interferes with normal brain functioning and creates the “high” feeling. Over time brain metabolism and activity is affected. At some point the changes that occur in the brain turn drug abuse into a chronic relapsing illness that does not get better without treatment (National Institute on Drug Abuse [NIDA], n.d.).

Individuals who have the disease are encouraged to seek treatment that will enable them to remain abstinent and engage in a life-long recovery process. Treatment typically includes a range of interventions that are designed to address the bio-psycho-social complexities of the disease, e.g., medical treatment, cognitive restructuring, social skills training, family therapy, group therapy, and etc. Individuals are typically encouraged to attend Alcoholics Anonymous, Narcotics Anonymous, or other self-help groups in addition to professional treatment (see <http://www.aa.org> and <http://www.na.org>).

Cognitive Behavioral Models

The cognitive behavioral models of addiction have been less widely applied as a unitary explanation for the etiology of substance use disorders than the disease model in the United States. However, a large body of research provides empirical support for the effectiveness of cognitive behavioral interventions in affecting substance use behaviors. Consequently, cognitive behavioral interventions are increasingly being incorporated into addiction treatment programs regardless of the program’s philosophical underpinning, i.e., disease model vs. cognitive behavioral model.

The cognitive behavioral models view substance use behavior as the result of the cognitions (thoughts, beliefs, understandings and feelings) that precede it. Social learning theory posits that cognitions such as expectancies, self-efficacy, and attributions mediate the pathway from the stimulus to the substance use response. Several interacting factors influence the development of substance abuse problems: (1) the individual’s genetic risk and temperament influence whether the substance use will be reinforcing or punishing to the individual, (2) the response of the social environment, and (3) effects of operant conditioning that reward and maintain use. Individuals begin to use substances as a coping strategy to manage stressors and situations in their lives. Consequently, self-efficacy is diminished and positive expectancies related to substance use increase. A perpetually reinforcing cycle of use emerges. The physiologic consequences of sustained substance use (craving, tolerance, and withdrawal) engage classical conditioning processes and contribute to ongoing substance abuse (see Hesselbrock, Hesselbrock, and Epstein, 1999). Treatment programs that are rooted in the cognitive behavioral models emphasize coping skills training, relapse prevention training (based in social learning theory), cue exposure, urge surfing, and family interventions (based in family behavioral models) (see Annis & Davis, 1989; O’Farrell & Fals-Stewart, 2003; Marlatt, 1985; Monti, Kadden, Rohsenow, Cooney, & Abrams, 2002; Monti & Rohsenow, 2003). Individuals may be encouraged to participate in self-help groups such as Smart Recovery (see <http://www.smartrecovery.org/>).

Family Models

Substance use disorders in the family both impact and are impacted by the family system. There are currently three models regarding family functioning and substance use disorders: family disease model, family systems model, and behavioral family model.

The family disease model suggests that the disease of addiction affects families as well as individuals. The disease develops in the individual who has the substance use disorder via biological and possibly environmental factors (as described in the disease model of addiction) and is maintained via family functioning. The disease manifests itself in other family members in the form of enabling. Family members who have not received help often unwittingly engage in roles and behaviors that maintain the family disease. This dynamic results in the non-addicted family members experiencing a “loss of self” and having an external focus on gaining control (Brown, 1988). They may also experience shame, emotional numbing, low self-esteem, depression, anxiety, rage, and interpersonal problems. Family members are encouraged to seek recovery support for themselves and participate in the Al-Anon program (and Alateen for adolescents) to ameliorate the effects of the family disease on them (see <http://www.al-anon.org>). Some may also need individualized or group therapy, especially those who also grew up in a family where substance abuse was a problem.

The family systems models hypothesize a series of homeostatic functions in families that have implications for the processes associated with an individual’s recovery from alcohol or drug abuse/dependence. The underlying assumption is that an individual’s maladaptive behavior (e.g., substance abuse) reflects dysfunction in the system as a whole (Van Wormer, 1995). As such, the substance abuse serves an “adaptive” function for the family system as a whole. For example, the family is allowed to divert its attention away from and to avoid even more threatening issues (e.g., a source of conflict that threatens the system’s integrity as a whole) by attending to a member’s substance using behavior. In this conceptualization, the substance use behavior transcends the individual and is relational, thus the relationships are a necessary focus of intervention (Waldron & Slesnick, 1998). These types of approaches are designed to address and restructure family interaction patterns that are associated with the substance abuse. As a result, the substance abuse is no longer “needed” by the family system for its survival. (Excerpted from NIAAA, 2005b)

The family behavioral models are founded on the principles of social learning theory. The underlying assumption is that substance use disorders are acquired and maintained through interactions with the social environment. This includes observational learning (e.g., imitation of role models), operant learning (e.g., behaviors are enhanced or suppressed through reinforcing or punishing consequences), and the presence or absence of opportunities provided by the environment. In this framework, family is important in the development and maintenance of substance use disorders for several reasons (McCrary, 1989; Waldron & Slesnick, 1998):

- Their behaviors can act as stimulus cues that trigger drinking responses;
- Family members act as models for specific substance-related behaviors, as well as for more general coping strategies (e.g., observation of substance use to relieve stress);
- The family may influence an individual's emotional and physical reactions which are associated with vulnerability to substance abuse;
- Their responses can act to reinforce or punish efforts at sobriety, abstinence, or reduction of substance use;

- Family members may interfere with the individual experiencing the negative consequences of drinking, and this shielding encourages perpetuation of the drinking.

(Excerpted from NIAAA, 2005b) (See O'Farrell & Fals-Stewart, 2003 for a discussion of clinical application.)

Discussion Points/Questions

1. Consider the models of addiction that have been presented and discuss their utility from a social work perspective.
2. Consider the Gruber & Taylor, 2006 article and discuss the relationship between family systems, substance abuse, and associated family based problems.
3. Clarify your beliefs and values about substance abuse and individuals who abuse substances by considering the following questions:
 - What do you believe causes substance use disorders to develop in individuals?
 - Do you believe individuals who have substance use disorders are to blame for their problems?
 - Do oppression, unequal access, and unequal opportunities in social systems contribute to the development of substance abuse and associated problems?
 - Do substance abuse problems fall under the purview of social work practice?

Second Hour

Effects on Children Exposed to Familial Substance Abuse or Substance Dependence

Prevalence

Grant (2000) estimates that one out of every four children (28.6%) in the US is exposed to familial alcohol abuse or dependence. SAMHSA, Office of Applied Studies (2003) estimates that of the 70 million children who resided with at least one parent in the US in 2001, over six million (9 %) lived with at least one parent who abused or was dependent on alcohol or an illicit drug. Of these children, more than four million resided with a parent who abused or was dependent on alcohol only, nearly one million lived with a parent who abused or was dependent on an illicit drug, and more than .5 million resided with a parent who abused or was dependent on both alcohol and an illicit drug. The wide variation in the estimates of the number of children who are exposed to substance abuse in the family is due to methodological differences in the research. In any case, it is clear that many children in the US are exposed to substance abuse or substance dependence in their families.

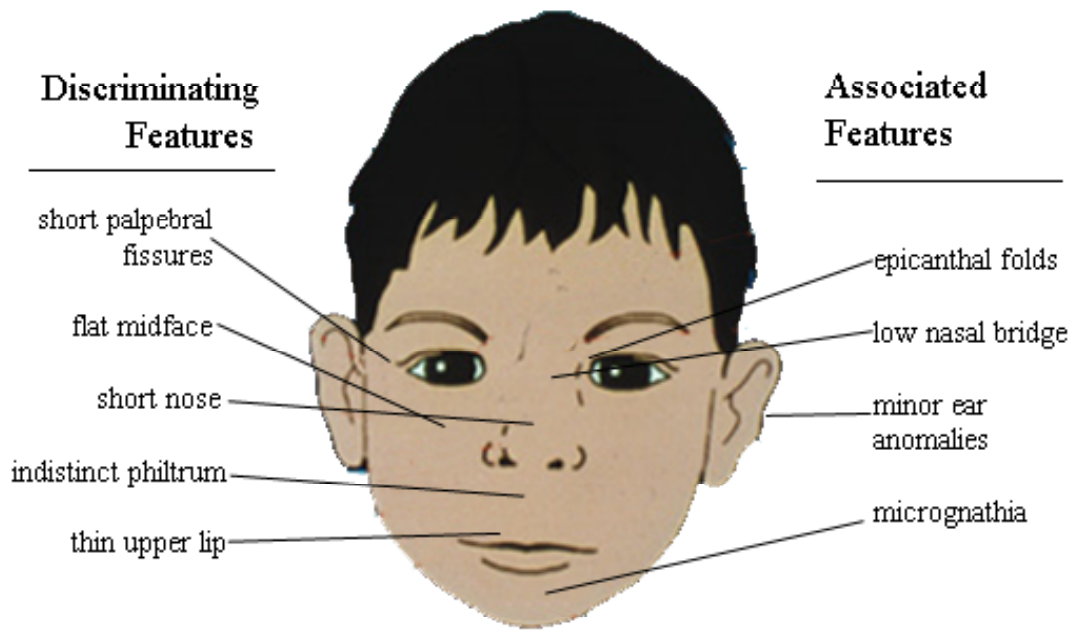
Fetal Exposure

Neonates are at risk for experiencing problems associated with their mothers' substance use while pregnant. Substance abuse is typically associated with other factors such as poor prenatal care, risky environments, medical problems, and co-occurring psychiatric problems (Lagasse & Lester, 2000). These factors can contribute to the problems that infants experience. Thus, it is difficult to determine the unique effects of substance use without consideration of the constellation of other biopsychosocial factors. It is important to note that not all children who have been affected by prenatal substance use are COAs. It is possible that a non-addicted mother's use of alcohol or another drug (even certain medications) during pregnancy will contribute to problems in the developing fetus. Keeping these considerations in mind, the following health problems that are related to substance use during pregnancy have been identified.

Fetal Alcohol Spectrum Disorders (FASD) include a variety of problems that alcohol exposed infants may experience. FASD range in severity and include behavioral problems, cognitive impairments, and birth defects. These effects can endure throughout the life of the child. One severe consequence of fetal alcohol exposure is Fetal Alcohol Syndrome (FAS). FAS is the leading preventable cause of mental retardation in the United States. It is characterized by prenatal and postnatal growth retardation, central nervous system impairment, and dysmorphic facial features. The three primary facial features associated with FAS are:

- Short palpebral fissures (small eye opening), thought to be related to impaired development of the eyes and orbital cavity;
- A thin vermilion border (borders of the upper lip);
- Long flat philtrum (space between nose and upper lip), related to developmental changes in the mid-face.

Other discriminating (short nose, flat mid-face) or associated (epicanthal folds, low nasal bridge, ear anomalies, and small jaw/receding chin) features are common in children who have FAS as well (see



The Young Child

NIAAA, 2005c).

Fetal exposure to drugs other than alcohol has also been associated with pre-natal and postnatal problems. Specific syndromes that can be associated with specific drugs, as is the case with FAS and alcohol, have not been identified. It is difficult to gather accurate information on specific combinations and dosages of drugs that a mother may have used. The conditions that drug exposed infants appear to be at higher risk for include: prematurity, small gestational age, failure to thrive, neurobehavioral symptoms (including withdrawal symptoms), infectious diseases, urogenital abnormalities, myocardial infarction, blood flow restriction, and Sudden Infant Death Syndrome (American Academy of Pediatrics, 1998; ARCH National Resource Center for Respite and Crisis Care Services, 2006).

Research indicates that the combination of developmental stage, dose of the substance, and other psychosocial factors influences how a child will be affected to fetal exposure to alcohol and other drugs. Given the risk of teratologic effects from licit and illicit drugs, it is strongly advised that pregnant women abstain from substance use and exercise extreme care when using any type of medication.

Effects of Parental Substance Use Disorders on Children

Researchers have identified some problems that appear to be more prevalent among children of substance abusing parents (COA) than non-COA including hyperactivity, attention deficit disorder, lower IQ, school absenteeism, behavior problems, delinquency, cognitive problems, alcoholism, drug addiction, emotional instability, social maladjustment, anxiety, depression, poor social support, and low self-esteem (see Anda et al., 2002; Gruber & Taylor, 2006; Johnson & Leff, 1999; Lieberman, 2000; Peleg-Oren & Teichman, 2006; Serrins, Edmundson, & Laflin, 1995; Sher, 1991a, 1991b) [Use the NACoA fact sheet handout to discuss effects]. COAs are more likely to be abused and neglected by their parents. The neglect places them at risk to be exploited or abused by individuals outside of the family. COAs are at increased risk to develop addiction or psychiatric problems, although most do

not. Those COAs who do develop addiction or psychiatric problems do not present any particular syndrome.

COAs appear to be especially vulnerable to the risk for maladaptive behavior because they have combinations of many risk factors present in their life. The single most potent risk factor is their parent's substance abusing behavior; this single risk factor can place children of substance abusers at biological, psychological, and environmental risk. In many cases it is unclear whether the effect on the child is a direct biological effect related to either exposure to drug effects via parental use (i.e., cognitive problems related to fetal drug exposure), genetic vulnerability (i.e., development of substance use disorders), comes about as a result of social factors (i.e., poor parenting, family dysfunction, poverty), or a combination of these or other unidentified factors.

Although it is clear that COAs are at increased risk to experience a host of problems, it is also clear that many COAs exhibit resiliency. There are sub-groups of COAs who, despite all odds, do, in fact enjoy good health from birth, experience a positive environment at home, and develop rather normally into socialized, competent, and self-confident individuals. The resilient child is somehow able to compensate and cope with the various negative biological or environmental influences in his/her life (see Werner & Johnson, 2000). Certain individuals may be able to manipulate their environment by choosing roles and goals in life which stabilize their developmental process and bring them the positive reinforcement they need to develop a positive self-image, and eventually a relatively healthy life. Other individuals may be able to master the processing of incoming information and to understand the information in such a way as to choose positive behaviors in life which compensate for whatever problems are present.

Research suggests that there are multiple determinants of children's degree of vulnerability to adverse events: the nature of the event, the duration of the event, the dosage or intensity of the event, the presence of mitigating or compensatory factors in the environment, intrinsic and acquired resiliencies, interpretations of the events, and resources for coping with the events (Anthony & Cohler, 1987; Begun & Zweben, 1990; Berkowitz & Begun, 2003). The presence of caring adults and peers in the life of the COA (non-substance abusing parent, teachers, community group leaders, friends, parents of friends, siblings, aunts, uncles, grandparents, etc.) support the development of hope, self-esteem, and self-confidence which seem to be the keys to transcending growing up with an addicted parent (Werner & Johnson, 2000).

Optional Classroom Activity

View and discuss the video *Lost Childhood: Growing up in an Alcoholic Family* (see <http://www.lostchildhood.org> or <http://www.health.org> for ordering information including viewers' guide).

Discussion Points/Questions

1. How should pregnant mothers who are substance abusers be dealt with?
2. Should children of substance abusing parents be removed from the home? If so, for how long, and under what conditions?
3. What differentiates a resilient child from a child who experiences problems associated with their parent's substance abuse?

Third Hour

Helping Strategies

Assessment

Social workers should routinely incorporate questions about substance use into assessments on adults, children, and families. Individuals should at least be asked about what substances they use and how often they use them. Individuals should also be asked about the substance use behaviors of other members of their family. Asking the simple screening question “ Have you ever been concerned about someone in the family who is drinking alcohol or using drugs?” can open a frank discussion about substance abuse in the family (Adger et al., 2004). The social worker should consider whether the pattern of use being described indicates that substance abuse or substance dependence is occurring.

Some indicators of substance use disorders in individuals are:

- Loss of interest in activities that were previously enjoyed
- Changes in personality (shifts in values, attitudes, beliefs, and personal style)
- Changes in appearance (neglects hygiene, neglects appearance)
- Reduced memory and concentration
- Emotional problems (anxiety, depression, anger, agitation, mania)
- Financial problems (finances are drained)
- Legal problems (driving under the influence, disorderly, assault, theft, drug distribution)
- Health problems (liver disorders, stomach problems, HIV/AIDS, hepatitis, etc.)
- Family problems (fighting, violence, absence)
- Work problems (tardy, absenteeism, intoxication, hangover)

There are numerous screening and assessment measures on adult substance use (see Allen & Columbus, 1995; NIAAA, 2005d). The CAGE is a brief screening tool that can easily be incorporated into assessment interviews (Ewing, 1984). The acronym CAGE stands for **C**utting down, **A**nnoyance, **G**uilt, and **E**ye openers. The CAGE was originally developed to screen for alcoholism, but has been adapted to screen for both alcohol and drug abuse in individuals CAGE-AID (Brown & Rounds, 1995) and to screen for substance abuse in the family (Frank, Graham, Zyzanski, & White, 1992; Werner, Joffe, & Graham, 1999). The CAGE may be less sensitive or valid in certain cultural groups (Volk, Cantor, Steinbauer, & Cass, 1997) and with women (Bradley, Boyd-Wickizer, Powell, & Burman, 1998).

[Provide handout on CAGE]

If a child exhibits any of the following, it is important to consider the potential for substance abuse in

the family:

- Behavioral problems – internalizing behaviors (e.g., depression and anxiety) or externalizing behaviors (e.g., defiance, aggression, rule breaking)
- Emotional problems
- School difficulties- absenteeism, tardiness, poor performance
- Recurrent episodes of trauma or injuries
- Vague somatic complaints
- Shabby appearance

Prevention and Intervention

Given that COAs are a heterogeneous group, there is no specific prevention or intervention strategy that is indicated for all of them. It is important to note that many COAs do not exhibit problems and that COAs should not be pathologized simply because they are COAs. Many COAs function well and only need support or guidance. Social workers should carefully assess the child's situation and provide support or interventions at the level that would best meet the individual needs of the child.

Emshoff & Price (1999) describe the prevention programs that are often used to address the effects of substance abusing parents on children. **Universal prevention** programs are generally delivered in schools or other large social organizations and are geared to all children in the system. They provide education on addiction, values clarification, and skill building (e.g., refusal skills and emotion management). These types of programs “cast a broad net” and are able to reach a number of COAs without stigmatizing them. A less expensive approach is **selective prevention** programs. Selective prevention programs are delivered through schools, churches, and other community organizations to children who have been identified as being from a family where substance abuse is a problem. These programs are limited by the risk of stigmatizing the child and the exclusion of children who are COAs, but have not self-identified. **Indicated prevention** and **intervention** programs are for COAs who have been identified as experiencing problems and are delivered through existing treatment and social programs. They are sometimes delivered in schools, but present challenges in terms of labeling and stigmatizing the child. These types of programs also require that staff in agencies receive specialized training. The costs associated with providing the programs have limited their implementation.

Intervention programs for COAs are typically delivered in group format. Moe (2000) emphasizes the importance of establishing an atmosphere in the group that is conducive to trusting, talking, and feeling. The key ingredients are: enter the children's world, create a safe and nurturing environment, provide experiential learning, acknowledge children's learning styles with varied activities, and have fun. The emphasis in such groups is on skill building and reducing shame.

COA-specific interventions are most commonly provided in schools, substance abuse treatment programs, and free standing COA programs. Student Assistance Programs in the school system are uniquely positioned to identify COAs and provide appropriate levels of support and referral unobtrusively. Student Assistance Programs often apply interventions to the school as a whole, e.g., awareness-raising campaigns and other prevention programs as described above. They also can provide direct interventions including group and individual counseling, faculty support,

mentorship, etc. Substance abuse treatment programs typically offer family programs ranging from psychoeducation to family therapy. Some facilities offer intervention and support programs directly aimed at the children. Some freestanding COA intervention and educational support programs are available; however they are rare.

Some teenagers find the support of Alateen helpful. Alateen is a 12-Step self-help program for teenagers who have a family member or friend with alcohol problems. Alateen is a component of Al-Anon Family Groups (12-Step program for family and friends of individuals who have alcohol problems). Alateen groups typically have an adult advisor from Al-Anon. (<http://www.alateen.org>)

COAs may present to healthcare providers, social service agencies, educational institutions, churches, and community programs with problems related to their exposure to familial substance abuse/dependence. They may also be part of a family that presents to one of these systems. Social workers and other professionals in these settings sometimes provide specific interventions for COAs. More typically, general mental health, social, educational, or religious interventions are applied. The children are better served when their status as a COA is recognized and intervention strategies that are sensitive to the specific needs of the child are applied.

There are several barriers to participation in support or intervention programs for COAs that social workers need to consider and address when they are working with COAs or developing programs for them. The child may be fearful of how they will be perceived if others find out that they go to a program; parents may refuse to consent to their child's participation in a program; parents may refuse to participate in a program with their child; if the parents do participate, the child may be fearful of disclosing their feelings in front of the parent. Ideally, services for COAs would be offered in a variety of settings at varying levels of intensity. In any case, children should be prepared for participation in a program via discussions regarding the program and the child's feelings about going (see Morehouse, 2000).

What Can Social Workers Do?

Social workers should routinely assess individuals, families, and children for substance abuse problems. How the social worker responds is influenced by the setting in which they work and the client population that they work with. For example, a school social worker who recognizes that a child is being affected by the substance abuse problems of their parent (s) can help the child by providing education and support to enhance their resiliency. It is unlikely that the school social worker would be in a position to directly intervene with the parent or the family. On the other hand, social workers who work in child protective services typically work with the family and are in a position to recommend or require treatment that addresses the addiction problem in the addicted individual as well as support and interventions for the family as a whole or for individual family members.

It is important to bear in mind that children who are not being severely affected by their parent's substance abuse should not be placed in intensive treatment. The type of intervention provided (if any) should match the child's needs. In any case, the National Association for Children of Alcoholics (NACoA) suggests that the "seven **C's**" should be communicated to children who are growing up in families where substance abuse is a problem: you didn't **Cause** it; you can't **Cure** it; you can't **Control** it; but you can help take better **Care** of yourself by **Communicating** your feelings, making healthy **Choices** and **Celebrating** yourself.

Optional Classroom Activity

Consider the following case vignettes and discuss the “best” course of action that the social worker can take to address the needs of the child.

Vignette 1 – Joe

Joe is a 9 year old white male who resides with his mother, father, and two younger brothers in Baltimore, MD. He attends Baltimore City schools and is currently in the 3rd grade. Joe was referred to the school social worker by his teacher who reports that Joe comes to school appearing very tired and he falls asleep in his classes. After some discussion with Joe, the social worker learns that Joe’s parents are frequently not at home in the evening. Joe cares for his two younger siblings. He waits up for his parents as he worries about them driving home drunk.

Vignette 2 – Mary

Mary is a 12 year old African American girl who resides with her mother, father, and three sisters in Detroit, MI. Mary participates in the after-school programs for youth at the YMCA. Mary is very outgoing and enjoys participating in the athletic and mentoring programs. She is comfortable with her peers. Mary appears to benefit from her activities. The social worker who is employed by the YMCA to work with youth learns from another child that Mary’s mother smokes marijuana.

Vignette 3 – Sammy

Sammy is a 3 year old Native American boy who resides with his mother in New York City. A neighbor called the Child Protective Services hotline to report that she was concerned about the safety of the child. The neighbor knows that the child’s mother regularly uses crack cocaine as she has seen her buying and using the drug in the alley behind the apartment building. She has noticed bruises and strap marks on Sammy in the past. The neighbor reports that she is very concerned as she is hearing a child screaming and crying in the apartment.

Discussion Points/Questions

1. How can social workers integrate screening questions for substance abuse/dependence in families into their routine assessments?
2. How can social workers influence agency policy to foster assessment, appropriate intervention, and referral for COAs and their families?
3. How can social workers support COAs who are not exhibiting any problems?

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CHILDREN OF ADDICTED PARENTS: IMPORTANT FACTS

Alcoholism and other drug addiction have genetic and environmental causes. Both have serious consequences for children who live in homes where parents are involved. More than 28 million Americans are children of alcoholics; nearly 11 million are under the age of 18. This figure is magnified by the countless number of others who are affected by parents who are impaired by other psychoactive drugs.

1. Alcoholism and other drug addiction tend to run in families. Children of addicted parents are more at risk for alcoholism and other drug abuse than are other children.

- Children of addicted parents are the highest risk group of children to become alcohol and drug abusers due to both genetic and family environment factors.¹
- Biological children of alcohol dependent parents who have been adopted continue to have an increased risk (2-9 fold) of developing alcoholism.²
- Recent studies suggest a strong genetic component, particularly for early onset of alcoholism in males. Sons of alcoholic fathers are at fourfold risk compared with the male offspring of non-alcoholic fathers.³
- Use of substances by parents and their adolescent children is strongly correlated; generally, if parents take drugs, sooner or later their children will also.⁴ Adolescents who use drugs are more likely to have one or more parents who also use drugs.⁵
- The influence of parental attitudes on a child's drug taking behaviors may be as important as actual drug abuse by the parents.⁶ An adolescent who perceives that a parent is permissive about the use of drugs is more likely to use drugs.⁷

2. Family interaction is defined by substance abuse or addiction in a family.

- Families affected by alcoholism report higher levels of conflict than do families with no alcoholism. Drinking is the primary factor in family disruption. The environment of children of alcoholics has been characterized by lack of parenting, poor home

management, and lack of family communication skills, thereby effectively robbing children of alcoholic parents of modeling or training on parenting skills or family effectiveness.⁸

- The following family problems have been frequently associated with families affected by alcoholism: increased family conflict; emotional or physical violence; decreased family cohesion; decreased family organization; increased family isolation; increased family stress including work problems, illness, marital strain and financial problems; and frequent family moves.⁹
- Addicted parents often lack the ability to provide structure or discipline in family life, but simultaneously expect their children to be competent at a wide variety of tasks earlier than do non-addicted parents.¹⁰
- Sons of addicted fathers are the recipients of more detrimental discipline practices from their parents.¹¹

3. A relationship between parental addiction and child abuse has been documented in a large proportion of child abuse and neglect cases.

- Three of four (71.6%) child welfare professionals cite substance abuse as the top cause for the dramatic rise in child maltreatment since 1986.¹²
- Most welfare professionals (79.6%) report that substance abuse causes or contributes to at least half of all cases of child maltreatment; 39.7% say it is a factor in over 75% of the cases.¹³
- In a sample of parents who significantly maltreat their children, alcohol abuse is specifically associated with physical maltreatment, while cocaine exhibits a specific relationship to sexual maltreatment.¹⁴

- Children exposed prenatally to illicit drugs are 2 to 3 times more likely to be abused or neglected.¹⁵

4. Children of drug addicted parents are at higher risk for placement outside the home.

- Three of four child welfare professionals (75.7%) say that children of addicted parents are more likely to enter foster care, and 73% say that children of alcoholics stay longer in foster care than do other children.¹⁶
- In one study, 79% of adolescent runaways and homeless youth reported alcohol use in the home, 53% reported problem drinking in the home, and 54% reported drug use in the home.¹⁷
- Each year, approximately 11,900 infants are abandoned at birth or are kept at hospitals, 78% of whom are drug-exposed. The average daily cost for each of these babies is \$460.¹⁸

5. Children of addicted parents exhibit symptoms of depression and anxiety more than do children from non-addicted families.

- Children of addicted parents exhibit depression and depressive symptoms more frequently than do children from non-addicted families.¹⁹
- Children of addicted parents are more likely to have anxiety disorders or to show anxiety symptoms.²⁰
- Children of addicted parents are at high risk for elevated rates of psychiatric and psychosocial dysfunction, as well as for alcoholism.²¹

6. Children of addicted parents experience greater physical and mental health problems and higher health and welfare costs than do children from non-addicted families.

- Inpatient admission rates and average length of stay for children of alcoholics were 24% and 29% greater than for children of non-alcoholic parents. Substance abuse and other mental disorders were the most notable conditions among children of addicted parents.²²
- It is estimated that parental substance abuse and addiction are the chief cause in at least 70-90% of all child welfare spending. Using the more conservative 70 percent assessment, in 1998 substance

abuse and addiction accounted for approximately \$10 billion in federal, state and local government spending simply to maintain child welfare systems.²³

- The economic costs associated with Fetal Alcohol Syndrome were estimated at \$1.9 billion for 1992.²⁴
- A sample of children hospitalized for psychiatric disorders demonstrated that more than 50% were children of addicted parents.²⁵

7. Children of addicted parents have a high rate of behavior problems.

- One study comparing children of alcoholics (aged 6-17 years) with children of psychiatrically healthy medical patients found that children of alcoholics had elevated rates of ADHD (Attention Deficit Hyperactivity Disorder) and ODD (Oppositional Defiant Disorder) measured against the control group of children.²⁶
- Research on behavioral problems demonstrated by children of alcoholics has revealed some of the following traits: lack of empathy for other persons; decreased social adequacy and interpersonal adaptability; low self-esteem; and lack of control over the environment.²⁷
- Research has shown that children of addicted parents demonstrate behavioral characteristics and a temperament style that predispose them to future maladjustment.²⁸

8. Children of addicted parents score lower on tests measuring school achievement and they exhibit other difficulties in school.

- Sons of addicted parents performed worse on all domains measuring school achievement, using the Peabody Individual Achievement Test-Revised (PIAT-R), including general information, reading recognition, reading comprehension, total reading, mathematics and spelling.²⁹
- In general, children of alcoholic parents do less well on academic measures. They also have higher rates of school absenteeism and are more likely to leave school, be retained, or be referred to the school psychologist than are children of non-alcoholic parents.³⁰

- In one study, 41% of addicted parents reported that at least one of their children repeated a grade in school, 19% were involved in truancy, and 30% had been suspended from school.³¹
- Children of addicted parents compared to children of non-addicted parents were found at significant disadvantage on standard scores of arithmetic.³²

9. Maternal consumption of alcohol and other drugs during any time of pregnancy can cause birth defects or neurological deficits.

- Studies have shown that exposure to cocaine during fetal development may lead to subtle but significant deficits later on, especially with behaviors that are crucial to success in the classroom, such as blocking out distractions and concentrating for long periods.³³
- Cognitive performance is less affected by alcohol exposure in infants and children whose mothers stopped drinking in early pregnancy, despite the mothers' resumption of alcohol use after giving birth.³⁴
- Prenatal alcohol effects have been detected at moderate levels of alcohol consumption in non-alcoholic women. Even though a mother may not regularly abuse alcohol, her child may not be spared the effects of prenatal alcohol exposure.³⁵

10. Children of addicted parents may benefit from supportive adult efforts to help them.

- Children who coped effectively with the trauma of growing up in families affected by alcoholism often relied on the support of a non-alcoholic parent, stepparent, grandparent, teachers and others.³⁶
- Children of addicted parents who rely on other supportive adults have increased autonomy and independence, stronger social skills, better ability to cope with difficult emotional experiences, and better day-to-day coping strategies.³⁷
- Group programs reduce feelings of isolation, shame and guilt among children of alcoholics while capitalizing on the importance to adolescents of peer influence and mutual support.³⁸
- Competencies such as the ability to establish and maintain intimate relationships, express feelings, and solve problems can be improved by building the self-esteem and self-efficacy of children of alcoholics.³⁹

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CAGE HANDOUT

The CAGE is a brief screening tool that can easily be incorporated into assessment interviews (Ewing, 1984). The acronym CAGE stands for **C**utting down, **A**nnoyance, **G**uilt, and **E**ye openers. The CAGE was originally developed to screen for alcoholism, but has been adapted to screen for both alcohol and drug abuse in individuals CAGE-AID (Brown & Rounds, 1995) and to screen for substance abuse in the family (Frank, Graham, Zyzanski, & White, 1992; Werner, Joffe, & Graham, 1999). The CAGE is a screening tool and as such, is used to determine if an in-depth assessment of potential substance use disorders or problems should occur. The CAGE may be less sensitive or valid in certain cultural groups (Volk, Cantor, Steinbauer, & Cass, 1997) and with women (Bradley, Boyd-Wickizer, Powell, & Burman, 1998).

Item responses on the CAGE are scored 0 or 1 (no = 0, yes = 1). A higher score is indicative of substance abuse problems. A total score of two or more is considered to be clinically significant and the individual/family should be further assessed for substance abuse problems. Many authors suggest that even one positive answer on the CAGE is clinically significant and warrants further assessment (Adger et al., 2004).

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CAGE

Have you ever felt you should **C**ut down on your drinking?

Have people **A**nnoyed you by criticizing your drinking?

Have you ever felt bad or **G**uilty about your drinking?

Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (**E**ye opener)?

CAGE-AID

Have you ever felt you should **C**ut down or stop drinking or using drugs?

Have people **A**nnoyed you by criticizing you for your drinking or drug use?

Have you ever felt bad or **G**uilty about your drinking or drug use?

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (**E**ye opener)?

The Family CAGE

Have you ever felt that anyone in your family should **C**ut down on their drinking?

Has anyone in your family ever felt **A**nnoyed by criticisms about their drinking?

Has anyone in your family ever felt bad or **G**uilty about their drinking?

Has anyone in your family ever had a drink first thing in the morning to steady their nerves or to get rid of a hangover (**E**ye opener)?

RESOURCES

Websites

Addiction Technology Transfer Center <http://www.nattc.org>

Adult Children of Alcoholics <http://www.adultchildren.org>

Al-Anon <http://www.al-anon.org>

Alateen <http://www.alateen.org>

Alcoholics Anonymous <http://www.aa.org>

Center for Substance Abuse Prevention <http://prevention.samhsa.gov>

Center for Substance Abuse Treatment <http://csat.samhsa.gov>

Child Trends <http://www.childtrends.org>

Children of Alcoholics Foundation <http://www.coaf.org>

Lost Childhood: Growing Up in an Alcoholic Family <http://www.lostchildhood.org>

National Association for Children of Alcoholics <http://www.nacoa.org>

National Clearing House for Alcohol and Drug Information <http://www.health.org>

National Council on Alcoholism and Drug Dependence <http://www.ncadd.org>

National Institute for Alcohol Abuse and Alcoholism <http://www.niaaa.nih.gov>

NIAAA Social Work Curriculum for the Prevention and Treatment of Alcohol Use Disorders <http://pubs.niaaa.nih.gov/publications/Social/main.html>

National Institute on Drug Abuse <http://www.nida.nih.gov>

Narcotics Anonymous <http://www.na.org>

SMART Recovery <http://www.smartrecovery.org/>

Substance Abuse and Mental Health Services Administration <http://www.samhsa.gov>

Books, Chapters, and Articles

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Videos

Lost Childhood: Growing up in an Alcoholic Family (see <http://www.lostchildhood.org> or <http://www.health.org> for ordering information).

Lots of Kids Like Us (see <http://www.gtrvideo.com>)

Addiction and the Family: Healing and Recovery (see <http://www.recoverymonth.gov> or <http://www.health.org> for ordering information).

Program Materials

SAMHSA's *Children's Program Kit: Supportive Education for Children of Addicted Parents* (see <http://www.health.org> for ordering information).

Other Resources about Children of Alcoholics

See NACoA's website, www.nacoa.org

