



Serving Children Prenatally Exposed to Substances

Assumptions/Myths

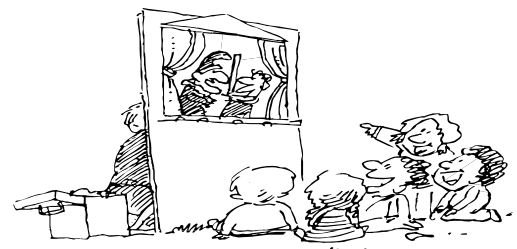
**Kansas Inservice Training System (1999)
Kansas University Center on Developmental Disabilities
2601 Gabriel, Parsons, KS 67357
620-421-6550 ext. 1618 or 1-800-362-0390 ext. 1618
email: kskits@mail.ku.edu
web: kskits.org**



Facilitative Classroom Processes For Children Who Are At-Risk Due To Prenatal Substance Exposure

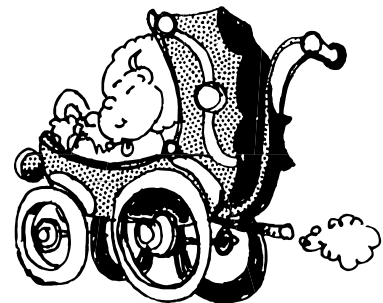
- √ Respect: Adults must be respectful of children's work and play space.
- √ Attachment: A major goal for each child is to develop an attachment to one of the adults in the classroom.
- √ Feelings: Feelings are real, important, and legitimate; children behave and misbehave for a reason, even if it cannot be figured out.
- √ Mutual discussion: Talking about behavior and feelings, done with empathy rather than judgement, validates the child's experiences and sets up an accepting atmosphere.
- √ Role model: Teachers need to model behavior that is appropriate for children to imitate.
- √ Peer sensitivity: Until children have the experience of having their own needs repeatedly and consistently met, they will not become aware of the needs and feelings of others.
- √ Decision making: Teachers need to recognize the importance of, and provide many opportunities for, children to make decisions for themselves.
- √ Curricula: Should be developmentally appropriate and promote experiential learning, interaction, exploration, and play in a context that is interesting and relevant.
- √ Play: Adults must actively facilitate children's play activities by helping them extend the complexity and duration of such activities.
- √ Rules: The setting should be one in which the number of rules specifically told to the children is limited.
- √ Observation and assessment: Assessment should be made during play, at transition time, and while a child is engaged in self-help activities.
- √ Flexible room environment: The setting should allow materials and equipment to be removed to reduce stimuli or added to enrich the activity.
- √ Transition time plans: Transition should be seen as an activity in and of itself with a beginning, middle and end.
- √ Adult/child ratio: There should be enough adults to promote attachment, predictability, nurturing and ongoing assistance in learning appropriate coping styles.

Adapted from: "Today's Challenge: Teaching Strategies for Working with Young Children Prenatally Exposed to Drugs/Alcohol." Carole Cole, Victoria Ferrara, Teresa Garcia, Deborah Johnson, Mary Jones, Maria Schoenhaus, Rachelle Tyler, Valerie Wallace, PED Teachers, Los Angeles Unified School District, Maria Anne Poulsen, Ph.D., University Affiliated Program, Children's Hospital, Los Angeles.



Basic Assumptions When Working With Children Prenatally Exposed to Drugs

- √ Facilitating a home/school partnership is an essential part of the curriculum.
- √ Each child and family must be served as individuals with particular strengths and vulnerabilities; attempting to list common characteristics for both children and mothers hides unique strengths and vulnerabilities of each mother-child relationship.
- √ These children are more alike than different from their typical peers.
- √ Prenatal drug exposure can cause a continuum of impairments from severe handicapping conditions to risk factors; however, there is no “typical profile.”
- √ Children show a pattern of performance that is often inconsistent and unpredictable; they “sporadically” master skills.
- √ Behaviors seen are the result of a constellation of risk factors resulting from possible organic damage, early insecure attachment patterns, and often ongoing environmental instability.
- √ Better coping skills require increased self esteem, self control, and problem solving mastery.
- √ Intervention strategies, to be effective, must attempt to counteract prenatal risk factors and stressful life events; protective factors and facilitative processes must be built into classrooms.
- √ Program intervention is best achieved when all professionals concerned with the family have regularly scheduled times to meet and plan.
- √ Research has shown that the progress of children at risk is enhanced when they are placed in predictable, secure, and stable environments where they can form attachments with nurturing, caring adults, e.g., teachers, babysitters.



Strategies for the Healthy Development of the Child Who is At-Risk

Teachers who develop a strong relationship with the child who is at-risk, encourage that child's sense of self, self-mastery and self-esteem when they:

- √ Provide for individualized adult/child personal interaction as part of each day's routine (touch, eye contact, and hugs, cuddling and/or talking).
- √ Model, encourage, recognize, acknowledge and respond to the child's expressions of feelings, wants and needs.
- √ Encourage and support self-dependence in self-help, play and learning activities.
- √ Allow the child opportunity to "help" in the classroom as an important member of the group.
- √ Provide the child with a toy of his own for the day.
- √ Model and encourage the re-creation of daily living experiences in representational play.
- √ Allow the child to lead in adult/child play on a regular basis.
- √ Provide for and encourage decision-making.
- √ Support the child on difficult tasks.
- √ Allow use of transitional objects.
- √ Develop individualized "Hello" and "Good-bye" rituals between self and child.
- √ Encourage and praise all attempts at developmental mastery.



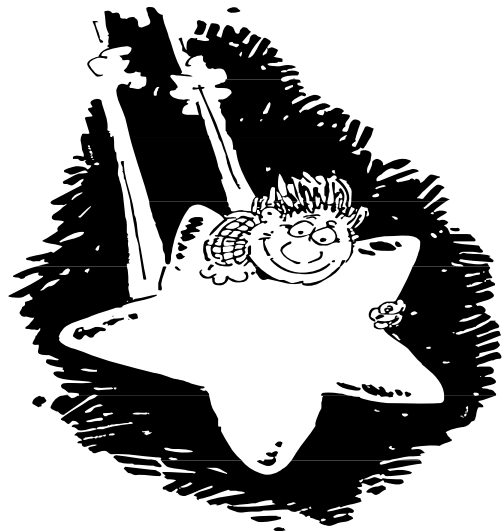
Teachers create a protective responsive environment that helps the child who is at-risk learn to organize and regulate his behavior when they:

- √ Work with a consistent team of classroom personnel.
- √ Establish classroom routines and rituals to allow the child to anticipate events.
- √ Provide and review daily “pictorial reminders” of class routines on a daily basis.
- √ Routinely alert the children that an activity will soon be over.
- √ Prepare children for new changes in daily routines or classroom personnel.
- √ Protect children from the overstimulation of materials, people, movement, light and noise.
- √ Provide children who are at-risk with explicit expectations/recognition of positive behaviors.
- √ Set consistent limits on harmful behaviors.
- √ Match the level of behavioral expectations with the level of the child’s behavioral maturity.
- √ Help the child recover from stressful situations.
- √ Build relaxation in as part of the program.
- √ Provide the child who is at-risk with a self-selected plan of respite when he is feeling overwhelmed.
- √ Intervene before problems escalate to out of proportion behavior.



Teachers facilitate adaptive functioning in the child who is at-risk when they directly teach those tasks that non-risk children learn incidentally. Teachers help the child who is at-risk learn to compensate for his disorganized behaviors when they:

- √ Verbally/non-verbally guide behavior in close proximity with eye contact and/or touch.
- √ Model, rehearse and guide positive peer interactions (turn-taking, prosocial behaviors).
- √ Model, rehearse and guide peer conflict resolution.
- √ Help the child who is at-risk appreciate the “cause and effect” of his behavior.
- √ Model, rehearse and guide play activities.
- √ Allow the child who is at-risk to practice developmental tasks with tolerance for messiness and dawdling.
- √ Help the child who is at-risk focus and attend to all parameters of developmental tasks.
- √ Provide verbal and/or non-verbal cues for spatial/motor and problem solving tasks.
- √ Encourage the independent use of alternative problem solving/task mastery strategies in peer and solitary play.
- √ Provide and encourage language to help the child who is at-risk learn to reflect upon a situation before acting (Stop-Think-Act).



The Early Childhood Research Institute on Substance Abuse Challenges the Myths of Prenatal Substance Abuse

1. What kind of woman uses drugs while she is pregnant?

2. What is the drug most commonly abused by women during pregnancy?

3. But isn't cocaine the most harmful to the unborn child?

4. How many children are exposed to harmful substances before birth?

5. How many of those children will show damaging effects?

6. What can be done for those children who do show effects from prenatal exposure to alcohol or other drugs?

7. What about the future? What can be done to reduce the risk of prenatal substance abuse?

Answers

1. All kinds. The misconception that prenatal substance abuse is primarily confined to women of color living in the inner cities is based on biases in both testing and reporting. Recent studies have found similar rates of illegal drug use during pregnancy among whites and non-whites, among urban and suburban, and rural women, and in both the public and private sector.

2. Alcohol. Estimates based on the most recent NIDA survey suggest that women were 16 times more likely to have used alcohol as cocaine during pregnancy. The second most frequently reported drug of abuse was nicotine. Marijuana was third; then crack/cocaine.

3. Contrary to reports in the popular press, data-based research on the effects of prenatal exposure to cocaine is incomplete, inconclusive, with many methodological shortcomings. Empirical literature is suggestive of widely varying consequences of exposure to cocaine in utero—from minimal to profound. One problem researchers have is sorting out the effect of cocaine exposure from the many other confounding variables which may also contribute to the infant's outcome: polydrug use, poor maternal nutrition, lack of prenatal care, low birthweight, prematurity, or socioeconomic status of the family, to name a few.

We know more about the effect of alcohol exposure on the unborn child, since alcohol, unlike cocaine, is associated with a cluster of physical and mental symptoms which can be identified as a syndrome. And the strongest empirical association with infant mortality to date is with another legal drug—nicotine.

4. A recent estimate based on NIDA reports suggests that as many as 2.6 million babies a year are born exposed to alcohol at some time before birth; 1.3 million are exposed to nicotine; 611,200 to marijuana; and 158,000 to cocaine.

5. It is too soon to tell. The sparse data that have been reported so far seem to indicate that not all children exposed to prenatal substance abuse are adversely affected. Remarkably, the most extensive follow-up studies of fetal exposure to legal and illegal drugs report identifiable effects in about 30-40% of the children in the preschool years.

Unfortunately, the rate of problems may increase in later years, since symptoms associated with early neurological insults, such as the central nervous system damage seen in some drug-exposed infants, may not be manifested until preschool or school age.

6. We can start by treating these young children the same way we treat other youngsters once they are identified as having special needs. We are unaware of any data on the effectiveness of any developmental interventions specifically designed for alcohol or other drug-affected children—nor do we advocate such an approach. Favorable reports are emerging from model programs across the country that are relying on accepted practices in family-focused intervention and early childhood special education in treating drug-affected children.

7. A first step is recognizing that prenatal substance abuse is not just a drug problem. Other issues are involved and must be simultaneously addressed, including substance abuse treatment programs for women (with children), universal prenatal care, health care, nutrition/supplemental food programs, vocational training, child care, housing, transportation, and mental health services. Obviously, the needs faced by children from substance abusing environments cannot be met by any one community agency. Barriers to negotiating multiple service providers must therefore be removed through increased service coordination/case management.

As we continue to look for the long term consequences of prenatal exposure to alcohol or other drugs, we must take into consideration the interactions of young children with various caregivers, in different settings, and across time. We must learn to identify not only the factors which make children vulnerable, but also those influences which may be protective.

Predicting the Long-Term Effects of Prenatal Substance Abuse

A QUIZ

DIRECTIONS: Circle the characteristics that may be exhibited by children who have been prenatally exposed to alcohol and/or other drugs.

Irritable

Hyperactive

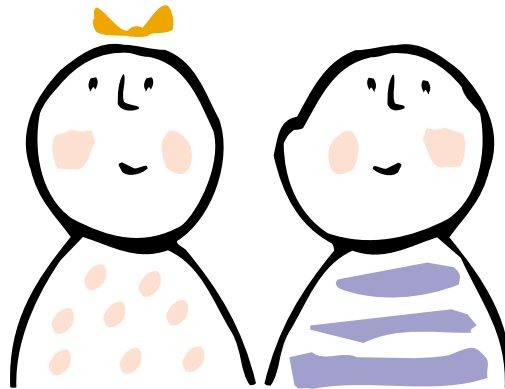
Unusual physical features

Normal IQ

Fearless

Lacking emotional expression

Talkative



Eager to please

Withdrawn

Normal appearance

Mental retardation

Cautious

Affectionate

Language delayed

ANSWERS: All of the contradictory characteristics listed above have been used in the empirical literature to describe preschoolers who have been exposed to alcohol and/or drugs before birth. To date, there is **NO TYPICAL PROFILE** of a child who has been exposed to substances prenatally.

Compiled by: The Early Childhood Research Institute on Substance Abuse, Juniper Gardens Children's Project, 1614 Washington Blvd., Kansas City, Kansas 66102, 913-321-3143.

Infants Prenatally Exposed to Drugs

A QUIZ

The following statements refer to infants who have been exposed to alcohol and/or other drugs before birth. Mark each TRUE or FALSE.

These babies

- _____ 1. Have obvious physical problems at birth.
- _____ 2. Are often smaller when born, but catch up on most measures of growth during the first year of life.
- _____ 3. Are irritable and hard to comfort in the early months due to drug withdrawal.
- _____ 4. Do not bond with caregivers.
- _____ 5. May overreact to sensory stimulation.
- _____ 6. May fail to show strong feelings in response to people or objects.
- _____ 7. Follow a different sequence of development than other babies.
- _____ 8. Are no more at risk for child abuse and neglect than other children from similar backgrounds.
- _____ 9. Are more likely to be born with AIDS and other sexually transmitted diseases.
- _____ 10. Seem to show consistent improvement when placed in an early caregiving environment that is responsive and predictable.



KEY: Only 2, 5, 6, 9, and 10 are TRUE. The other statements are either misconceptions or overgeneralizations based on inadequate empirical information to date.

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