Resilience and Substance Abuse among School-aged Children

Sarah Jane Racal
Lecturer, College of Nursing, Christian University of Thailand, Nakhonpathom City, 73000, Thailand
Email: racalsarahjane@gmail.com

Abstract

Substance abuse is a key concern for society which affects individuals, families, and communities across various age groups, culture, and race. Among children and adolescents, the incidence rate has been increasing continuously. It is an undeniable reality that many affected individuals do not receive the needed treatment and rehabilitation. It is then the aim of this study to redirect focus on the promotion of mental health and prevention of psychological disabilities such as the development of substance abuse among young children. This review of literature highlights the role of resilience as a protective factor among children and adolescents in the prevention of later substance abuse. Aside from its indicators, correlates of resilience such as individual (e.g. age, gender, race, temperament, and cognitive capacity), family (e.g. quality parenting and family relationships), and social factors (e.g. peer acceptance, and economic status) are discussed to hopefully serve as a guide in strengthening resilience against later substance abuse among young children.

Keywords: resilience; substance abuse; school-aged children

1. Introduction

Among children and adolescents, literature has honored the major role of “resilience”—positive adaptation amidst adversity, in substance abuse prevention and mental health promotion (Luthar, Cicchetti, and Becker, 2000). The middle childhood stage or school-aged children are prone to adversities. They experience dramatic changes in social participation beyond their own families, which, along with peers, social and educational environment. Their ability to successfully overcome adversities and maintain positive mental and social health outcomes are affected.

Children exposed to poverty, violence, and are given less opportunity for growth and development are at higher risk for developing later substance use disorders. Despite these, there are still children who successfully overcome challenges and maintain a healthy psychological state. In many studies involving children, resilience for substance abuse is measured by assessing a child’s behavior problems postulating that children with lower resilience, as manifested by more behavior problems, are at greater risk for developing later substance abuse. Variables identified
to influence resilience in children include gender, temperament, poverty, maternal psychopathology and family relationships (Bennett, Bendersky, & Lewis, 2007; Connell and Goodman, 2002; CrissPettit, Bates, Dodge, & Lapp, 2002; Dubois-Comtois, Moss, Cyr, & Pascuzzo, 2013; Sood et al., 2001).

2. State of Knowledge and Gap of Existing Knowledge

The World Health Organization (WHO/UNDCP, 2003) predicts that from 11% total disease burden in the year 1990, substance abuse alongside other mental disorders will surpass all physical illnesses such as ischemic heart disease and diabetes as a major cause of disability by 2020. In the year 2000, tobacco, alcohol and illicit drugs contributed to about 12.4% of all deaths worldwide (UNODC, 2013). Among children and adolescents, substance abuse is increasing worldwide. As reflected in the 2011 survey released by the National Survey on Drug Use and Health (NSDUH) involving the age group of 12 to 17 years and older, around 22.5 million Americans were considered as current drug users while a drastic increase of 1.2% or 3.6 million users was observed between the years 2007 to 2011. Initiation of drug use on an average day as reported in 2010 and 2011 brings about 7,639 alcohol drinkers, 4,594 new illicit drug users and 400 new marijuana new users. Approximately, this brings to 8,400 new users per day and the number continues to increase.

In certain countries, substance abuse is becoming a serious concern even among young children. The United Nations International Children’s Emergency Fund (UNICEF) reports suggest that substance abuse is a rising phenomenon against the children of Iraq (IRIN News, 2007) with a 30% increase since 2005 and a nearly 10% increase in 2012 (World Health Organization, 2011). In the 2007 news report from Baghdad, preliminary survey showed high cases of addiction among street children and the middle class.

In the South-East Asian region, a joint project by the World Health Organization and United Nations International Drug Control Programme(WHO/UNDCP) involving three rapidly changing countries—Thailand, Philippines and Vietnam, revealed that the young people as early as 10 or below are vulnerable to substance use. Statistics showed that first use of either cigarette, beer, wine and cannabis are first started by the age group of <10-12 years old. Among these countries, the Philippines has the greatest number of young people initiating illicit substances at an earlier age and engage in a wider variety of substances compared to Thailand and Vietnam accounting to around 2.3% to 7% in the use of cannabis, heroin, cocaine, ecstasy and injections (WHO/UNDCP, 2003). Furthermore, in a research study conducted by the Dangerous Drugs Board of the Philippines, the age group of 10-19 with 469,749 users in 2008 is considered as most vulnerable to drug abuse. Initiation of drug use as early as 8 to 9 years old is recorded highest in the Regions X, VII and National Capital Region (Balmes, Arambulo, & Ferriolis 2008).
3. Consequences of Substance Abuse

Substance abuse consequences include developing serious mental and physical illnesses such as respiratory complications, depression and HIV/AIDS; involvement in illegal activities such as driving under the influence of alcohol, selling illicit drugs, crimes; broken families and social relationships and even loss of career (World Health Organization, 2010). Psychotic symptoms also emerge especially with the use of Cannabis (Chen & Lin, 2009) while memory and cognitive problems occur in people using methylenedioxymethamphetamine (MDMA) It is estimated that out of 11-21.2 million people injecting drugs, approximately 4 million may be living with HIV/AIDS (UNODC, 2010).

Among the illicit drug users, only very few are reported and very few received the treatments. Globally, only around 12% to 30% received treatment in 2008 which is translated that between 11 and 33.5 million problem drug users did not receive their needed treatment (UNODC, 2010). There are an increasing number of individuals needing treatment for illicit drug use regardless whether a need for one is perceived or not. In the 2011 report by NSDUH, 19.3 million persons aging 12 years and older needed treatment but did not receive any. For multiple drug users, very few received treatment for both drugs and alcohol use and almost half of this group reported that they have used their own resources to receive the recent specialty treatments. In the Philippines, there is no officially identified national epidemiological data collection system for alcohol and drugs (World Health Organization, 2010). However, it is estimated that 62.5% of all cases received treatment from the public sector with out-of-pocket payment as the most significant financing method.

This creates a big concern and question especially to the marginalized members of society—the poor, the jobless, the less educated and the unreported cases. Considering the challenges of treating substance use disorders—high relapse rates, lack of treatment resources, and social stigma; there is a need to halt the growth of substance abuse through promotive and preventive efforts especially among children and adolescents.

Based on the evidences furnished above, the following inferences were drawn: The phenomenon of substance abuse is 1) a serious global concern and burden; 2) bringing detrimental consequences to different sectors of society—the individual, family and community; 3) prevalent across age groups; 4) increasing in rate even among young children; and 5) facing great challenges in treatment and rehabilitation. Unless something is done to halt the increasing rate of substance abuse, society will continue to face its consequences at a greater gravity and because treatment and rehabilitation are difficult, promotive and preventive efforts are crucial. In the previous sections, initiation of illicit drugs mostly begins at the adolescent stage, thatis
between 10 and 19 years old (WHO, 2010). Hence, preventive and promotive efforts can be best targeted to younger children.

4. The School-Aged Children

The primary goal of illness prevention and health promotion is to change behavior—broadly defined as action, emotion and cognition. An interesting age group that is very amenable to the change in behavior is middle childhood or the school-aged children (Lester et al., 2006). Famous theorists, Freud and Piaget consider this stage as the plateau in development, or the time when children consolidate the gains they had during the rapid growth of the preschool and when preparing for adolescence (Eccles, 1999). The middle childhood stage is characterized by the following 1) the ability to identify and articulate one’s emotions and of others 2) acquisition of self-competence 3) the ability to reason and make sense of the world and 4) intense interest in moral issues (Charlesworth, Wood, & Viggiani, 2007).

A child’s ability to express emotions and be sensitive to others is collectively termed as ‘emotional intelligence’. It is the ability to motivate oneself and persist in the face of frustrations, to control impulse and delay gratification, to regulate one’s moods and keep distress from swamping the ability to think, to empathize and, to hope (Goleman, 2006). An interesting activity for children called the marshmallow test can be viewed in YouTube (https://www.youtube.com/watch?v=QX oy9614HQ). This is where several kids wrestle waiting to eat a marshmallow for another one, a simple test on self-control and delaying of gratification.

The acquisition of self-competence is a recognized developmental task in this stage. This is referred to by Erikson (1963) as the stage of Industry vs Inferiority where a child seeks for opportunities to exhibit individual skills, abilities, talents and achievements. A middle child’s experiences at this stage may delay a child’s attempts to attain self-mastery. The family, the school and the community play a major role in helping children attain a growing sense of self-competence by providing opportunities to both fail and succeed along with sincere feedback and support. Acquiring this serves as a protective factor during adolescents and early adulthood.

During this period, children develop thinking and conceptual skills and advances in learning and understanding. Awareness skills also dramatically develop in middle childhood. As the child is exposed to the school and community, one gains an awareness of culture, gain more information in problem solving, and takes the perspectives of others. Through understanding others and learning from the environment, children build their capacity to reason.

Another very important milestone in the middle childhood stage is moral development enhanced by direct teaching and inclusion of moral values such as
kindness, respect, honesty. In elementary school setting, children are at higher risk of bullying than that in high school or college (Astor, Benbenishty, Pitner, & Meyer, 2004). In moral development, the family, school, peers and the greater community play a major role in shaping a child’s unique values and goals.

Children from 6 to 11 years begin to experience dramatic changes in social participation beyond their own families. The family, peers, social and educational environment help shape a child’s moral, cognitive, and emotional developments. Being able to achieve a sense of competence, to define and articulate ones emotions, to provide sound reasoning in the common sense of the word, and to assimilate expected community values are essential elements to successfully overcome adversities and maintain positive mental and social health outcomes.

However, the current society bombards the child with challenges that are threatening to one’s psychological well-being. Growing in poverty, experiencing abuse and neglect, exposure to substance abuse and parental psychopathology (Lester et al., 2006) all put a child to a greater risk of long-term psychological dysfunctions. Though many children in these circumstances end up with long-term problems as adults, many are still able to overcome adversities and grow into well-functioning adults. This has been an intriguing phenomenon to researchers—a question on why is it that some children growing up in adverse circumstances still attain positive psychological outcomes? To answer this question, researchers had been exploring since 1970 the individual and contextual influences that protect the child at risk from later negative outcomes, a term they refer to as ‘resilience’.

In the recent years, there has been a shift of research and practice from a deficit-based approach related to maladaptive functioning and psychopathology to the approach that highlights strengths and resources to improve adaptive functioning so as to attain positive outcomes. This strength-based approach has led to the exploration of the concept ‘resilience’.

5. Resilience

The World Health Organization has referred to ‘resilience’ as one of the aspects that can promote positive mental health and prevent substance abuse (WHO, 2004). Evidences from research have shown that this is a major protective factor significantly related to later substance abuse (Meschke & Patterson, 2003). In a study conducted among 173 adolescents, 11 to 18 years of age in a foster care in Lithuania, it was found out that a stronger general resilience is negatively correlated \( r = -.191, p < .05 \) with a lower frequency of tobacco, alcohol and drug use (Isganaityté & Cepukiené, 2012). In another research study supported by the National Institute on Alcohol Abuse and Alcoholism, Alim and colleagues also referred to resilience as crucial to the prevention of substance abuse (Alim et al., 2012). In their study, the
The term ‘resilience’ had its origins from early literature in psychiatry to examine children who appeared to be “invulnerable” to difficult life situations. Over time, the word invulnerable has been replaced by the word ‘resilience’ and a new field of research was born (Ramirez, 2007). The origin of research on resilience is deeply rooted in the history of medicine, education and psychology. It was in the year 1970 when resilience research emerged under the context of developmental psychology or the study of behavior and adaptation using a developmental perspective (Lester, et al., 2006). To date, various definitions and research perspectives on resilience have emerged ranging from biological or neurological explanations to behavioral and psychosocial viewpoints.

The concept of resilience has received numerous definitions from scientists and other disciplines. It is understood as positive adaptation or the ability to maintain or regain mental health, despite adversity (Herrman, Stewart, Diaz-Granados, Berger, Jackson, and & Yuen, 2011). Cicchetti (2010) has expanded the definition covering ‘protective and vulnerability’ forces at multiple levels of influence—culture, family and the individual. Another definition is by Brooks (2006), that is, being able to lead a more successful life than expected despite being at a greater risk than the average for serious problems.

Aside from various definitions, there is also confusion about the conceptualization of resilience as a trait vs. a dynamic process (Luthar et al., 2000). Rooting from the literatures of Block and Block (1980), the term ego-resiliency came out. This refers to a group of traits that show general sturdiness and resourcefulness of character. Thus, the terms “ego-resiliency” and “resilience” differ for two reasons. First, ego-resiliency is a trait while resilience is a dynamic process; and second, ego-resiliency does not imply exposure to adversity while resilience does.

This paper will be using resilience as the topic of interest and by the definitions given above; resilience can be characterized by the following: a) a dynamic process; b) requires exposure to adversity; c) is multidimensional and d) results to positive adaptation. By this distinction, development of resilience-based interventions, health promotion and prevention strategies as well as the empirical studies on the outcomes of such interventions are possible.

The brain, genes, and their interactions with the environment contribute to resilience in individuals. The brain is considered as the major organ that determines successful adaptation to change, the major organ that contributes to one’s resilience. It is related to the process known as “allostasis” present in higher animals as they attain the stability through change and protecting homeostasis amidst environmental stressors (Karatereos & McEwen, 2013).

Key structures in the brain affecting emotionality and cognition are the hippocampus, the amygdala and the prefrontal cortex. However, these structures do not influence allostasis by their own they are also affected by environmental stress depending upon the stage of life. A child for instance, with adverse experiences, can have an altered resilience making it more difficult for them to normally respond to challenging situations (e.g. poverty) but when exposed to the right circumstances such as quality family relationships and school support, the brain can re-enter plastic states to mitigate negative outcomes (Karoteos & McEwen, 2013).

Aside from the brain function, gene and environment interactions have been of great interest in recent research in both humans and rhesus monkeys. For instance, a specific-polymorphism (“short” allele) in the promoter region of the serotonin transporter (5-HTT) gene is associated with deficits in neurobehavioral functioning in infancy and poor control of aggression and low serotonin metabolism throughout juvenile and adolescent development in monkeys who were reared in peers but not in monkeys reared with their mothers and peers during infancy (Suomi, 2006). In human studies, Caspi, Harrington, Milne, Amell, Theodore, and Moffitt(2003), followed a large sample of young adults prospectively from early childhood and onwards and demonstrated that allelic variation in the promoter region of the serotonin transporter gene was associated with significant differences in the number of depressive symptoms observed in these young adults—but only if they also had experienced childhood neglect or abuse or were experiencing high levels of concurrent stress. Genetic studies in China show that genetic influences account for 30%-70% of vulnerability to substance abuse and are induced by multiple genes that make up only minor contribution to the variance of substance abuse risk. Researchers from the National Institute on Drug Dependence and Institute of Mental Health of China recognize the complex condition of substance abuse that results from a combination of interactions among factors including environment, neurobiological changes and personality traits (Sun and Buys, 2012).

A person’s environment influencing the process of resilience and interacting with the brain and genetic influences include parent, family and peer relationships. In a qualitative study involving children (7 to 13 years) of substance users whose parents are in a treatment center, it was revealed that the path to resilience, according to the participants, is centered on intangibles and not really on having more money to live a good life. The interviewees referred to the intangibles as
those coming from large and quality sources of support in their childhood coming from friends, relatives and educators. It is a life that provides them a venue for expression, education and free from illicit substances.

Other than the environment, one’s personality trait or specifically, a child’s temperament also influences the process of resilience. Temperament refers to a relatively stable, early appearing, biologically-rooted individual differences in behavioral traits (Wachs, 2006). There are evidences from literature indicating that one’s temperament may promote resilience. If it does, a critical question is which particular dimensions of temperament are linked to the process of resilience. The body of literature identifies that easy-difficult temperament, emotionality, sociability, self-regulation and attention-task orientation are some of the dimensions of temperament closely linked with resilience (Lester et al., 2006).

Children with an easy temperament were found to have a significantly lower levels of behavior problems (Ruchena, Prior, Sanson, and Smart, 2005), higher levels of behavioral adaptation at school and home (Wyman, Cowen, Work, Hoyt-Meyers, Magnus, Fagen, 1999), as well as high levels of social competence. Similarly, children with high levels of positive emotional reactivity present a good resilience through low behavioral, emotional problems, lower substance abuse problems (Wills, Sandy, Yaeger, Cleary, and Shinar, 2001), and high levels of social and emotional competence. The dimension of sociability did not differ much with the findings, children who are experiencing stress yet are highly sociable have lower levels of behavior and emotional problems and high levels of cognitive performance (Kim-Cohen, Moffitt, Caspi, and Taylor, 2004).

Fewer behavioral problems are observed in children who are flexible as compared to those with a rigid temperament. A low level of internalizing behavior problems can be observed among children who were rated by their parents as having a high level of self-regulation (Lengua&Long, 2002). Attention-task orientation as a characteristic of resilience in children can be viewed in terms of both temperament and cognitive domains (Wachs, 2006). Children rated as high in task orientation or focusing exposed to divorce or high levels of family stress have significantly low levels of substance abuse problems and behavior problems. It is not surprising that in these findings children regarded as resilient have significantly fewer behavior problems and better social competence.

In a research review conducted by Walsh, Dawson, and Mattingly(2010), it was presented that indicators of resilience in childhood functioning fall around three main categories behavioral and emotional competence, social competence, and academic achievement. Among these, behavior and emotional competence is mostly associated with the development of later substance abuse. In several research studies, resilience in children had been assessed through the extent of behavior problems.
In rural Australia, the resilience of a community of children and adolescents (5-16 years old) was assessed using the Strengths and Difficulties Questionnaire (SDQ), a screening tool composed of five scales: emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems and prosocial behavior which are designed to detect emotional and behavioral problems as well as social functioning as rated by their parents and teachers (Dunstan & Todd, 2012). In another study by Bell Romano, & Flynn (2013) stated that behavioral resilience was assessed among 531 5-9 year olds living in the out-of-home care in Canada using the same questionnaire, the SDQ to assess conduct and emotional problems and prosocial behavior.

Resilience was also assessed in a study aiming to explore factors that differentiate children with poor adjustment from those with resilience (Graham-BermannGruber, Howell, and Girz, 2009). Resilience among 219 children in families exposed to intimate partner violence were assessed by measuring the child’s emotional and behavioral problems within two broad categories, internalizing and externalizing behaviors, using the Child Behavior Checklist (CBCL) created by Achenback in 1991. The same measurement was used for resilience in a longitudinal study by Criss and colleagues (2002) involving 585 families with 5-year-old children followed up until grade 2. Their internalizing and externalizing behaviors were assessed by their teachers at 2nd grade using CBCL. Given these studies, behavior problem as a correlate of resilience among school-aged children will be the focus of this paper and will be explored further. Behavior problems represent a key developmental outcome and serves as a strong predictor of future adjustment (Guttmannova,Szanyi, and Cali, 2007). Majority of child researchers have classified behavior problems as either internalizing or externalizing manifestations of behavior. Internalizing behavior is characterized by an over control of emotions usually directed to self and includes social withdrawal, feelings of worthlessness or inferiority and dependency. Externalizing behavior, on the other hand, is characterized by an under control of emotions directed to others including difficulties in relating with others, rule breaking, irritability and belligerence (Achenbach& Edelbrock, 1978; McCulloch, Wiggins, Joshi, & Sachdev, 2000)).

7. Factors Influencing Behavior Problems in Children

Research has consistently linked several factors to behavior problems in children and can be grouped into a) Individual b) Family and c) Community factors. Individual factors include age, gender, ethnicity or race, temperament, and academic performance or cognitive capacity. Family factors include prenatal exposure to alcohol and cocaine, marital conflict, ineffective parenting, maternal psychopathology and distress and experience of abuse, poor parent or mother-child interaction such as punitive or too caring rearing patterns, exposure to violence, history of familial neglect and institutional rearing, and the experience of abuse. Community factors
Individual factors studied in relation to behavior problems in children include age, gender, race or ethnicity, temperament, and academic performance or cognitive capacity. In middle childhood, males have higher levels of behavior problems compared to females as seen in many researches (Bennettet al., 2007; Dubois-Comtois et al., 2013; Sood et al., 2001). In a longitudinal study involving 243 French-speaking mother-child dyads it was found out that male gender is a predictor of externalizing and internalizing behavior problems with a standard canonical discriminant function coefficient of .26, $r=0.27$, $p < 0.01$ for externalizing problems (Dubois-Comtois et al., 2013). This is supported by another longitudinal study involving 517 kindergarten to grade 2 students who are part of 585 families being studied. Results showed that males are more prone to developing externalizing behavior problems ($r= .19$, $p <.001$). However, two studies reviewed did not show the same results. Separate studies by Spratt et al., (2012) and McFarlane,Groff, O'Brien, & Watson (2003) presented that children do not significantly differ in internalizing and externalizing behavior problems when classified according to gender. Spratt and colleagues studied 3 to 10-year-old children with and without a history of familial neglect and those who experienced institutional rearing. Results showed that their behaviors do not significantly differ according to gender. Similarly, McFarlane and colleagues involved the mothers in assessing their children’s (18 months to 18 years) behaviors. Differences in the findings of these studies could be due to the type of research method, longitudinal studies tend to reveal significance in gender while cross-sectional researches showed otherwise.

Gender, however, is not a stand-alone factor in most studies. Male children exposed to prenatal alcohol and cocaine (Sood et al., 2001), those with abused mothers (McFarlane, et al., 2003), have experienced poor mother-child interaction and ambivalent attachment patterns (Dubois-Comtois et al., 2013) are at highest risk of developing behavior problems. It appears also that males who receive quality child care are given more protection against the development of behavior problems than girls (Votruba-Drzal, Coley, Maldonado-Carreno, Li-Grining, & Chase-Lansdale, 2010). Gender is also associated with other factors related to behavior problems such as peer acceptance, harsh discipline, and friend’s aggression (Bell et al., 2013).

Race as a factor showed varied results. In two of the studies review race did not have any relationship with behavior problems in children (McFarlane et al., 2003; Spratt et al., 2012). However, in a study involving 531 5-9 year olds from out-of-home care, ethnicity is correlated with externalizing behavior problems ($r=.19$, $p <.001$) as well as with harsh discipline, ecological disadvantage and peer acceptance (Bell et al.,
2013). Similarly, a high protection against the development of behavior problems can be observed in African American children than for Hispanic, White or other children (coefficient= 3.13, p <.05). On the other hand, children with difficult temperament (r=.10, p <.05) is correlated with the development of externalizing behavior (Criss et al., 2002; Martel et al., 2009). In another study by Martel and colleagues (2009), it was found out that poor reactive control or poor temperament leads to a disruptive behavior (r = -.43, p <.01) in children and eventually later substance abuse. A child’s cognitive capacity as reflected in academic performance is negatively correlated with behavior problems in school aged children (Bell et al., 2013; Kim-Cohen et al., 2013) with r = -13, p <.01 and r= - 0.253, p <.05, respectively. The better a child performs in school, the lesser are the manifestations of behavior problems.

7.2 Family Factors

A huge body of research studies had pointed to the significance of parenting and family relationships in the manifestation of behavior problems in children. Prenatal exposure to alcohol and cocaine, marital conflict, ineffective parenting, maternal psychopathology and distress and experience of abuse, exposure to violence, history of familial neglect and institutional rearing, and the experience of abuse in the family were among the factors identified.

Children who are exposed prenatally to alcohol regardless of quantity of intake have significantly higher odds by 3.2 of having delinquent behavior with a variance of 0.6%-1.7%. This is a study of 506 parent-child dyads involving women who reported alcohol consumption of at least 0.5 oz per day whose children were assessed at 6-7 years of age (Sood et al., 2001). Similar results were found among 10.5 year olds who were prenatally exposed to cocaine but this time there was an interaction between exposure and gender. Cocaine exposed males had higher behavior problems than females [$F (1,142) = 4.05, p<.05]$.

Many studies also showed the important role of maternal factors in the emergence of behavior problems in children. In a meta-analysis including 134 studies with children showed that mental health problems in mothers such as depression were significantly associated with both externalizing and internalizing problems even psychopathology in children (Connell and Goodman, 2002). This is confirmed by a study conducted by Dubois-Comtois, Moss, Cyr, & Pascuzz (2013) involving dyads of mother and child whereby results showed that maternal psychosocial distress such as depression actually predicted the presence of externalizing ($discriminant function coefficient= 0.55, r = .58, p <0.01$) and internalizing behavior problems ($discriminant function coefficient= 0.65, r = .58, p <0.01$) above clinical cut-off levels. In another study, maternal psychopathology also came out one as the most significant predictor of adverse behavior outcomes in children; accounting for 13.0% to 29.1% variance of the overall symptom scores (Sood et al., 2001). Children whose mothers were victims
of abuse, specifically, intimate partner violence also had a remarkably higher behavior problem than those whose mothers did not (McFarlane et al., 2003). This result is from a study conducted among 330 Black, White and Hispanic children who were exposed and not exposed to intimate partner violence.

Other than maternal factors, parent-child relationship as characterized by controlling attachment patterns either punitive or caregiving type can also predict membership in both child internalizing and externalizing clinical problem groups. Children who were controlled by punishment showed more aggressive and delinquent behaviors as well as symptoms of anxiety and depression while those who experienced control in a caregiving pattern showed greater symptoms of simple phobia and more thoughts of suicide that their secure peers. The quality of mother-child interactions was significant too (coeff = -.05, r = -.39, p <.01). In this study, mothers with higher stress or depression levels showed a strained interaction and a lack of mutual pleasure. Given such an unsatisfactory parental behavior, the child learns that he cannot rely on the parent for help in regulating their internal emotional states and adapt to stressful situations leading to the development of internalizing and externalizing behavior problems (Dubois-Comtois et al., 2013; Criss et al., 2002).

In relation to parenting is a similar issue on family neglect. Research supports that positive family atmosphere is related to low levels of behavior problems in children. Those who have experienced neglect—physical, medical, emotional neglect or abuse, have higher levels of behavior problems as well as symptoms of cognitive and language deficits. Neglect is a strong predictor of behavior problems, in a study involving 3 to 10 year olds, a high variance of 41% and 49% for internalizing and externalizing behavior problems, respectively can be accounted for from the experience of neglect in the family or a care-giving relative (Graham-BermannGruber, Howell, and Girz, 2009). This is supported by a retrospective study of inmates with substance abuse who had experienced neglect such as being left alone and psychological maltreatments during their childhood (Cuomo, Sarchiapone, Giannantonio, Mancini, & Roy, 2008).

7.3 Community Factors

Peer acceptance which include companionship, and having a sense of connection to the bigger group is negatively correlated (r = -.42, p <.001) with behavior problems in children. A similar concept to peer acceptance is friendship consisting of intimacy, and trust and support which is also negatively correlated (r = -.21, p <.001) the development of behavior problems as well (Criss et al., 2002). As to the relationship between the quality of child care given outside their homes and behavior problems, a study was conducted on 2,400 low-income children from age 0 to 14, it was found out that good quality care was linked to significant reductions in externalizing behavior (r = 2.16, p <.050) among children (Votruba-Drzal et al.,
8. Summary

Given the preceding information, understanding resilience as reflected in the emotional and behavior problems among children is significant in the prevention of later substance abuse. Although further studies need to be conducted to strengthen such claim, existing literature showed that among young children being male, having poor temperament or self-control, weak academic performance or cognitive capacity, early exposure to alcohol and other illicit substances, experiencing violence, neglect and trauma early in the family, poor family and social relationships, and low economic status either independently or interdependently influence the development of later substance abuse in life. This multidimensional nature of substance abuse shows the need for support and coordination from different units of society especially the family and not only from healthcare professionals.

9. Conclusion

Substance abuse is a serious problem that affects individuals, families and communities across different cultures and geographical locations. It leads to physical and mental health deterioration and has social consequences such as crimes and family destruction. For years, treatment has been a challenge considering the professional expertise and financial costs needed. It is imperative then to also redirect focus on the prevention aspect of this phenomenon. Literature has shown that resilience is one of the major factors that prevent later substance abuse. Since ‘emotional and behavioral competence’ is an indicator of resilience and is found to be associated with substance abuse, it is important to assess and intervene on early behavior problems among young children. This literature review shows that individual, family, and community factors may strengthen resilience especially among young children so as to prevent later substance use disorders and eventually control its associated consequences. Further studies may be directed to identifying the predictors of later substance abuse across different age groups and cultural background, assessing and identifying the factors influencing emotional and behavioral competence as an indicator of resilience among children, and exploring possible programs to strengthen resilience among young children.

References


