PARENTAL BEREAVEMENT AS A RISK FACTOR FOR SUBSTANCE ABUSE

Barbara Jones, PhD, MSW

The death of a child is an unfathomable loss that creates a personal, psychological, and often spiritual crisis for parents. Bereaved parents report a paralyzing sense of sadness, trauma, and emptiness that may continue for many years. The intensity of the grief and the high potential for isolation can place many bereaved parents at risk of coping through increased substance use or substance abuse.

Social workers play a critical role in helping bereaved parents in a variety of practice settings. Hospital and hospice social workers often find themselves working with parents of a dying child and then continuing to support the parents in bereavement. Social workers also may work with suddenly bereaved parents in the emergency room, in victim services, in support groups, or in private practice. Unfortunately, very few clinicians receive specific training in how to support bereaved parents in their long and arduous grief journey (Jones, 2006).

It is important that social workers have the skills for assessment and intervention with bereaved parents and that they are aware of the potential for substance abuse in this situation.

As medical technology continues to advance, increasingly fewer children die from preventable causes in the United States. Children who once might have died from prematurity, birth complications, or congenital anomalies now survive. Similarly, advances in pediatric medicine mean that survival rates have increased for childhood diseases and accidental injuries. When a child does die, however, the rarity of such an occurrence creates a paradox for the parents: Their grief is more intense, but they are less likely to receive the support they need for the duration of the bereavement process (Doka, 2002).

The fact that death is not frequently discussed in Western culture can further exacerbate parental grief. Some parents report a profound sense of disenfranchisement and loneliness (Cincotta, 2004). Research indicates that the effects of parental bereavement are particularly intense and long-lasting compared with the effects of other types of bereavement (Field & Behrman, 2003).

Recognizing Complicated Grief

The death of a child increases the risk of a complicated response (Rando, 1993). Social workers should be aware of the distinction between typical grief responses and complicated grief. While
From the Chair

Since the beginning of my social work career 25 years ago, I have always been impressed by the challenging work of clients overcoming addictions to alcohol, tobacco, and other drugs. Addictions are devastating to individuals and families, and extremely costly to communities and nations. Without a doubt, it is easier to prevent an addiction than to overcome one. Yet, as a society, we tend to be reactive rather than proactive in the prevention of substance abuse disorders.

In this issue, we focus on best practices in prevention of substance abuse disorders with high-risk populations such as women of childbearing age, substance-abusing female inmates, and bereaved parents. While prevention efforts and research have increased over the past decade, we still have much to learn about developing and implementing effective prevention strategies for vulnerable groups in our society.

• Barbara Jones discusses the complicating factors of stress and trauma for parents who experience the death of a child. The prolonged and traumatic bereavement period following the death of a child can place parents at high risk for substance abuse disorders.

• Danielle Parrish and I have co-authored an article on best practices for the prevention of fetal alcohol spectrum disorder (FASD). While all women who drink alcohol during pregnancy are at risk of having an FASD baby, women of color and women with less than a high school education are at greatest risk.

• Michele Rountree examines effective HIV/AIDS prevention methods for female inmates, particularly women at high risk for HIV/AIDS and substance abuse disorders. As an expert on HIV/AIDS, substance abuse, and domestic violence among women of color, Dr. Rountree delineates programs and protocols for social workers and administrators.

I hope you enjoy this issue of the newsletter.

Best regards,

Elizabeth C. Pomeroy, PhD, ACSW, LCSW
common grief reactions may include sadness, depression, anxiety, somatic concerns, and feelings of hopelessness, complicated grief is best understood as an extreme and function-impairing version of mourning (Rando, 1993). Social workers should watch for complicated grief symptoms in the grieving parent, such as experiencing intrusive thoughts about the deceased, yearning for the deceased, searching for the deceased, excessive loneliness since the death, purposelessness about the future, numbness, detachment, difficulty believing or acknowledging the death, feeling that life is empty or meaningless, feeling that a part of oneself has died, shattered world view, assuming symptoms of harmful behaviors of the deceased person, excessive irritability, or bitterness or anger related to the death (Prigerson & Jacobs, 2001).

Factors that can exacerbate parental bereavement include loss of the parental function and identity, loss of sense of self, secondary losses such as loss of hopes and dreams, the traumatic nature of many childhood deaths, loss of a potential future caretaker, loss of a sense of immortality, intensified affective responses, lack of social support, and frequent and intense reactions on the anniversary of the death.

Increased Risk of Substance Use and Abuse

When a child dies, parents often experience traumatic symptoms and intense grief reactions that place them at high risk for complicated grief and mourning. This grief response, coupled with a lack of support, can increase the risk that a parent may cope with the loss through increased substance use or abuse. In addition to complicated grief responses, some parents may have other risk factors for substance abuse, such as family history of substance abuse, depression, anxiety, current use patterns, previous addiction history, or extreme isolation and lack of support. Any of these risk factors, coupled with the recent death of a child, may signal the need for additional support and possible treatment.

Interventions to Consider

Social workers may encounter parents at any point along the trajectory of their bereavement process, including before the child has died in the case of life-threatening illness and sudden accidents. While there is no one correct way to help a parent whose child has died, social workers should keep certain considerations in mind.

Tips for Intervention

- Conduct a full loss history to identify bereaved parents.
- Conduct a substance use/abuse history.
- Identify and acknowledge the loss.
- Provide grief counseling, even many years after the death.
- Identify peer support groups such as Mothers Against Drunk Driving, Parents of Murdered Children, Compassionate Friends, and hospice support groups.
- Encourage journaling.
- Encourage the parent to tell the child’s life story and death story.
- Identify particular areas of difficulty, such as death notification, making end-of-life decisions, traumatic death, family relationship problems, and insensitive or painful remarks made by others.
- Address alcohol/substance use as counterproductive to healing and refer for treatment.
- Identify and support other methods of coping.
- Acknowledge secondary losses of role, family, and community.
- Acknowledge the lifelong nature of parental bereavement.
- Encourage continuing bonds and significant rituals.
- Acknowledge feelings of disenfranchisement.
- Normalize the grief response.
In the aftermath of a death, especially that of a child, there is usually an outpouring of support to the family. However, as time passes, most parents report a steady decline in the amount and frequency of informal support they receive. Community and family members “move on” and expect, usually unrealistically, that the bereaved parent will do so as well. Many bereaved persons report that their needs for support increase in the second and third year, just as the support is dwindling. These parents may turn to social workers for support.

Sometimes bereaved parents present to the social worker with a nonbereavement concern, such as marital difficulties, job-related problems, parental struggles with surviving children, or substance use concerns. The first intervention should be a full loss history on the client, regardless of the presenting problem.

Once the loss is identified, social workers should acknowledge the loss and provide support for the bereaved parent’s feelings. This is especially important in light of the often disenfranchised nature of parental bereavement. Grief counseling for the loss may include a review of the child’s life, an exploration of the circumstances surrounding the death, and support for the secondary losses that have occurred as a result of the death. Social workers can encourage bereaved parents to elaborate on aspects of the death that were particularly troubling, especially if the death occurred suddenly or traumatically. Most bereaved parents need to deal with the feeling that they should have somehow prevented the death of their child. Parents need to have their intense grief reactions normalized and supported.

If the parent is using or abusing substances, it is important for the social worker to treat or refer to treatment. Social workers should also identify peer support groups for bereaved parents.

The death of a child is a devastating life event that causes parents extreme distress emotionally, physically, and spiritually for many years. Such a loss puts parents at risk for substance use/abuse. Social workers should assess, treat, or refer any potential substance use and abuse problems for this vulnerable population. Social workers should also conduct comprehensive loss histories to identify bereaved parents who may be in need of counseling for complicated grieving.

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References
Fetal alcohol spectrum disorder (FASD) poses a serious threat to the health and well-being of women, children, and families in the United States. FASD describes a range of possible effects that may occur in a person whose mother drank alcohol during pregnancy. Often, these effects include physical, mental, behavioral, and learning disabilities. It is important for social workers to know evidence-based prevention strategies and to provide their female clients of childbearing age with education on alcohol, pregnancy, and FASD.

National guidelines urge women not to drink any alcohol during pregnancy (NIAAA, 2000a). The specific threshold at which drinking alcohol during pregnancy is dangerous has yet to be determined, but there is growing evidence that as little as one drink a day can harm fetal development (Day, 1995). Since the fetus may be particularly vulnerable in early pregnancy, women should abstain from drinking alcohol while they are trying to become pregnant (Stratton, Howe, & Battaglia, 1996). It is estimated that as many as 40,000 babies are born each year with FASD (SAMHSA, 2006).

Children with FASD are often difficult to parent, require a variety of educational and developmental resources, and may present with behavioral problems that involve interaction with mental health or juvenile justice systems and, eventually, the adult prison system. Fewer than 10 percent of adults with FASD are able to live independently (Streissguth, Barr, Kogan, & Bookstein, 1996).

Although most women abstain from drinking alcohol or substantially reduce their level of alcohol use during pregnancy (Kaskutas, Greenfield, Lee, & Cote, 1998), significant
numbers of women continue to drink during their pregnancies (Stratton et al., 1996). Given the extraordinary costs associated with FASD, it is not surprising that many efforts have been undertaken to prevent women from consuming alcohol while they are pregnant.

A variety of prevention strategies exist; the classification system proposed by the Institute of Medicine is a useful framework for reviewing prevention efforts (NIAAA, 2000b). The classification includes the following: (a) universal preventions—health messages aimed at the general public, some of which contain messages to pregnant or preconceptional women; (b) selective preventions—health messages or interventions geared toward members of a particular subgroup whose risk is higher than average; and (c) indicated preventions—prevention interventions that target women known to be at high risk of having an alcohol-affected child because they drink heavily or have a child with FASD.

**Universal Prevention Strategies**

In February 2005, the surgeon general released the following recommendation, reconfirming a 1981 proclamation that warned women not to drink during pregnancy: “Pregnant women and women who may become pregnant should abstain from alcohol consumption in order to eliminate the chance of giving birth to a baby with any of the harmful effects of the fetal alcohol spectrum disorders.”

Since 1981, several studies have investigated the effectiveness of the alcoholic beverage warning label and other universal messages, such as warning posters in restaurants. Initially, these efforts did increase awareness of the risk associated with drinking alcohol during pregnancy, but the effects of the warnings subsided over time (Hankin, 2002) and ultimately had only a minor impact on behavior (Stratton et al., 1996).

**Selective Prevention Strategies**

Selective prevention efforts generally target women of childbearing age. Manwell and others (2000) used a randomized experimental design to examine the impact of a 15-minute, physician-delivered counseling intervention that addressed the risks of alcohol use during pregnancy on 205 women of childbearing age. The women who received the brief intervention significantly reduced both binge drinking and seven-day alcohol use compared with women in the control group. In addition, follow-up data indicated that women in the experimental group who later became pregnant drank significantly less frequently and had fewer binge drinking episodes than before their pregnancies.

Project CHOICES, a four-year study by the Centers for Disease Control and Prevention, researched an ethnically diverse sample of 190 women of childbearing age who were determined to be at risk for an alcohol-exposed pregnancy (Ingersoll, Floyd, Sobell, & Velasquez, 2003). The intervention focused on educating the women to avoid having an alcohol-exposed pregnancy either by using effective contraception or by abstaining from drinking. The women were provided with four motivational interview sessions and one family planning session. Six months after the intervention, researchers found that more than 51 percent of the women were no longer at risk for an alcohol-exposed pregnancy because of either effectively using contraception or deciding against drinking during pregnancy.
Indicated Prevention Strategies

Indicated prevention efforts target the women at highest risk, including those known to be heavy drinkers and those who have previously given birth to an alcohol-affected child. Studies of indicated prevention efforts are scarce but provide some valuable information. Early intervention is essential to reduce a woman’s drinking level and decrease the probability that she will give birth to an alcohol-affected infant.

The Parent Child Assistance Program (PCAP) is an evidenced-based intervention model designed for mothers who are at severe risk for substance abuse (Ernst, Grant, Streissguth, & Sampson, 1999). The program complements existing community treatment interventions by providing participants with paraprofessional advocates. The program aims to prevent future alcohol-exposed births by helping mothers quit drinking alcohol or motivating them to choose effective family planning methods. The PCAP model includes the following steps: (a) establishing a relationship between the mother and the paraprofessional; (b) identifying client goals; (c) establishing links with service providers (including transportation); (d) establishing written agreements; (e) role modeling and teaching basic skills; and (f) evaluating the outcome. Each paraprofessional advocate has a caseload of 12 to 15 clients and their families. The advocates work with each family from the birth of the target child until that child is three years old. The authors of the study report that most women enroll in the program close to the time of delivery. This is consistent with research that indicates that this high-risk population often does not obtain prenatal care. Advocates conduct weekly home visits for the first six weeks, then biweekly visits.

Help Seeking for AOD Misuse among Social Workers: Patterns, Barriers, and Implications

Abstract

Social workers experience alcohol and other drug (AOD) problems, yet little is known about how they deal with these issues. To begin to address this gap in knowledge, this study presents data from a sample of NASW members and describes how frequently social workers seek support for AOD problems, the kinds of assistance they typically obtain, how helpful they find the assistance, the barriers that discourage them from seeking help, and the relationship between help seeking and impairment. The data suggest that social workers do not frequently seek help, even when they are high-risk AOD users. Respondents reported a number of personal reasons for not obtaining assistance, but when they sought help, they found both peer support and formal treatment beneficial. Help seeking was also related to a variety of professional impairments. Implications for practice and research are discussed.

after that. Research findings at 36 months indicate that PCAP is a promising approach in helping high-risk women enter substance abuse programs, abstain from alcohol and drugs, or enter treatment during subsequent pregnancies; use efficient methods of family planning; and increase access to health and social services for themselves and their children (Ernst et al., 1999).

**Implications for Social Workers**

Social workers have a responsibility to “enhance human well-being” (NASW, 1999, p. 1). Integrating an FASD prevention message into their practice is one way social workers can help reduce one of the most preventable forms of mental retardation and other serious physical, mental, behavioral, and learning deficits. Because FASD affects children and their development, it also affects families, schools, and other institutions. Thus, social workers are likely to interact with those affected by FASD in a variety of settings. It is crucial that social workers increase their understanding of FASD and help their clients with information on both the prevention and diagnosis of the disorder. If it is too late to prevent FASD, early diagnosis can result in vital interventions and better outcomes.

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**References**


HIV/AIDS PREVENTION WITH SUBSTANCE-ABUSING INCARCERATED WOMEN

Michele A. Rountree, PhD, MSW

Social workers play a crucial role in the delivery of interventions to HIV/AIDS-infected incarcerated women. Many women in correctional facilities may have engaged in risky sexual practices and, without intervention, are likely to continue to do so upon release. The absence of culturally and contextually relevant interventions can place incarcerated women and their home communities at a heightened risk for infection. Social workers in correctional settings and community programs can play a crucial role in the delivery of interventions to HIV/AIDS-infected women who are incarcerated or have recently been released.

The Centers for Disease Control and Prevention (CDC, 1999) estimates that for every five HIV-positive persons newly identified by counseling and testing programs, one infection is averted through adoption of safer sexual behaviors. For incarcerated women, one of the primary risk factors for infection is injection drug use (McClelland, Teplin, Abram, & Jacobs, 2002). The following is a fictitious first-person case narrative of an HIV peer educator who was convicted on drug charges. It is based on the author’s work with incarcerated women and underscores the positive effect of HIV/AIDS prevention programs in correctional settings.

I am a peer educator working with an HIV/AIDS prevention program in a substance abuse felony punishment treatment facility. I can understand why many of the inmates are terrified to know their HIV status. I share with many of the women here a history of addiction to crack cocaine, IV drug use, and engaging in “survival sex” just to get the next fix. Many of us were caught selling drugs and convicted. When I first entered the facility, at the orientation, they told us that we might be at risk for HIV and said we could attend a program that offered HIV testing and HIV education. I took the HIV test anonymously and tested positive. I won’t kid you—I was shocked and terrified. I was referred to the medication unit and to support groups in the facility. As terrified as I was about being HIV positive, I was able to deal with it because of the support I received in the program. For the sake of their loved ones, I hope that many of the women test negative. What has been most helpful in my healing is helping other women. The HIV risk-reduction program helps those of us in recovery learn ways to protect ourselves and to reduce the transmission of HIV/AIDS. I would like to believe that none of us will ever use again, but if we do, we have the information we need to keep ourselves from getting infected or from passing along the disease.

Psychosocial group intervention can be effective with incarcerated women infected with HIV/AIDS, not only for changing risk behaviors but also for reducing depression, anxiety, and trauma, and increasing HIV information among this population (Pomeroy, Abel, & Kiam, 1999). Other programs offered in correctional settings include substance abuse treatment, HIV counseling and testing, behaviorally based prevention interventions, HIV primary care, supportive services, interventions to prevent HIV-related stigma and discrimination, transitional...
planning, and community-based case management services at release (Dean-Gaitor & Fleming, 1999).

A psycho-educational group program was used with 87 incarcerated women over a two-year period. Each session lasted 90 minutes and included a 45-minute educational presentation and a 45-minute discussion on cognitive-behavioral and task-centered techniques. The following is an outline of the 10 sessions:

Session 1—Provide an overview of HIV/AIDS with a supportive emphasis on building self-esteem and group trust.

Session 2—Educate participants on opportunistic infections. Discuss coping strategies for depression and ways to challenge irrational thoughts.

Session 3—Present strategies on how to prevent HIV transmission. Continue supportive functions outlined in the previous session.

Session 4—Discuss the difference between healthy and unhealthy relationships. Provide supportive component addressing ways to cope with anxiety.

Session 5—Continue educating participants on the importance of adopting safer sex practices. Continue addressing anxiety coping methods discussed in the previous session.

Session 6—Discuss the risk factors of drug use and users’ heightened risk for HIV/AIDS infection. Provide support and information on coping with anger through the use of communication skills.

Session 7—Provide participants with information on how to stay healthy. Continue the supportive focus of the previous session, with an emphasis on anger management.

Session 8—Provide resources on finances and building confidence while supporting participants in developing problem-solving and goal-setting skills.

Session 9—Focus on empowering participants in planning for their futures and recognizing personal resources.

Session 10—Focus on what has been accomplished over the course of the 10-week program.

Confidentiality among group members is of paramount importance. Social workers employed by the correctional system or contracted by a jail or prison system may need to seek outside supervision to help them deal with the many ethical issues that arise. Other considerations may include the incorporation of diversity: Facilitators and materials should reflect the ethnic and racial makeup of group members.

The proportion of incarcerated women who are infected with HIV/AIDS has substantially increased. Social workers can provide mental health and psychosocial support in a cost-effective manner to these women, who might not otherwise receive support and education.

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SAMHSA NEWS DESCRIBES SUCCESSFUL TREATMENT: DRUG COURT ALTERNATIVE TO INCARCERATION

Research shows that treatment drug courts provide successful alternatives to incarceration for defendants with addiction problems who constantly cycle between crime, incarceration, release, relapse, and recidivism. The cover story in the March/April 2006 issue of SAMHSA News highlights treatment drug courts—often referred to simply as drug courts—funded since the late 1990s by the Substance Abuse and Mental Health Services Administration (SAMHSA).

Close supervision, drug testing, and the use of sanctions and incentives help ensure that offenders stick with their treatment plans while public safety needs are met. The article also describes family drug courts, which target parents whose substance abuse puts them at risk of losing custody of their children.

SAMHSA News is a free publication that focuses on pressing issues in the mental health and addictions fields. Issues are published bimonthly, and available in both hard copy and electronic formats. The March/April 2006 issue is available online at: http://alt.samhsa.gov/SAMHSA_News/index.asp

SAMHSA, a public health agency within the U.S. Department of Health and Human Services, is the lead federal agency for improving the quality and availability of substance abuse prevention, addiction treatment and mental health services in the United States.

References
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