THE ADOPTION AND SAFE FAMILIES ACT OF 1997: POLICY IMPLICATIONS FOR PRACTICE WITH SUBSTANCE ABUSING PARENTS WHO HAVE MALTREATED THEIR CHILDREN

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Under the Adoption and Safe Families Act passed by Congress in 1997, public child welfare authorities must review all foster care cases when a child has been in placement for 12 months. If parents have not made progress toward reunifying with their children, the state may proceed to terminate parental rights and place a child for adoption. States have the option of establishing an even shorter time frame for reviewing parents' progress when children are under three years of age. Minnesota, for example, has chosen to review cases of infants and young children at six months of care. These mandatory reviews and limited time frames are designed to insure permanency for children and to prevent them from languishing in foster care for years with no permanent futures. The law recognizes that one year, or even six months, is a long time to a child developmentally, especially to an infant or toddler for whom psychological attachment to a stable, consistent caregiver is essential to future wellbeing.

At the same time that federal child welfare policy is recognizing and supporting children's need for permanency, the pervasive contribution of drug and alcohol abuse to child maltreatment and out-of-home placement of children is acknowledged (Huang, Cerbone, & Gfroerer 1998; Reid, Macchetto, & Foster 1999; U.S. Department of Health and Human Services 1999). The Child Welfare League of America reports that 80 percent of states identify parental substance abuse as "one of the two top problems exhibited by families reported for child maltreatment." A study of children in foster care in California and Illinois carried out by the Government Accounting Office found that 60 percent of those in care for at least 17 months as of September 1997 had parents who were substance abusers.

A state study in Oregon found that 65.6 percent of children entering foster care between 1995 and 1997 did so because of parental substance abuse. Other studies of the incidence of parental substance abuse in families of children entering foster care have presented similar findings: parental substance abuse is present in one-half to two-thirds of cases of child maltreatment (Curtis & McCullough 1993; Magura & Laudet 1996; Murphy, Jellinek, Quinn, Smith, Poitrast, & Goshko 1991).

Studies of substance abusing parents have found child-rearing beliefs and attitudes that heighten risk for child abuse (Williams-Peterson, Myers, Degen, Knisely, Elswick & Schnoll 1994), as well as elevated rates of first-time reports to child protective services (Jaudes, Ekwo, & Van Voorhis 1995), re-reports (Wolock & Magura 1996), and out-of-home placements of maltreated children (Nair, Black, Schuler, Keane, Snow, & Rigney 1997). Research also suggests that these are families whose children are likely to remain longer in care while parents struggle, sometimes futilely, to overcome their addictions and put their lives back together (Curtis & McCullough 1993; Goerge & Harden 1993; Walker, Zangrillo, & Smith 1994). The Adoption and Safe Families Act may in part have been born out of frustration with this seemingly intractable problem.

As is well-known among those who treat addicted persons, as well as those who have overcome addictions themselves, dependence on mind-altering, mood-altering chemicals is not easily overcome. It is a process that often consists of several episodes of sobriety and return to using over a period of time. Research suggests that this is particularly true for substance abusing women who often have fewer resources, both personal and instrumental, for overcoming addiction and maintaining sobriety (Nelson-Zlupko, Kauffman, & Dore 1995). Thus, addicted mothers, who are often the only available parent, may have a particularly difficult time meeting the 12 month time frame for family reunification of the Adoption and Safe Families Act.

How, then, can practitioners working with families in the child welfare system address the treatment needs of substance abusing parents in a way that enables them to sustain sobriety, reconstruct their lives, and still comply with the time limits for reunification

with their children under current child welfare policy? In order to develop better approaches to working with such parents, it is first necessary to understand the linkages between parental substance abuse and child maltreatment. To this end, a three dimensional model of these linkages is proposed that reflects current research in the field. Using this model, various avenues for intervention and treatment are offered to address this significant social problem.

LINKING SUBSTANCE ABUSE AND CHILD MALTREATMENT

Substance abuse links to child maltreatment in three ways. First, there is the *direct effect* of the substance(s) used *on parents' behavior*. Different types of controlled and illicit substances have different pharmacological effects on the organism. These effects may result in distortions of behavior that profoundly impact the individual's ability to function as a parent. Good parenting requires sensitivity to the social, emotional, and physical needs of the dependent child and consistency in responding to those needs (Belsky 1984). Mind-altering and mood-altering chemicals profoundly impact the individual's cognitive and affective functioning in ways that severely inhibit the capacity for sensitive and consistent parenting.

The second way parental substance abuse may be linked to child maltreatment is its *effects on the context* in which parenting takes place. The partners a parent chooses, the physical environment in which a family resides, and the social interactions of a parent with the world outside the family, all contribute to the context for child rearing. A parent whose partner relationships revolve around substance use and abuse, whose addiction robs the family of essential economic resources, and whose social network is severely truncated due to others' rejection of his or her drug-using behavior, creates a child rearing context that has significant potential for child maltreatment. Recent studies show, for example, that although mothers are the most frequent perpetrators of child maltreatment, a genetically unrelated adult male in the household such as a stepfather or mother's paramour is the most likely perpetrator of fatal child abuse (Daly & Wilson 1994; Sedlak & Broadhurst 1996). As substance abusing women are more likely than men who are substance-involved to have a partner who also abuses drugs or alcohol and these partnerships are frequently serial relationships, the likelihood of having an unrelated adult male in a household where the mother is actively using is quite high. Other contextual factors associated with substance abuse and child maltreatment will be examined later on in this paper.

Finally, *a parent's own early history of abuse and neglect*, which studies have shown to be associated with drug and alcohol abuse in adolescence and adulthood (Harrison, Fulkerson, & Beebe 1997; Wilsnack, Vogeltanz, Klassen, & Harris 1997), may independently contribute to maladaptive parenting. Increasingly, research is showing the long-term effects of maltreatment in childhood on adult functioning, beginning with its effects on the individual's ability to form lasting emotional attachments to others (Banyard 1999; Briere & Elliott 1994; Bryer, Nelson, Miller, & Krol 1987; Chu & Dill 1990). Research on physical and sexual trauma in childhood has found evidence of Post-Traumatic Stress Disorder (PTSD) as a long-term outcome (Hubbard, Realmuto, Northwood, & Masten 1995; Roesler 1994). One of the characteristic sequelae of traumatic stress and a symptom of PTSD is emotional numbing and interference with cognitive problem-solving functions, both of which have been associated with child maltreatment.

Conceptualizing the linkage between parental substance abuse and child maltreatment as a complex interaction of these three factors enables us to refine our approach to intervention with substance abusing families. Many programs seeking to intervene with parents who are substance involved fail to appreciate the complexity of factors that may contribute to the failure of parenting in such families. Interventions are often designed to assess and address only the substance-abusing behavior, or at best, the substance abuse along with pressing basic needs such as housing or income. Seldom is there appreciation for, and efforts to assess and address, the effects of the parent's own early history of trauma, for example. In this paper, I argue that sobriety alone is not sufficient to insure the safety and wellbeing of children who are to be returned to a formerly chemically dependent parent. If the factors that contributed to the parents use of mind and mood-altering chemicals are still present, it is likely

that a) the parent will be unable to sustain sobriety, and b) that the children will be further maltreated. However, if the conceptual model presented here is used to assess the client in his or her situation and to develop a differential treatment plan based on this assessment, it becomes more possible to adhere to the time frame for permanency planning established in the Adoption and Safe Families Act of 1997, while insuring the safety and wellbeing of children reunified with previously substance-involved parents.

DIRECT EFFECTS OF SUBSTANCE ABUSE ON THE PARENTING FUNCTION

Different chemical substances have different physiological effects on the user and therefore affect the user's behavior in various ways. For example, drugs such as amphetamines and opioids, including cocaine, are stimulants to the central nervous system. They release dopamine which results in the euphoric high that is part of the addictive process (Jaffe 1992). With amphetamines the user is mentally and physically stimulated to the point of requiring little sleep. He or she feels full of energy, sometimes to bursting. Because their own sleep-wake cycle is so distorted by the drug, a parent on amphetamines may be unable to attend to a child's need for structure and pattern that is so essential to optimal physical and psychological growth. Further, the parent may become impatient or irritated with the child who is unable to adapt to the parent's level of energy. Also accompanying the influx of energy is suppression of appetite which is why amphetamines have been prescribed as diet pills. When a parent is not hungry and therefore not preparing meals for herself, she may also fail to appreciate a child's hunger and not insure that he is fed on a regular basis.

Cocaine has a somewhat different effect on both the physiology of the organism and on the parenting function. In addition to an influx of energy, cocaine also heightens the senses. Colors are brighter, smells are stronger, noises are louder. Thus, a child's crying, which may be only a mild annoyance to a non-using parent, is magnified in its intensity to the parent on cocaine. Because of its biological effects, particularly after prolonged use, cocaine also increases irritability and aggression in the user. It can also result in psychotic distortions of thought such that the user imagines and acts on projections onto others of his or her own aggression.

Further, cocaine, particularly in the smokeable form known as crack, cycles rapidly through the body so that the high that is so physically and psychologically satisfying vanishes quickly, within 5 to 15 minutes in the case of crack, leaving in its wake anxiety, depression, and paranoia, as well as an intense craving for a return to the euphoric state (Gold 1992). Crack is cheap to buy and easy to use, making it both more accessible and acceptable to people with limited economic resources. It also heightens feelings of power and control over one's life, feelings that may be sorely lacking in those belonging to oppressed social groups. After it was widely introduced in the mid-1980s, crack quickly became the scourge of low-income inner-city communities. It is also the most addictive form of cocaine, producing damaging physiological effects after only brief use that are usually seen only after long-time intranasal use of powdered cocaine.

Child protective services (CPS) workers are well acquainted with the thousands of cases each year in which a parent addicted to crack leaves an infant or toddler alone for hours or sometimes days at a time to pursue the drug. CPS workers frequently investigate maltreatment reports in homes barren of furniture and appliances that have been sold to purchase crack and other drugs. The absence of food in the refrigerator or cupboards further attests to the parent's drug-induced inability to attend to her child's most basic needs. Recovering crack addicts testify to the ability of the drug to take over their lives, to dull them to any other need or responsibility except the getting and using of the drug. Some describe doing whatever it took to pursue their habit, even to sacrificing the health and wellbeing of loved ones.

Another factor that influences the substance-involved parent's ability to nurture her child is the effects of drugs or alcohol used during pregnancy on the neonate's neurobehavioral functioning. Although there is now some evidence that the long term consequences of prenatal drug use are not as uniformly dire as once thought, there are significant short-term effects that make parenting a drug-exposed infant more challenging. For example, cocaine-exposed neonates frequently demonstrate poorer state regulation, greater irritability, and greater sensitivity to

stimulation than non-exposed infants (DiPietro, Suess, Wheeler, Smouse, & Newlin 1995; Hawley & Disney 1992). Such babies are often difficult to comfort and console. Their irritable crying may frustrate and enrage a substance-using parent whose tenuous self-control is already loosened by the effects of the drugs he is using. If a parent's aggressive impulses are heightened by alcohol or other drugs (Bushman & Cooper 1990), the potential is rife for abusive behavior.

Because the drug-using life style is chaotic and unpredictable, substance abusing parents may have little understanding of, or ability to meet, a young child's need for structure and consistency (Bauman & Dougherty 1983). And, because of inhibition in cognitive development that may result from using mind-altering chemicals over time, substance abusing parents often fail to develop problem-solving skills and the strategies for coping with stress and frustration required for effective parenting (Davis 1990). As a result, they may rely on the kinds of harsh, punitive, and emotionally reactive disciplinary measures that they experienced as children, even while recognizing the pain such responses caused in their own lives.

CONTEXTUAL FACTORS IN THE LINKAGE BETWEEN PARENTAL SUBSTANCE ABUSE AND CHILD MALTREATMENT

According to current developmental theory, a child's psychosocial functioning is a product of the ongoing interaction of factors in the child, the family, and the social environment (Bronfenbrenner 1979; Lerner 1991; Sameroff 1993). Despite well-established effects on the developing fetus and the newborn, the long-term consequences of maternal drug use for the child may depend a great deal on the family and social contexts in which the child is raised (Harden 1998). Researchers who have followed drug-affected newborns into the preschool years with mixed findings regarding psychosocial development have concluded that the effects of prenatal drug exposure are mediated by environmental factors such as income, family structure, and parenting competence (Azuma & Chasnoff 1993; Hawley, Halle, Drasin, & Thomas 1995; Zuckerman & Brown 1993).

Research with drug-using women, in particular, sheds light on the ways in which these factors impair their parenting. For example, substance-abusing women are often socially isolated (Kauffman, Dore, & Nelson-Zlupko, 1995). They may have few, if any, social relationships that do not revolve around getting and using drugs or alcohol. Further, when a male partner is present, he is usually also substance-involved, making achieving and maintaining sobriety for the woman much more difficult (Reed 1985). When a sober male partner is present in a substance abusing woman's life, he is much more likely than a sober female partner of an addicted male to abandon the relationship (Kane-Caviola & Rullo-Cooney 1991). Substance abusers also have documented difficulties in keeping and sustaining positive interpersonal relationships, including family relationships (Bell & Legow 1996). Consequently, a high proportion of substance abusing mothers are socially isolated single parents. And single parents, as we know from demographic studies, are more likely to be poor and to live in high stress environments. They are also more likely to abuse and neglect their children (Gelles 1989; Sack, Mason, & Higgins 1985; Straus & Gelles 1986).

Research tells us that family social isolation and child maltreatment are associated (Kugler & Hansson 1988; Polansky, Ammons, & Gaudin 1985; Salzinger, Kaplan, & Artemyeff 1983; Testa 1992; Wahler 1980). Isolated mothers who lack emotionally gratifying and supportive relationships with other adults may seek nurturing from their children. When their young children are developmentally unable to meet these emotional needs, such parents may lash out at their children in hostile, rejecting, and punitive ways. Or, they may withdraw from them emotionally and physically with the aid of mood-altering drugs. Either way, maltreatment of the child results.

Further, the poverty that often characterizes families where resources are dis-proportionally used to support parents' chemical dependence is associated with other factors that independently correlate with child abuse and neglect (Trickett, Aber, Carlson, & Cicchetti 1991). These include higher rates of partner-on-partner violence and parent mental illness, particularly clinical levels of maternal depression.

Interpersonal violence characterizes the environments where drug and alcohol abuse occur (Kilpatrick, Acierno, Resnick, Saunders, & Best 1997; Ladwig & Anderson

1989; Miller, Downs, & Testa 1993; Zahnd, Klein, & Needell 1995). Further, an association between substance abuse and spousal or partner battering is frequently documented. One study found alcohol abuse present in well over half of a sample of 88 families in which battering of the mother by the father had occurred (Spaccarelli, Sandler, & Roosa 1994). Similarly, high rates of marital conflict and violence have been found in families where substance abuse is the identified problem (Reich, Earls, & Powell 1988).

An association between spousal or partner battering and child abuse has also been established (Jouriles, Barling, & O'Leary 1987; McCloskey, Figueredo, & Koss 1995). Children in homes where marital violence is occurring are at high risk for physical abuse themselves (O'Keefe 1994). Even when violence is not directed at them, children who witness violence between parents or other care-takers in the home demonstrate a range of negative developmental outcomes, including conduct disorders, anxiety, depression, and aggression against parents and peers (Carlson 1990; Fantuzzo, DePaola, Lambert, Martino, Anderson, & Sutton 1991; Kashani, Daniel, Dandoy, & Holcomb 1992; O'Keefe 1994).

In addition to the relationship between poverty, substance abuse, and family violence, there is also an association between poverty and mental illness, particularly depression in women (Belle 1990; Hall, Williams, & Greenberg 1985; Kaplan, Roberts, Camacho, & Coyne 1987). There is evidence that substance abuse is frequently an attempt to self-medicate for depression and other forms of mental illness, particularly in poor, oppressed inner-city populations who have little or no access to regular mental health care (Khantzian 1997, 1985; Weiss, Griffin, & Mirin 1992). The correlation between substance abuse and depression in women is high and has been widely documented (Brook, Whiteman, & Cohen 1998; Cottler, Abdallah, & Compton 1998; Merikangas & Stevens 1998).

Depression in mothers may be linked to child neglect through affective withdrawal and lack of attention to caregiving tasks, and to child abuse because of the irritability and aggression that are often symptomatic of clinical levels of depression. Studies of depressed mothers' parenting abound (Cohn, Campbell, Matias, & Hopkins 1990; Field, Healy, Goldstein, & Guthertz 1990; Gordon, Burge, Hammen, Adrian, Jaenicke, & Hiroto 1989; Hops, Biglan, & Sherman 1987; Leadbeater, Bishop, & Raver 1996). Particular attention has been paid to depressed mothers' interactions with their young children which have been found to be negative, critical, hostile, and rejecting when compared to nondepressed mothers (Gordon et al 1989; Radke-Yarrow, Nottelmann, Belmont, & Welsh 1993; Susman, Trickett, Iannotti, Hollenbeck, & Zahn-Waxler 1985). With their infants, depressed mothers show more negative affect, are less responsive and provide less stimulation in face-to-face interactions (Cohn et al 1990; Lyons-Ruth, Zoll, Connell, & Grunebaum 1986). There is concern that the maternal behaviors that help to insure secure early attachment in infants are not present in depressed mothers, resulting in insecure attachments that carry into toddlerhood and beyond (Lyons-Ruth et al 1986; Radke-Yarrow, Cummings, Kuczynski, & Chapman 1985; Teti, Gelfand, Messinger, & Isabella 1995). Research has shown that infants of depressed mothers begin to mirror the depressed affect in the earliest months of life, leading to inhibition in social interaction and exploratory behavior by 12 months of age (Field et al 1990). Such children are more likely to develop behavior problems, anxiety disorders, and affective disorders than children of nondepressed parents (Cummings & Davies 1994; Lyons-Ruth, Alpern, & Repacholi 1993).

While those studying the effects of parental depression have researched various factors, including marital conflict, stressful environments, and harsh disciplinary practices, which contribute to the demonstrated negative outcomes for children in such families, no studies could be located which specifically examined the interaction of depression, substance abuse, and child maltreatment. Given the established associations between physical and sexual abuse in childhood, adult psychopathology, including depression, and substance abuse, as well as between substance abuse and child maltreatment, this would seem a logical combination of factors for investigation. The following section will examine how a parent's early life experiences may contribute both to dependence on mind- and mood-altering drugs and to the perpetration of child abuse and neglect.

LINKAGES BETWEEN PARENTS' EARLY LIFE EXPERIENCES, SUBSTANCE ABUSE, AND CHILD MALTREATMENT

There is a growing research literature on the association between physical and/or sexual abuse in childhood and substance abuse, often beginning in early adolescence (Cohen & Densen-Gerber 1982; Caviola & Schiff 1988; Harrison et al 1997; Kaplan, Pelcovitz, Salzinger, Weiner, Mandel, Lesser, & Labruna 1998; Roesler & Dafler 1993; Rohsenow, Corbett, & Devine 1988). This relationship has been found in both clinic and community samples (Mullen, Martin, Anderson, Romans, & Herbison 1996; Widom, Ireland, & Glynn 1995). Kaplan and her colleagues (1998) found that physical abuse was a significant contributing factor over and above other risk factors to psychopathology, including substance abuse, in a clinical sample of adolescents. Findings of childhood sexual abuse among substance abusers range from just over 30 percent to 75 percent in various samples (Bollerud 1990; Cohen & Densen-Gerber 1982; Grice, Brady, Dunstan, Malcolm, & Kilpatrick 1995; Harrison 1989; Yandow 1989). Boyd (1993) found a strong relationship between early sexual abuse, subsequent onset of depression, and crack cocaine use in a sample of 105 predominately African American urban women. She noted the consistency of these findings with other studies that have found a similar association to alcoholism in Anglo-American women (Pribor & Dinwiddie 1992).

More recently, researchers have attempted to identify the pathway by which early sexual abuse leads to substance abuse in women (Brady, Killeen, Saladin, Dansky, & Becker 1994; Kilpatrick, Resnick, Saunders, & Best 1998; Swett & Halpert 1994). One such study noted the frequency of symptoms of Post Traumatic Stress Disorder (PTSD) in individuals who were sexually traumatized in childhood and posited that substance abuse represents an effort to manage the symptoms of this disorder (Epstein, Saunders, Kilpatrick, & Resnick 1998). Symptoms of PTSD relate to feelings of intense anxiety and include hyperarousal, avoidant behaviors, emotional numbing, and flashbacks to the traumatic event.

Epstein and his colleagues (1998) found in interviewing over three thousand women that those who reported a childhood experience of sexual abuse had twice as many PTSD symptoms as women who reported no such experience. Further, sexual abuse victims had double the number of alcohol abuse symptoms as women who had not been abused in this way. And, finally, those abuse victims who reported experiencing PTSD symptoms had twice as many alcohol abuse symptoms as abuse victims who had no symptoms of PTSD. From this, Epstein concluded that PTSD is the connecting pathway between early sexual abuse and later chemical dependence.

Given the demonstrable damaging effects of abuse and neglect on psychosocial functioning and development, it is highly likely that an adult who was subjected to severe maltreatment at a young age will be affected in negative ways. In their review of the literature on the long-term effects of physical abuse, Malinosky-Rummell and Hansen (1993) found compelling evidence for its impact in a variety of functional domains. One of these findings is that adults who were abused as children are more likely to be aggressive and violent toward others and to engage in antisocial behavior. A high correlation has been found among abuse and neglect in early childhood, symptoms of antisocial personality disorder in adulthood, substance abuse, and aggression, particularly in males. In one study of men imprisoned for assault, it was found that men who had been sexually abused as children were more likely to commit sexual assaults, while those who had been physically abused committed more physical assaults (Dutton & Hart 1992). As noted previously, studies suggest that parents who themselves were abused as children are more likely to abuse their own children than those who were not (Morton & Browne 1998; Oliver 1993).

Further, the direct impact of childhood maltreatment on functioning in the parent role cannot be underestimated. Burkett (1991) observed the parenting behaviors of 20 mothers who were sexually abused in childhood and compared them with 20 mothers who were not abused. She found the abused mothers to be more self-focused and to communicate with their children in blaming and belittling ways. One group of abused mothers was deeply depressed and appeared to have little emotional energy left for parenting. The members of this group were also more likely to be drug or alcohol involved. The other group of abused mothers was more positive

and engaged with their children, almost to a fault. They seemed to seek affirmation and nurturing from their children, rather than the other way around. Indeed, Burkett noted that both groups of abused mothers sought more emotional support from their children than did the nonabused mothers.

Herzog, Gara, and Rosenberg (1992) also explored the parenting behaviors of mothers abused as children, this time through a case design study. They found that mothers who detached themselves psychologically from their own childhood experiences of abuse, that is, they had failed to process feelings associated with this maltreatment, were more likely to hold unrealistically high expectations of their children's developmental capacities. Unrealistic expectations of children are a common finding in studies of abusive parents. Such expectations are believed to contribute to abusive behavior in that when the child is unable to conform, the parent interprets this inability as purposeful, and becomes enraged at what she sees as the child's willful opposition (Larrance & Twentyman 1983). Herzog and her colleagues interpreted these unrealistic parental expectations as the inability of the abused parent to identify with her child. Instead she projects onto the child an adultlike persona, removing from her vision of the child any sense of the vulnerability that characterized her own relationship with her childhood abuser.

Recent research has examined the relationship between childhood abuse, particularly sexual abuse, and the capacity for intimate relationships in adulthood (Alexander, Anderson, Brand, Schaeffer, Grelling, & Kretz 1998). This emerging area of research, which has found an association between severity of early sexual abuse and later difficulties in attachment to others, has promising implications for understanding the intergenerational transmission of child maltreatment. Limitations in a parent's capacity for attachment to a child may render that child more vulnerable to objectification and subsequent maltreatment by the parent as well as to experiencing and internalizing attachment difficulties of his or her own.

IMPLICATIONS FOR PRACTICE WITH SUBSTANCE-ABUSING FAMILIES UNDER THE ADOPTION AND SAFE FAMILIES ACT

It is clear from this examination of research on the relationship between parental substance abuse and child maltreatment that this is a complex dynamic that calls for thoughtful interventive approaches. First, there is the direct effect of mood- and mind-altering substances on a parent's psychosocial functioning, resulting in emotions and behavior altered in ways detrimental to parenting and to the positive development of children. Second, there is the context in which parenting takes place that is also profoundly affected in negative ways by the parent's substance abusing behavior. The poverty, interpersonal violence, social isolation, the presence of unrelated substance abusing adults in the home, and parental mental illness, particularly depression, that frequently co-occur with parental substance abuse are all associated both with child maltreatment and with high risk to normative psychosocial development of children. Many of these factors, of course, exist independently of parental substance abuse and of child maltreatment. All parents who are poor or who live in violent circumstances do not abuse or neglect their children. However, according to the research on factors which place children at high risk of developmental psychopathology, the presence of multiple risk factors greatly increases the probability that children will suffer adverse consequences. Further, these kinds of high risk environments also place extraordinary stress on parents, even those who function well. For a parent whose functioning is already impaired by the use of drugs or alcohol, living in such a stressful environment increases the likelihood that he or she will lose control and become abusive, or, conversely, withdraw physically and emotionally from a child.

Finally, there are the effects of a parent's own childhood experiences of abuse on both the probability of becoming a substance abuser and the psychodynamic consequences manifested in behaviors associated with child abuse and neglect. There is evidence that a high proportion, estimated at one third, of parents who are abused as children will go on to severely maltreat their own children (Oliver 1993). Another third of such individuals are thought to be more vulnerable than normal to effects of environmental stress. They can be easily pushed by stressful circumstances into engaging in maltreating behavior. Then, there is the final third of parents maltreated in childhood who are resilient in the face of this developmental threat.

These parents are indistinguishable from other parents who were not abused or neglected as children. It is the first two groups that are thought to be at highest risk of also developing problems with substance abuse, thereby compounding the likelihood that they will become perpetrators of child maltreatment themselves.

How can we help these families to better parent their children? There are no simple solutions. Interventions must be directed toward each of the three substance abuse/child maltreatment pathways identified in this paper. Simply getting clean and sober is not enough. Nor will court-ordered parenting classes alone suffice. Interventions must take place at multiple levels: with the substance abusing parent, with her children, and with the context in which they live. Substance abuse treatment programs must recognize the special problems faced by chemically dependent parents, particularly mothers, who cannot turn away from their other responsibilities to focus all their energies on getting clean and sober as the traditional substance abuse treatment model requires (Nelson-Zlupko, Dore, Kauffman, & Kaltenbach 1996; Nelson-Zlupko et al 1995). These programs must begin to address the multiple factors in the lives of parents which make sobriety difficult to sustain, particularly their struggles with parenting their children and with their own childhood trauma. Models have been developed and tested for including parents and children together in inpatient and outpatient substance abuse treatment programs (Catalano, Haggerty, & Gainey 1998; Kumpfer, Molgaard, & Spoth 1996). By including children, substance abuse treatment programs can address their myriad problems stemming from abuse and neglect by chemically addicted parents, thereby disrupting the intergenerational transmission of both substance abuse and child maltreatment. Both recovering parents and their children benefit from learning a range of new social skills including communication, problem-solving, decision making, stress management, anger management, assertiveness, and coping with feelings (Kumpfer 1998). Helping maltreated children address their emotional and behavioral difficulties also serves to reduce the stress on recovering parents, an important factor in preventing relapse.

Substance abusing, maltreating parents are often referred to parenting programs as part of a reunification plan. However, current research on the effectiveness of parenting programs with this population suggests that training in the skills of child management is not enough (Dore & Lee 1999). Many parent training programs, particularly those based on social learning theory, require a level of cognitive focus and commitment to carrying out task assignments that many parents in recovery do not possess. They also presuppose an ability to empathize with another and to place a child's needs above one's own that may not be realistic for the newly recovering parent because of her own needs for nurturing and psychosocial development. Parenting programs that serve this population must pay attention to the parent's difficulties in interpersonal functioning, her lack of social skills, and her diminished social network, as well as her relationships with her children.

Parenting programs aimed at enhancing attachment behaviors in parents of infants show great promise for maltreating parents who lack sensitivity and responsiveness to their infants (Erickson, Korfmacher, & Egeland 1992; van Ijzendoorn, Juffer, & Duyvensteyn 1995). Given that many substance abusing parents suffer from underlying depression which is still present in sobriety, and given that depression in caregivers has demonstrated effects on the quality of the attachment between parent and child, techniques that have been developed for enhancing attachment in infants of depressed mothers seem especially applicable here (Field 1995). When a formerly substance abusing parent has been separated from her young child in foster care placement, the bonds of attachment are necessarily weakened. Interventions designed to strengthen these bonds before reunification takes place are essential. Regular parent-child visitation that includes structured bonding activities is one such intervention.

We must also discover how disrupted or tenuous attachments between newly sober parents and their older children in care can be strengthened as well. These children, while loving their parent, usually also have a great deal of unresolved anger at the parent for past maltreatment, or for failing to protect them from abuse by others. As a result, they may engage in very provocative behavior designed to test the parent's love and commitment. Some older children have also func-

tioned as surrogate parents in households where the adults were incapacitated by substance abuse. This is a role that brings some feelings of satisfaction and outside validation, in addition to stress, for the child. He or she may be unprepared to relinquish that role to a newly sober parent. A parent who is unaware of this dynamic or unprepared for the child's subsequent acting out may be unable to manage the stress it presents. This speaks to the need to educate parents regarding the variety of possible reactions of the child to reunification and in non-coercive ways of responding to them.

A common feeling in newly sober parents is overwhelming guilt about their treatment of their children while they were using mind and mood-altering drugs (Kauffman et al 1995). This guilt can contribute to relapse, or it can motivate parents to actively seek change. The latter requires great deal of support, direction, and encouragement from an informed clinician or case manager who can act as the central, guiding figure as the parent moves toward reunification and maintains sobriety. Studies have demonstrated the importance of this central, supportive helper in the achievement and maintenance of sobriety and in reunifying children with formerly maltreating parents (Nelson-Zlupko et al 1996; Pharis & Levin 1992). Unfortunately, the Adoption and Safe Families Act, like so much of child welfare legislation, makes no provision for ongoing supportive work with formerly substance abusing families once reunification has taken place and the real work of reestablishing as a family has begun.

CONCLUSION

The maltreatment of children by parents and other caregivers is a significant social problem today. A major contributing factor to this social problem is parental substance abuse. Current child welfare statistics indicate that parental substance abuse is present in a high proportion of families whose children are removed to foster care. Current child welfare legislation has strictly limited the amount of time these parents have to achieve sobriety and establish a stable home for their children to return to from care. Recently enacted policies give parents 12 months or less to achieve the goal of family reunification before parental rights are severed and a child is released for adoption. Given the demonstrated difficulties of overcoming addiction and achieving permanent sobriety, to say nothing of establishing a financially stable living situation for a family, these time limits are restrictive, indeed.

The question then becomes one of "How can parents who are struggling with sobriety best be helped to achieve the goal of family reunification?" This article has proposed a model for understanding the linkages between parental substance abuse and child maltreatment as a first step in the helping process. The model suggests that clinicians must assess the client's substance abuse history and its impact on parenting on a variety of factors, not just with regard to whether or not a parent is currently sober. Of particular concern is the parent's own early history of abuse and neglect, which contributes both to pathological states such as depression and anxiety which underlie substance abuse, and to deficits in the basic skills of parenting such as the ability to place the needs of another above one's own. Further, the chemically dependent parent's activities such as maintaining primary relationships with substance abusing others may create a context which makes sobriety difficult to sustain.

In order to achieve success in the reunification of families where parents have abused mind and mood-altering drugs, the practitioner must assess the level of risk of return to substance abusing behavior on the three dimensions discussed here. Further, he or she must actively intervene with the parent to develop skills and strategies for coping that address these particular risks. Finally, sustaining sobriety requires ongoing support, encouragement, and education around potential obstacles to this goal. Some of these obstacles and the interventions to address them have been identified and discussed here.

Despite the good intentions of legislators and policy makers to create possibilities for permanence for children through the Adoption and Safe Families Act of 1997, there is much yet to be done. There are not enough adoptive homes to create permanent families for all the children entering foster care from maltreating families in this country: half a million at last count. Thus, we must find more effective ways to develop the capacities of fragile families, beset by chemical dependence, to provide stable, loving homes for their own children. Provision of sub-

stance abuse treatment programs that can intervene at an earlier point—ideally during pregnancy—to prevent out-of-home placement in the first place is essential. Residential programs providing treatment to parents and their children together would not only help to prevent child maltreatment but would also meet another goal of public child welfare policy, that of family preservation. When children from substance abusing families must be removed to foster care and family reunification becomes the goal, necessary and sufficient services as described here must be made available. These should include ongoing supportive services that can continue once reunification has taken place. As anyone who has worked with abused and neglected children knows, their first loyalty and concern is with their families of origin, no matter how inadequate their parents may seem to the outside observer. Termination of parental rights and adoption into a family of strangers should be a last resort for these children, not the first response that takes the onus of responsibility off child welfare administrators.

END NOTES

[1]The term child maltreatment as used here includes all forms of child abuse and neglect. Current research suggests that most forms of maltreatment occur in combination (Manly, Cicchetti, & Barnett 1994; Ney, Fung, & Wickett 1994). Only about 5% of cases of maltreatment of children appear to be of a single type.

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