

MOTHERHOOD & DRUGS

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Sheila smoked crack throughout her pregnancy. When her baby was born--two months premature and "as purple as a plum"--she still couldn't stop. "Within a few hours after I gave birth," she remembers, "while my baby was in the intensive care unit, I got out of my bed, took the pipe I had smuggled into the hospital, went into the bathroom and had a good smoke."

Sheila's case is hardly unique. Never before in our history have so many women of childbearing and childrearing ages been addicted to so many powerful--and plentiful-- drugs.

How widespread is the problem?

* More than one out of ten pregnant women use illegal drugs during pregnancy.

* Each year 375,000 newborns face some damage from their mother's use of alcohol and other drugs.¹

* Six thousand children a year are born with fetal alcohol syndrome, the third leading cause of birth defects in the U.S. and the number one cause of mental retardation.

* At some hospitals, one out of five admits to the neonatal intensive care unit is related to the mother's drug use; at Sacramento's U.C. Davis Hospital, one out of four women given urine screens during labor or delivery tested positive for cocaine, amphetamines or heroin²; at Jackson Memorial Hospital in Miami, one in eight births is affected by cocaine³; and at one Detroit hospital, more than 40

percent of newborn babies were found to have been exposed to drugs in their mother's womb.⁴

* In New York City 8 out of every thousand children are born addicted, up from 1.5 per thousand 20 years ago.⁵ In Los Angeles, 20 percent of the babies in intensive care are there because of maternal drug use.⁶ In San Diego in 1987, 700 newborns tested positive for drug exposure or addiction, a 100% increase over 1986.

* In Los Angeles, 2,500 cases involving drug-affected infants came before the courts in 1989.⁷

* Nationwide, 8 to 14 percent of women of child-bearing age are alcohol- or drug-dependent.

The Number One Drug: Alcohol. While most discussions on maternal drug use focuses on illicit substances, alcohol is the most widely used--and abused--of all chemicals. Alcohol readily passes through the placenta into the developing fetus, where it packs a powerful wallop. Because the fetus is able to eliminate alcohol at about half the adult rate, if the mother is drunk, the fetus is even drunker--and stays drunker longer. The fetus's undeveloped liver can't neutralize alcohol. It can only get rid of it by passing it back into the mother's bloodstream--where it can be broken down at about a rate of one ounce an hour. If the mother's alcohol level stays high, the fetal alcohol gets even higher, damaging brain, eyes and genitals, and disrupting gastrointestinal and facial development--the fetal alcohol syndrome. Given enough booze, the mother may suffer a morning hangover. For the fetus, as one doctor put it, "the hangover may last a lifetime."⁸

The effects of alcohol on the unborn child have been known for centuries, yet it was not until 1973 that the syndrome was clinically identified and labeled.⁹ The Federal Government issued no warning about alcohol's effect on the unborn until 1981. And even today, according to a survey conducted by the Bureau of Alcohol, Tobacco and Firearms, 40 percent of adult Americans have never heard of fetal alcohol syndrome and don't know what it means.

Despite the widespread ignorance--or because of it--more than five percent of children born to alcoholic mothers suffer from fetal alcohol syndrome. While some deformations become less apparent as the child matures, others may require surgery to correct.¹⁰ Many babies born with fetal alcohol syndrome have the smell of liquor on their breath.¹¹ The average IQ of FAS children is between 65 and 80, compared to a "normal" IQ of 100.¹² Fetal alcohol syndrome is the number one cause of mental retardation, and the only cause that is completely preventable.

Less severe than fetal alcohol syndrome, fetal alcohol effects (FAE) are often no less impactful, and affect at least 36,000 newborns a year.¹³ Prenatal exposure to alcohol leads to a five point reduction of a child's IQ at age four¹⁴ and slower reaction time and attention deficit by age 7.¹⁵ Exposing a fetus to more than 3 drinks a day triples its chance for a subnormal IQ.¹⁶

Is there a safe threshold for alcohol use? A 1987 report by the National Institute of Child Health and Human Development reported that one or two drinks a day increased the risk of fetal urogenital malformations.¹⁷ A British study found that even 100 grams of alcohol a week in the first trimester doubles the chance of a child being born with low birth weight.¹⁸

And women who drink and breast feed should note: water-soluble drugs like alcohol are present in breast milk in the same concentrations as in the blood.¹⁹ A 1989 study indicates that even a moderate intake of alcohol by breast-feeding mothers--as little as one drink a day--can cause "slight but significant" damage in children's ability to crawl, balance or throw by the time they are 1 year old. Ruth E. Little, epidemiologist at the University of Michigan, estimates that 10 percent of breast-feeding mothers regularly consume alcohol.²⁰

While some doctors may still be advising mothers that a "glass of wine with dinner won't hurt," the American Medical Association advises pregnant women to abstain. Period.

Where do things stand with pregnant women now? The number of pregnant women who drink alcohol fell from 32 percent in 1985 to 20 percent in 1988. They're now less than half as likely as nonpregnant women to drink, and about a fourth as likely to be heavy drinkers. But for the pregnant women who continue to drink, the average number of drinks they take per month has remained the same, about four. (Pregnant Afro-American women, however, averaged 6.5 drinks, smokers averaged 6.) Those women at greatest risk of drinking during pregnancy were smokers (more than 40 percent drank), unmarried women (35 percent), college graduates (30 percent) and those between the ages 35-45 (33 percent).²¹

The Cocaine Plague. After alcohol, cocaine is undoubtedly the most significant drug problem for pregnant women, and one that has grown enormously. In one New York City hospital in 1982, for instance, cocaine was the drug of choice for one third of all pregnant addicts. Last year it was the drug of choice for 90 percent.²² Since 1983, drug-related admissions to New York City's neonatal wards has increased by nearly 40 percent a year. Neonatal clinics throughout the city are running well over capacity, causing a quality of care crunch. The numbers of babies needing foster homes places an additional burden on the foster care system, which Bruce C. Vladeck, president of the United Hospital Fund, described as "collapsing." The epidemic is hitting the non-white population especially hard. In New York State overall, 1,700 drug-affected

babies were born in the first six months of 1987; 1,400 were non-white.²³ In Washington, D.C. cocaine was one of the main causes in the 40 percent rise in infant mortality between 1988 and 1989.²⁴

Cocaine ingested by a pregnant woman can cause premature birth, or cerebral strokes in the unborn child. It is unsafe at any dosage. According to Dr. Warren Wasiewski of Penn State's Milton M. Hershey Medical Center, even just one hit of cocaine may be enough to cause defects, or death. And though the effects of one snort may wear off in the mother in a fairly short time, in the fetus the effects may linger for days.²⁵

Cocaine raises blood pressure, increases heart rate and pumps adrenaline into the bloodstream. This adrenaline causes the uterine artery--which supplies blood, nutrients and oxygen to the placenta--to squeeze tight, cutting off some of the oxygen reaching the unborn child.

Cocaine and other stimulants can lead to secondary anorexia. The expectant mother's protein consumption is often minimal, and severe vitamin deficiencies are common. Furthermore, cocaine babies get less oxygen because placental blood vessels constrict during binges and withdrawals.²⁶ This oxygen deprivation may be what triggers the higher rate of kidney and urinary tract deformities in cocaine babies.²⁷ It is difficult to exaggerate the consequences of the cocaine epidemic. One nursery director put it this way: "Never in my medical career have I seen so much suffering as cocaine has brought."²⁸

Crack is cocaine's most potent and addictive form. In some cities more women than men use crack and, according to some experts, many of these women are pregnant.²⁹ Crack's effects on the unborn child's nervous system are devastating. At birth, they are sometimes temporarily blind. After four weeks, many turn strangely rigid for days. At one year, they are apathetic to toys and joyless. At 18 months they are withdrawn and lack emotion. At two years, they have difficulty concentrating.

In 1988, 200,000 cocaine babies were born in America.³⁰ Two and a half billion dollars was spent on their intensive care. And the bills have just started coming in. While detox alone costs nearly \$30,000, an additional \$40,000 per baby is needed to prepare them for kindergarten. Special learning programs will cost about \$10 billion more. Yet, even if the money is found to fund these programs, it is likely that 40 percent of these children will drop out of school and many will need a lifetime of special care.^{31, 32} By the year 2000, if current trends continue, there will be 4 million cocaine-exposed children.³³

Crack smoked in the same room with a toddler can also have serious consequences. According to a report published in The American Journal of Diseases of Children and elsewhere, there is mounting evidence that the passive inhalation of crack smoke by youngsters can cause extreme lethargy and may

even lead to seizures. In 1989 a ten month old Philadelphia girl died suddenly and without apparent cause. At first, she was classified as a victim of Sudden Infant Death. Lab reports later showed that her blood contained cocaine. Why had she died? Because she sat in a room filled with crack addicts. The medical examiner of Philadelphia claims that crack smoke has been a factor in the death of at least 17 children less than 1 year old from 1986-89. Dr. David Bateman of the Harlem Hospital Center in New York City has been quoted as saying, "What we're seeing is just the tip of the iceberg."³⁴

The effects of crack are being felt particularly hard in the black community. In one study, more than 80 percent of black drug-exposed babies tested positive for cocaine, compared to less than 10 percent of white drug exposed babies.³⁵ The irrevocable fetal brain damage that crack can cause is creating what Douglas Besharov, former director of the National Center on Child Abuse, has called a "bio-underclass."³⁶ As one sociologist observed, crack has turned the one-parent family into a no-parent family. It has "overwhelmed the maternal instinct,"³⁷ and is "interfering with the central core of what it is to be human,"³⁸ both for mother and child. Babies cannot be turned over to the care of crack mothers, so newborns in some hospitals languish in pediatric wards for weeks being held and nurtured only when absolutely necessary.³⁹

Because drug abusing women and their are children are vulnerable to all the opportunistic ills of the drug epidemic--from organic damage, to malnutrition, to abuse--getting them off drugs is seen by some concerned professionals as the most urgent problem in chemical dependency today. Tragically, however, a large number of chemically dependent mothers and mothers-to-be remain beyond the reach of help. Of the more than 72,000 babies born in California with prenatal exposure to drugs, little more than 10 percent get county or state help.⁴⁰ There is no reason to believe that other states have a better record.

And help is hard to come by even in the private sector. In some cases, as Dr. Janet Chandler of Chicago's Northwestern Perinatal Center for Chemical Dependence has observed, most treatment centers are so worried about the liability of working with pregnant women that they either won't let them in, or they ask them to leave.⁴¹ In other cases, resources don't begin to meet the demand. In San Diego, for example, which offers some of the best treatment services for women in the nation, applicants can wait up to six months for admission into one of the 30 beds set aside for drug-abusing women with children. Of the 121 residential beds available for female alcoholics, only a dozen are reserved for women with children.⁴² In New York City, more than half of all drug treatment centers would not admit pregnant women.⁴³

Nationwide, child care services for women who need inpatient or outpatient treatment, or simply need to get to AA meetings, are extremely scarce. Furthermore, female addicts tend to lack both support systems and resources.

They are more likely than males to have been abandoned by family and spouse, and are less likely to be employed and or have health insurance benefits.

Compounding this grim picture is the societal denial that obscures the entire issue of mothers and drugs. We'd just rather not hassle with it. As recently as 1982, the National Institute on Drug Abuse reported that "little attention has been paid to the treatment needs of mothers and their children and how such needs can be addressed." Despite the enormous health problems that a drug-dependent pregnancy poses to the unborn child, for instance, few OBGYNs question expectant women about their drug habits. "That's where the denial begins," says Diane Morton, Co-Chair of the San Diego Council on Pregnancy and Chemical Dependency, "in the doctor's office. He may glean chemical dependency from the woman, but he's reluctant to act on it and doesn't refer her to someone who can help."

According to Dr. Martha Johns, Medical Director of the Sharp Preventive Medicine Center, "Doctors need to develop history taking that focuses on health risk behaviors. All too frequently we identify chemical use only in pregnant women who have had no prenatal care and who have a positive drug screen on the very heels of their delivery date."

Yet even women with adequate prenatal care keep their drug habits going. Why is the "average mother" who gives birth to a drug-exposed infant likely to have given birth to at least one other such child? Why don't these women ask for help? "For that to happen," says Jesse Arble, Co-Chair of the San Diego Council on Pregnancy and Chemical Dependency, "the mother has to have someone who will advocate for her."

Arble's point is critically important. Pregnant drug users are understandably reluctant to seek prenatal care, fearing that their child, when born, will be put on a 48-hour hold and possibly placed in foster care, while they are mandated to treatment. Child Protective Services act as advocates for the child. No such agency exists to further the needs of the chemically dependent pregnant woman. The pregnant user's avoidance of treatment is compounded by her frequent lack of awareness that confidential, anonymous help awaits her in AA, NA, and among therapists in the treatment community.

When an addict gives birth, she finds herself unprepared for the many responsibilities of parenting, and incapable of experiencing its rewards. If the mother herself comes from a dysfunctional family--as is often the case--she has no model on which to build skillful and loving parenting. Furthermore, bonding with an addicted baby who is in the throes of withdrawal is difficult at best.

Some addicts do manage to struggle through their children's early infancy pretending to be competent, but in their hearts they feel like maternal failures. It

is this terrible knowledge that they are bad mothers that many women addicts find so difficult to endure. Each woman believes that she is the only mother who has failed and often refuses to discuss her feeling with others. The feeling is one of abject shame.

What makes this shame such a seemingly intractable emotion is that it is inextricably entwined with the shame she felt as a child when she suffered abuse at the hands of her own mother and other caretakers. Pia Mellody calls this "carried shame." She is carrying her mother's shame, and her mother's shame. To begin facing this shame she must realize: this chain of abuse and shame did not originate with her, but she may have the power to end it. Barbara St. Amant, Recovery Educator for children from disrupted families at the Counseling and Recovery Institute in San Diego, describes her own early recovery as a time when "the biggest fear was that I would recreate the legacy of dysfunction."

According to therapist Stephanie Covington, Ph.D., the recovering woman cannot approach and heal the wounds between her and her own children, or become an effective parent, until she has reflected back and salved the wounds with her own mother. She may not be able to do this face to face, either because her mother is dead, or still abusing chemicals, or inaccessible in other ways. But a therapeutic group of women can powerfully provide the setting in which the relationship of this new mother and her own mother is healed. "The support system of a woman's peer group," Covington says, "offers the recovering mother perhaps her first experience of loving acceptance, validation and respect, fostering self-respect and self-worth, the very foundation for according her own children loving acceptance, validation and respect." The women's group helps her to reparent herself in a setting where mothers mother each other.

So, in healing the recovering mother, very often we are talking about building a person from childhood up, in very short order. The twin pillars of her recovery as a mother include forgiveness--healing the child within--and skills learning--empowering the adult within. For those mothers in 12-step programs, it is essential to include forgiveness and empowerment in the Ninth Step, of making amends--to herself first. Only then, perhaps, will she be ready to reestablish a relationship with her children. As Ms. St. Amant says, "I had to give myself permission not to be perfect, not to know all the right things to do. I had to use tools that didn't exist in my own family, like sharing feelings openly. I learned to get past the fear that I wasn't adequate to provide for my child."

Despite all the obstacles, the issues facing the addicted mother are fairly easy to identify and treat, a stark contrast to the issues raised by the affected perinate. Legally, the fetus doesn't have any rights until it is born, so one of the more perplexing questions now facing legislators is: when does child abuse occur? Putting in place social services to deal with challenge like this is proving

frustratingly difficult. Merely calling for the prosecution and internment of addicted mothers-to-be is at best a clumsy attempt to protect the unborn child from violation of its apparent rights. It protects the child by separating it at birth from its "unfit" mother. In 1990, the California Supreme Court refused to hear the appeal of a mother whose child had been taken from her when he tested positive for amphetamine at birth.⁴⁴ Such legislation, says Ms. Arble, "makes adversaries of the mother and child."

Others argue that, if the mother is abusing chemicals with a fetus in her womb or a child in her arms, they are adversaries and the legislation is rightful. Studies have conclusively established that children of chemically dependent women are at particularly high risk for physical abuse, and alcoholism and opiate addiction.⁴⁵ In New York City, two thirds of all child abuse and child neglect cases involve parental drug abuse.⁴⁶ But some experts maintain that child abuse is a given of parental drug abuse. As Kathleen FitzGerald succinctly puts it, "there may be child abuse without alcoholism, but there is no alcoholism without child abuse."

But research--and our own experience--also shows that addicted women can learn to be effective parents if they are taught and nurtured.⁴⁷ So, is it enough to prosecute and not treat? If treatment is offered the pregnant woman with one hand, while prison and child custody await her with the other, will she avail herself of the first alternative in a double bind? Furthermore, Arble notes, "So many such babies are now in the child protective system, babies are being warehoused. The system can't cope."

There are few facilities or resources for children of addicted mothers. Even when mothers receive treatment, their young children rarely do. Out of the dozen hospital chemical dependency treatment programs we contacted in San Diego, for example, only two said that treating children under twelve--the very family members who are often the neediest and most scarred--was a routine part of their family program. Asked why such a dearth of children's services existed, Dan Valentine, Youth Program Coordinator of the C.A.R.P. Family Center for Alcohol and Drug Treatment in San Diego, suggested that when mothers first get sober, "their guilt is too extreme. Only later, they finally get the strength to examine the generational transmission of the disease, and then they want to be able to say, 'the buck stops here.'"

Addicted women have a higher birthrate than sober women, and their children are at least 4 times more likely to themselves develop a future chemical dependency problem. These children are in need of massive educational efforts. Yet, as Douglas Braun, M.F.C.C., therapist and consultant, points out, "Most programs that address kids, like the 'Just Say No' campaign, use appeals that totally bypass kids of chemically abusing parents. 'How can drugs be bad if my mother uses them?' shrugs the COA [child of an alcoholic] kid very logically. No

one is speaking to these kids, the ones who most need these efforts." According to Dr. FitzGerald, fewer than 5% of children of alcoholics receive treatment.⁴⁸

Yet, as many of us have observed, when children do receive help, their responsiveness is touching beyond words. One mother who attended a 6 to 8 week rehabilitation program for recovering women at the Clairemont Neighborhood Recovery program, which included a concurrent program called "Happy Child," (a unique service in this County) told the following story: "I didn't want to come one night, but Roger insisted on coming." Roger was six.

Mothers with poor parenting skills compounded by chemical dependency typically make parents who swing from permissive to punitive by arbitrary turns, who set no limits and no boundaries, and offer their children little stability; parents who are, in short, heartbreakingly inconsistent. Our crack addict Sheila spoke of lavishing her child with expensive presents one day and then taking them all back for refunds the next day.

By contrast, the newly recovering mother can overcompensate for her former emotional uninvolvedness by becoming overbearing, obsessively attentive and compulsively strict. The child is once again the victim of extreme behavior. At these times, a relationship with a 12-step sponsor can be invaluable. "Slow down. Relax. That's too harsh," are common words of timely advice. Or, the family may benefit from family therapy, which gives each member the chance to lay out their issues together and set an agenda. For a newly recovering family, beset by hair-trigger anger and lack of communication skills, this is no mean task.

It is, in fact, an heroic accomplishment. For in healing the relationship with her child, a recovering mother is often trying to break the multigenerational cycle of drug abuse which leads to child abuse which leads to drug abuse and so on.

As Douglas Braun put it, "Imagine a mother trying to be a sober parent when she herself has never received sober parenting. These mothers are breaking the chains of generations of addictive parenting. They need to be given enormous credit for what they're attempting to do--to 'rewrite' the next chapter of their family history."

How do mother and child heal the wounds together?

With courage, with support, delicately, slowly, step by step.

SIDEBAR MATERIAL:

ALCOHOL AND MINORITIES

Alcohol's poisonous effect on women and their unborn children is felt most strongly among certain minorities who are particularly vulnerable to it's effect. Alcoholism may be the most critical health problem among Afro American women. While the overall number of Afro Americans who die from cirrhosis of the liver each year is double that of Anglo Americans, black women between the ages of 15 and 34 have cirrhosis of the liver rates more than 6 times that of white women. If a black woman and a white woman drink the same amount during pregnancy, the black woman is seven times more likely to give birth to a baby showing some alcohol-related abnormality.

Native American Indian babies may be even more vulnerable.⁴⁹ Whereas only about 1 percent of children worldwide are born with some defect or disability due to maternal alcohol use, among the Indians of the Plains, the Southwest and Canada, the rate is from 5 to twenty-five times greater. Says one doctor at the University of New Mexico, the rate is on the rise in every tribe surveyed.⁵⁰ And, twenty-five percent of Indian mothers who give birth to an FAS child also give birth to another FAS child.⁵¹ According to Carl A. Hammerschlag, former chief psychiatrist for the Phoenix Area Indian Health Service, "there are Indian communities where, if we include the morbidity from Fetal Alcohol Syndrome Effect, the death rate exceeds the live birth rate."⁵²

In a report to congress on alcohol and health, the Secretary of Health and Human Services wrote, "Alcohol-related illness and injury rates among American Indians are three times higher than the general population. Among American Indian men, accidents are the second leading cause of death and account for nearly one-fourth of deaths. Homicide and suicide rates are double the rates for the general population. Liver cirrhosis is the fourth leading cause of death among American Indians." The rate of cirrhosis deaths among Native American women is more than 36 times the rate of Caucasian women: it kills one out of four Indian women.

All in all, observes pediatrician Geoffrey Robinson, we are witnessing "a devastation that is worse than smallpox."⁵³ With little public awareness of the Indians' plight, with little Federal money available to fight the problem, and with Indian poverty rampant--unemployment rates at some reservations running at nearly 90 percent--few experts have any hope for a short term solution.

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ANGEL'S STORY

By the time I was four months pregnant I was homeless, mentally ill, and supporting myself as a prostitute. They told me in OBGYN that because I had been doing drugs the whole time the baby was starting to form they were already in its tissue, and that even if I kicked right then and didn't miscarry there was still a very good chance that the baby would be born addicted. The kinds of drugs I had been doing can stay in your system for about a year. But it was like a blessing. I had been told I couldn't have no more kids I thought maybe I'll clean up my act and start over.

They talked to me about going into a live-in drug program but at the time I was so into drugs and the streets that that was like saying, "Let's go to jail." All I could think of was that these social workers were going to plot how to take my baby. So I decided I wasn't going to go back no more.

I wanted to try to kick, but I was really, really far along then, and scared to try. I thought I'd wait till seven and a half or eight months, since the baby's going to be born addicted anyway, maybe go ahead and kick in my eighth month when the baby was strong enough to survive possibly a miscarriage.

I did get clean once. I went up to the doctors for the first time in three months and got tested and it came back clean and they were just so happy with me. And about two weeks later I got in a fight with my boyfriend and he took me back downtown from his mom's house. Somebody waved a needle under my face, and that was it, I was off to the races. I'm not a very strong person. A lot of people think I am and in some ways I am but emotionally I'm weak. And if I'm browbeaten emotionally it don't take much.

My social worker told me that when the baby was delivered if either one of us came up with more than just a trace in the blood, the baby would be taken. The first day that he was born he was real quiet cause they usually are and he still had enough dope in his system to pacify him and everything was cool. But the second day he showed signs of addiction and they slapped a hold on him.

That meant laying in bed watching all these mommies come in and give birth and take their babies home and know that I wasn't going to take mine. They're sitting there trying to tell me how to bathe him and stuff and I told the nurse, "Why are you doing this? Why show me how to take care of something you know I'm not going to get to take home?" I said, "Isn't it bad enough that I got to walk out of here without my baby? You got to torment me while I'm here."

And she didn't understand that. She looked down on druggies. They don't understand there are extenuating circumstances that make you become that, and you stay that way. Not everybody's equipped to handle life. Some people just can't deal with it and drugs is their escape so they can deal with it. She didn't understand that.

I dreaded that fourth day. When that day came I mean I just cried all the way out of the hospital. I fought it for a year. I told them I wanted him back. And finally this new social worker who was really, really nice came and talked to me and she said, "Do you really want him? Do you really want him to go through the lifestyle you live?"

And I told her, "No. I want him but I don't want him that bad." Deep down inside I knew this was the best thing. He was a responsibility I wasn't ready to handle. I couldn't deal with myself. Even though I loved the baby, and wanted the baby, I couldn't give him the attention he needs because I can't give myself no attention. The only thing on my mind was getting well so I didn't hurt, and getting high so I didn't hurt. There's a lot of conflict and emotions about it. There's days that you cry and days that you don't. Days that you're glad the baby ain't there, days that you wish it was.

To be honest with you, I really wish I'd gone ahead and had an abortion, or that I'd been ready enough to go in a drug program and then put him up for adoption. I wish he hadn't been born addicted. The poor thing went through hell for a year and they had to get him off what I had him hooked on with phenobarbital. Then he had to get off the phenobarbital. So the first two years of that kid's life was pretty rough. And I've got a lot of anger at myself for that.

I really didn't want to get pregnant. It was the last thing in the world I wanted to go through. And the whole time I was pregnant I was scared because I wasn't eating right, but those drugs had a grip on me. They were my first priority, it's like that Michael J. Fox commercial, like when you do drugs, they make the decisions for you? That was basically what was happening. The drugs were making my decisions. See you really don't think too clear about it. There are times when you wake up in the morning that it feels good and you feel the baby moving, but then there are times that you go out there and the guys won't date you because they're scared of hurting the baby, and you get angry because it means that much longer before you can get high.

There were times I was on a death trip and there were times it was like I was trying to take the baby out with me. And the sad thing about that was I didn't even realize I was doing that. I think maybe twice during the whole pregnancy it really hit me between the eyeballs what I was doing to the baby. The rest of the time my mind was so confused and spaced out I was lucky if I could remember

what day it was, let alone worry about the baby. I really think that they need to get some kind of legislation that if a woman is on drugs and becomes pregnant that she has to abort. A drug addict has no business carrying a baby. Because the baby is not your first priority and it has to be. And it's not. Your drugs are. The fact that your body hurts means more to you than what you're doing to that baby. You don't think about that, and when you do it's too late. Cause it doesn't take long for those little guys to get hooked. It takes less time than it takes for you because their systems are so tiny. It's not just in their blood stream, it's all through their body. When they told me it was all in the baby's tissue . . . I cried. It upset me. I had hoped and wished that I would be strong enough to kick.

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<u>DRUG</u>	<u>EFFECT ON FETUS</u>	<u>EFFECT ON BABY</u>
COCAINE	Seizures, CNS malformations	Irritability, muscle stiffness, startle reaction
ALCOHOL	FAS, mental retardation	Low body weight, restlessness, slow growth
HEROIN		Withdrawal, SID syndrome
STIMULANTS	Heart and brain defects	
POT	Miscarriage	Reduced sensitivity, tremors

NO CLASS DIFFERENCES

Drug-addicted babies are usually pictured as Afro-American or Hispanic. But according to Ira J. Chasnoff, president of the National Research and Education, the incidence of drug abuse during pregnancy among middle and upper income women may be vastly underestimated. A 1989 study in one Florida county found no significant differences in drug use among those women going to public clinics and those visiting private doctors who cater to upper income patients. However, minority women are ten times more likely to be reported to authorities, and poor women were more likely than middle-class women to be reported--less than 10 percent of the women had yearly incomes of more than \$25,000 and more than half had incomes of less than \$12,000. Chasnoff says that his study, "could change our whole concept of obstetric care because it suggests that a lot more women are using drugs during pregnancy than is widely believed."⁵⁴

AIDS AND DRUGS

Eighty thousand women of childbearing age are infected with the HIV virus. Each year, 2,000 children will be born infected with the virus and up to a third of them will eventually develop AIDS. Dr. Martha Gwinn of the national Centers for Disease Control says, "IV drug use is what is driving the epidemic in women, and, therefore, children." The women, and children, most effected are those in the inner cities, the so-called minority population.⁵⁵

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