

Article

# Parental stress and child behavioral outcomes following substance abuse residential treatment Follow-up at 6 and 12 months

Therese Killeen, R.N., Ph.D., C.S.\*, Kathleen T. Brady, M.D., Ph.D.

*Center for Drug and Alcohol Programs, 4 North, Department of Psychiatry and Behavioral Sciences, Medical University of South Carolina, 67 President Street, P.O. Box 250861, Charleston, SC 29425, USA*

Received 3 April 1998; received in revised form 9 July 1999; accepted 9 July 1999

---

## Abstract

Residential treatment programs specifically designed for alcohol/drug-addicted women and their children have become a popular treatment modality across the United States. Outcome evaluation of these programs are beginning to show promising results. In this article, outcome data from a study of a residential substance abuse treatment program for women and young children in rural South Carolina will be presented. Data from 35 women and 23 children in the area of addiction severity, parenting and child emotional and behavioral development at 6 and 12 months following discharge from a substance abuse residential treatment program is examined. Results showed that women who completed treatment had better scores on addiction severity and parental stress, and their children had improved behavioral and emotional functioning at 6 and 12 months after discharge from the program. These results suggest that residential treatment has benefits for mothers and their children. This data adds to the growing body of evidence supporting intensive and inclusive care for certain groups of individuals with substance use disorders during critical periods. © 2000 Elsevier Science Inc. All rights reserved.

*Keywords:* Parental stress; Child behavior; Residential treatment; Treatment outcome

---

## 1. Introduction

The detrimental consequences of maternal substance abuse on child growth and development has only recently emerged in the literature, as more children with documented exposure to substances of abuse in utero are targeted for longitudinal follow-up. One problem that exists with precisely pinpointing the adverse effects of drug exposure is the influence of numerous environmental and genetic factors that commonly co-occur with substance use in the growth and development of children. Lack of prenatal care, poor nutrition, poverty, and other environmental factors are all confounding issues. The majority of women who use any substances during pregnancy use a number of substances (nicotine, alcohol, etc.), making it impossible to differentiate the effects of any single agent. It has also been reported that substance-abusing women have more psychiatric comorbidity, history of victimization and domestic violence, poor interpersonal skills, poor parenting skills, and lack of healthy role models in their life (Brady et al., 1994; Daghestani, 1988; Marcenko & Spence, 1995; Rousaville et al., 1991).

Substance use disorders can cause a number of interrelated deficits in general functioning. McLellan et al. (1990) has shown that the severity of addiction is related to the combined severity of problems in other areas of life, such as medical, employment/economic, legal, drug/alcohol use, social/family, and psychiatric problems. Additionally, severity of problems in the mother can have a direct relationship with the severity of problems in the child. Substance abuse has been linked to severe child abuse and maltreatment (Black et al., 1994; Kelly, 1992; Murphy et al., 1991; Williams-Peterson et al., 1994). Substance-abusing mothers have been described as using more negative reinforcement in their parenting behavior than non-substance-abusing mothers (Bauman & Dougherty, 1983).

Most research dealing with childhood consequences of maternal substance abuse have been unable to specifically demonstrate a cause and effect relationship between drug exposure and child development and behavior. Richardson and Day (1994) found that the risk factors that covaried with cocaine use during pregnancy could explain most of the poor outcome. These risk factors included use of alcohol, tobacco, and cannabis; gestational age at birth; gender; and race. Hurt et al. (1995) found no differences between cocaine-exposed children and matched controls on mea-

---

\* Corresponding author. Tel.: 843-792-5232; fax: 843-792-7353.

*E-mail address:* killeent@musc.edu (T. Killeen).

asures of mental and psychomotor control. However, both groups displayed lower mean scores on these measures over time. The authors concluded that the decreases in the mental and psychomotor development may be more a result of low socioeconomic or minority status than in utero drug exposure.

Griffith et al. (1994) evaluated children exposed prenatally to drugs matched with children not exposed to drugs at 3-year follow-up. Drug-exposed children scored significantly lower on the verbal, as well as the abstract/visual reasoning ( $p < .05$ ) portion of the Stanford-Binet Intelligence Scale (SBIS). More importantly, he noted that drug-exposed children who remained in the drug-using households were significantly more delayed on the verbal reasoning portion of the SBIS than those living in drug-free households. Significantly more drug-exposed children were rated by caregivers on the Child Behavior Checklist as demonstrating more destructive, aggressive, and externalizing behaviors when compared with controls.

Azuma and Chasnoff (1993) studied the long-term developmental risk in children prenatally exposed to cocaine and other drugs. Cognitive ability, as measured by the SBIS, was significantly affected by drug exposure. This effect was mediated indirectly through an environmental factor (home setting), a behavioral factor (ability to sustain attention for extended periods), and a biological factor (head circumference).

Bender et al. (1995) studied preschool children of mothers who used crack-cocaine during pregnancy and after delivery, mothers who did not use during pregnancy but used after delivery, and mothers without a crack-cocaine use history. The prenatally exposed group scored significantly lower on receptive language ability ( $p < .05$ ) and visual-motor integration skills ( $p < .05$ ) than either of the other groups.

Much of the research suggest that postnatal substance abuse by the mother and the environment that this behavior creates may be more or equally as harmful to child development. It has been suggested that future research endeavors explore the impact of addiction related maternal lifestyle characteristics on child development (Richardson & Day, 1994).

Treatment options for women have been expanding. Programs are beginning to address the barriers that prevent women from entering and staying in treatment. Additionally, innovative gender-specific programs that address issues such as parenting, self-esteem, relationships, and domestic violence have become more common. Residential programs that accept both mothers and children are emerging as another promising treatment modality. The focus of treatment is to reintegrate both mother and child back into the community. It has become increasingly clear that many of the child developmental problems associated with maternal drug use can be reversed if the affected children have stability in their lives (Chasnoff, 1992).

This article will assess the impact of the therapeutic environment in a residential facility for women addicted to substances and children exposed to their mother's addiction. Parental stress and child behavioral and emotional health outcomes at 6- and 12-month postdischarge will be evaluated.

## 2. Methods

The study site was a residential treatment facility for drug-dependent women and their children in rural South Carolina supported by a grant from the Center for Substance Abuse Treatment (CSAT). This treatment facility had the capacity to treat approximately 16 women at any one time, with up to two children between the ages of newborn and 12 years of age. Residents were considered graduates of the program if they progress through four phases of treatment, which included stabilization, integration, actualization, and transition. Residents progressed through each phase at an individualized pace until they satisfied the objectives associated with that phase. If patients left prior to completion of phases they were considered premature discharges.

Program interventions were geared toward both substance-abusing mothers and their children. Substance abuse treatment programming was eclectic but included relapse prevention, 12-step participation, substance abuse education, parenting classes, as well as involvement in a number of community programs. Special programming for the children included therapeutic child care, counseling for psychological problems, drug/alcohol abuse education, structured mother-child interaction groups, medical services, and appropriate referrals to other services in the community.

Baseline assessments included the Addiction Severity Index (ASI; McLellan et al., 1990), Family Environment Scale (FES; Moos, 1986), Parenting Stress Index (PSI; Abidin, 1995), Infant and Child Development Inventory (Ireton & Thwing, 1974), Brigance Screen (Brigance, 1991), and Child Behavior Checklist (CBCL). Assessments on both the women and children were conducted every 6 months during program participation and at 6 and 12 months following discharge from the program. Six- and 12-month assessments included measurement of drug and alcohol use, psychosocial functioning and parenting stress for the women involved in the program, and measurement of psychomotor, cognitive, and emotional development for the children.

### 2.1. Instruments: child assessments

The CBCL is a 100–113-item Likert-type scale completed by mothers of children ages 2–3 and 4–18. Factor analysis revealed six subscales that could be categorized as internalizing problems (Social Withdrawal, Somatic Complaints, Sleep Problems, Depression) and externalizing problems (Destructive and Aggressive). This instrument has good test/retest reliability and validity (Achenbach et al., 1987). Scores are computed as *T* scores. A *T* score of 55 represents the 69th percentile and scores that fall below 55 are considered normal. Scores that fall above 55 are in the clinical range. The behavioral competence subscale, which is only done for children aged 4–18 years, rates areas associated with activities, social, and school functioning. Scores that fall below 55 on this particular subscale are considered maladaptive or in the clinical range.

متن کامل مقاله

دریافت فوری ←

**ISI**Articles

مرجع مقالات تخصصی ایران

- ✓ امکان دانلود نسخه تمام متن مقالات انگلیسی
- ✓ امکان دانلود نسخه ترجمه شده مقالات
- ✓ پذیرش سفارش ترجمه تخصصی
- ✓ امکان جستجو در آرشیو جامعی از صدها موضوع و هزاران مقاله
- ✓ امکان دانلود رایگان ۲ صفحه اول هر مقاله
- ✓ امکان پرداخت اینترنتی با کلیه کارت های عضو شتاب
- ✓ دانلود فوری مقاله پس از پرداخت آنلاین
- ✓ پشتیبانی کامل خرید با بهره مندی از سیستم هوشمند رهگیری سفارشات