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## Growth, Development, and Behavior in Early Childhood Following Prenatal Cocaine Exposure:

### A Systematic Review

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### Abstract

**Context**—Despite recent studies that failed to show catastrophic effects of prenatal cocaine exposure, popular attitudes and public policies still reflect the belief that cocaine is a uniquely dangerous teratogen.

**Objective**—To critically review outcomes in early childhood after prenatal cocaine exposure in 5 domains: physical growth; cognition; language skills; motor skills; and behavior, attention, affect, and neurophysiology.

**Data Sources**—Search of MEDLINE and *Psychological Abstracts* from 1984 to October 2000.

**Study Selection**—Studies selected for detailed review (1) were published in a peerreviewed English-language journal; (2) included a comparison group; (3) recruited samples prospectively in the perinatal period; (4) used masked assessment; and (5) did not include a substantial proportion of subjects exposed in utero to opiates, amphetamines, phencyclidine, or maternal human immunodeficiency virus infection.

**Data Extraction**—Thirty-six of 74 articles met criteria and were reviewed by 3 authors. Disagreements were resolved by consensus.

**Data Synthesis**—After controlling for confounders, there was no consistent negative association between prenatal cocaine exposure and physical growth, developmental test scores, or receptive or expressive language. Less optimal motor scores have been found up to age 7 months but not thereafter, and may reflect heavy tobacco exposure. No independent cocaine effects have been shown on standardized parent and teacher reports of child behavior scored by accepted criteria. Experimental paradigms and novel statistical manipulations of standard instruments suggest an association between prenatal cocaine exposure and decreased attentiveness and emotional expressivity, as well as differences on neurophysiologic and attentional/affective findings.

**Conclusions**—Among children aged 6 years or younger, there is no convincing evidence that prenatal cocaine exposure is associated with developmental toxic effects that are different in severity,

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scope, or kind from the sequelae of multiple other risk factors. Many findings once thought to be specific effects of in utero cocaine exposure are correlated with other factors, including prenatal exposure to tobacco, marijuana, or alcohol, and the quality of the child's environment. Further replication is required of preliminary neurologic findings.

RECENTLY, THE US SUPREME Court considered *Ferguson et al v City of Charleston*, a Fourth Amendment case (unreasonable search and seizure).<sup>1</sup> This case addresses a policy of the Medical University of South Carolina whereby health professionals, in cooperation with the local prosecutor, selectively screened the urine of medically indigent obstetric patients for cocaine metabolites.<sup>1-3</sup> Medical personnel reported positive results to the police, who would then come to the hospital to arrest prenatal and postpartum patients for possession of an illegal drug, delivery of drugs to a minor, or child abuse.<sup>3,4</sup> In the popular press, *People* magazine reported on C.R.A.C.K. (Children Requiring a Caring Kommunity), a controversial charity that raises money to give mothers with a history of illegal drug use financial incentives to accept long-acting contraception, or, in most cases, sterilization.<sup>5</sup> This charity and the policies at issue in *Ferguson v City of Charleston* reflect popular belief that women who use cocaine while pregnant inflict severe, persistent, and unusual impairments on their unborn children, recently described by a newspaper columnist as “blighted by a chemical assault in the womb.”<sup>6</sup>

Public expectations of “blighted” children fuel controversial punitive policies directed toward addicted mothers.<sup>7</sup> Since 1985, more than 200 women in 30 states have faced criminal prosecution for using cocaine and other psychoactive substances during pregnancy.<sup>7</sup> Scholars and professional organizations have condemned efforts to sterilize or criminally prosecute addicted mothers as ethically and legally flawed, racially discriminatory, and an impediment to providing appropriate medical care to these women and their children.<sup>3,4,7-9</sup>

Recent reviews<sup>10-15</sup> and articles<sup>16-18</sup> show that most initial predictions of catastrophic effects of prenatal cocaine exposure upon newborns were exaggerated. After controlling for confounders, the most consistent effects of prenatal cocaine exposure are small but statistically significant decrements in 1 or more parameters of fetal growth for gestational age<sup>12,13</sup> and less optimal neonatal state regulation and motor performance.<sup>10,11,14</sup> Clinically silent findings on neonatal cranial ultrasounds following prenatal exposure have been found in some studies,<sup>10,16</sup> but not others.<sup>17</sup> Prenatal cocaine exposure without concurrent opiate exposure has not been shown to be an independent risk factor for sudden infant death syndrome.<sup>15,18</sup>

Despite the neonatal data, beliefs about cocaine's teratogenicity impose a stigma on cocaine-exposed infants<sup>19,20</sup> and children at school age.<sup>21</sup> Teachers fear that “crack kids” will be too developmentally delayed or disruptive to be taught in traditional classrooms.<sup>22</sup>

Given the current public concern, health professionals need a critical synthesis of studies of postneonatal outcomes of children exposed to cocaine in utero in 5 domains: (1) physical growth; (2) cognition; (3) language skills; (4) motor skills; and (5) behavior, attention, affect, and neurophysiology.

## METHODS

### Data Sources

MEDLINE and *Psychological Abstracts* were searched for all human studies published in English from 1984 until October 2000 that included the words *cocaine*, *crack/cocaine*, *crack*, *pregnancy*, *prenatal exposure*, *delayed effects*, *children*, and *related disorders*. Even if cited in MEDLINE, abstracts or nonreviewed proceedings of scientific meetings<sup>23</sup> were excluded. Seventy-four published articles were identified.<sup>24-97</sup>

## Study Selection

We first applied selection criteria used by others<sup>98</sup>: all selected studies presented original research published in a refereed English-language journal, used human subjects, and used a control or comparison group. Detailed review was then restricted to studies that also met 3 criteria: (1) samples were prospectively recruited; (2) examiners of the children were masked to their cocaine exposure status; and (3) the cocaine-exposed cohort did not include a substantial proportion of children also exposed in utero to opiates, amphetamines, or phencyclidine, or whose mothers were known to be infected with the human immunodeficiency virus (HIV).

## Justification of Selection Criteria

Studies were classified as prospectively recruited if the samples of cocaine-exposed and unexposed mother-infant dyads were identified and enrolled either during pregnancy or immediately after birth. Prospective recruitment obviates recall bias, when caregivers of a child who has experienced an adverse outcome are likely to recall prenatal exposure in greater detail, and selection bias, when caregivers are more likely to enroll children with already suspected developmental impairments. Such biases in retrospective samples can produce an overestimate of the risk of negative developmental outcomes.<sup>99</sup>

In behavioral research, examiners' bias may unconsciously distort measurement of developmental/behavioral outcomes.<sup>99-101</sup> Investigators have shown that evaluators were more likely to code children's videotaped behavior as abnormal if the children were labeled as "crack kids" than if they were not.<sup>19,20</sup>

Lower developmental test scores in infancy and less adaptive behavior at school age have been linked to prenatal opiate exposure.<sup>102</sup> In samples where most cocaine-exposed children are also opiate-exposed, the independent effect of cocaine on outcome cannot be clearly delineated. For the same reason, samples where cocaine exposure was largely confounded with exposure to methamphetamines or phencyclidine were also excluded. Exposure to HIV in utero is correlated with poor developmental outcome not only among infected infants, but also among those who serorevert.<sup>103</sup> If most cocaine-exposed children in a sample are also offspring of HIV-infected mothers, it cannot be determined whether effects are due to cocaine or HIV exposure.

## Procedures

Two developmental/behavioral pediatricians (D.A.F., M.A.) and a neuropsychologist (W.G.K.) reviewed all articles. After excluding 38 articles according to the above criteria, the same 3 authors abstracted the data from the remaining 36 articles in detail. If a single article covered outcomes in more than 1 domain (eg, cognitive test scores and behavior), each domain was addressed separately. If there was uncertainty, contact was made with the corresponding author of the article to clarify interpretation of data. Disagreements were resolved by consensus.

Of the excluded studies, 20\* failed to mask investigators to children's cocaine exposure status. Seven<sup>24,27,28,36,39,40,53</sup> had no control group. Twenty-six<sup>†</sup> did not use prospective recruitment for some or all of their subjects. Thirteen<sup>‡</sup> primarily recruited children with in utero exposure to opiates, methamphetamines, or phencyclidine. Two<sup>32,44</sup> reported samples predominantly composed of children of HIV-positive mothers.

\*References 24, 27, 30, 31, 33-37, 41, 42, 48, 49, 52, 53, 55-57, 60, 61.

†References 24-27, 29, 30, 33-38, 40-44, 46-49, 51, 54, 58, 59, 61.

‡References 28, 30, 32, 34, 41, 42, 49, 50, 54, 55-57, 59.

## Data Extraction

The conceptual framework for data extraction was provided by recent theoretical advances in human behavioral teratology<sup>104,105</sup> delineating the implications of various methods of characterizing exposure to possible toxicants and of controlling for potential confounders. Many cocaine-exposed newborns are clinically indistinguishable from their unexposed peers,<sup>18,106</sup> so identification of exposed infants depends on maternal report or measurement of cocaine metabolites in biological matrices. Dose response is a critical issue in the study of all potential teratogens<sup>105</sup> but is difficult to ascertain for cocaine in human studies. Recently, infants' meconium and maternal hair have emerged as useful biological markers for estimating the dose of prenatal cocaine exposure.<sup>97,107-111</sup> However, at the time most cohorts available for study in the postneonatal period were recruited, assays of urine from mother or infant for benzoylecognine were the only biological indicators readily available. Urine assays do not reflect cumulative fetal drug exposure. Thus, researchers who address dose response rely on maternal interviews to classify levels of prenatal cocaine exposure, usually classifying 2 or more days a week during pregnancy as "heavier use."<sup>63,66,85</sup> For this review, we classified levels of prenatal cocaine exposure as heavier/lighter or as exposed/unexposed.

Even when their mothers do not use opiates, amphetamines, or phencyclidine, most cocaine-exposed infants are also exposed in utero to varying combinations of tobacco, alcohol, and marijuana.<sup>112</sup> The heaviest prenatal cocaine users are often the heaviest users of these other substances.<sup>109</sup> If prenatal exposure to tobacco, alcohol, and marijuana is not analytically controlled, their effects on neurodevelopment<sup>74,84,113</sup> may be misattributed to cocaine. If these substances are statistically controlled for without regard to the level of use, residual confounding may occur because of overaggregation of light and heavy exposure.<sup>104,114</sup> For this review, we considered whether prenatal tobacco, alcohol, and marijuana exposure are reported or not, are controlled analytically as dichotomous variables (exposed/not exposed), or are statistically controlled in a dose-related manner. However, statistical control in a dose-controlled manner offers the greatest assurance that effects of heavy tobacco, marijuana, or alcohol exposure will not be spuriously attributed to cocaine.

Interpreting cocaine effects is further complicated because the samples studied are, with a few exceptions,<sup>77,90,93,97</sup> drawn from economically disadvantaged, medically at-risk populations, whose characteristics are associated with high developmental risk without any psychoactive substance exposure. The number of environmental and medical variables, the accuracy of their measurement, and their distribution within the sample may influence the estimation of cocaine effects.<sup>104</sup>

The data were derived from 17 independent cohorts from 14 cities. Some cohorts were the subject of multiple articles, either at different ages or with differing analyses of the same data from a single age. Mutually exclusive samples were identified by author and city. For each article, a number of parameters were coded, including number of cocaine unexposed and exposed subjects and the number at varying levels of cocaine exposure if such data were available; how pregnancy exposure to tobacco, alcohol, and marijuana was addressed analytically and whether this exposure was significantly related to outcomes; what other covariates were matched, used as selection criteria, or controlled for statistically; which of these covariates influenced outcomes; and what, if any, statistically significant ( $P < .05$ , 2-tailed unless otherwise specified) cocaine effects were identified. Of the included articles, 4 do not report attrition.<sup>66,77,78,87</sup> In the others, sample retention from birth to the oldest age reported for the cohort ranges from 39%<sup>70</sup> to 94%.<sup>62</sup> Of these, 14 articles\* from 11 cohorts document the characteristics of those retained compared with those lost to follow-up.

\*References 64, 65, 67, 73, 74, 81, 83, 85, 89, 91-93, 96, 97.

## RESULTS

### Physical Growth

If level of exposure to other substances is not controlled, prenatal cocaine exposure appears to be associated in 2 cohorts with postneonatal decrements in weight or occipitofrontal head circumference,<sup>64,70,78,79</sup> but not in another<sup>89</sup> (TABLE 1). However, in 2 cohorts that did control for dose of prenatal exposure to tobacco and alcohol<sup>84,93</sup> no negative cocaine effect was noted on the children's weight, length, or head circumference. In 1 cohort, full-term unexposed children were longer than exposed or unexposed preterm children and their exposed full-term counterparts.<sup>71</sup>

### Standardized Cognitive Assessment

There is little impact of prenatal cocaine exposure on children's scores on nationally normed assessments of cognitive development (TABLE 2). Findings of cocaine effects depend on contextual factors, such as the child's history of prematurity, age at time of assessment, and the effects of prenatal exposure to other substances. Of the 9 studies evaluating prenatal cocaine effects on developmental test scores in infants, 5 found no effect,<sup>71,77,79,85,89</sup> including 1 that classified infants according to level of prenatal exposure to cocaine, tobacco, and alcohol.<sup>85</sup> Chasnoff et al<sup>70</sup> found that the 6-month-old infants whose mothers used cocaine, alcohol, and marijuana attained mean scores lower than infants of controls, but identical to those of infants whose mothers had used alcohol/marijuana without cocaine, suggesting no incremental impact of cocaine use. Mayes et al<sup>91</sup> reported bivariate association of lower psychomotor scores at 3 months with prenatal cocaine exposure, but not after statistical control for potential confounders. Alessandri et al<sup>63</sup> found no main effects of level of prenatal cocaine exposure on test scores at 8 or 18 months, but on post hoc comparisons children with the highest level of cocaine exposure in pregnancy (2 or more days a week) obtained significantly lower mental development scores at age 18 months than unexposed infants.

In very low-birth-weight infants, Singer et al<sup>96</sup> reported a negative association between prenatal cocaine exposure and developmental scores at 16 months corrected age, but in utero exposure to other psychoactive substances was not analytically controlled.

Six reports from 4 cohorts evaluated the association of prenatal cocaine exposure with cognitive test scores in children between the ages of 3 and 6 years.<sup>64,78,82,83,89,93</sup> Two articles presented results in a single cohort of 3-year-olds. In one, Azuma and Chasnoff<sup>64</sup> reported that children whose mothers only used alcohol and marijuana during pregnancy achieved mean IQ scores that were identical to those of children whose mothers had also used cocaine. In a second report of post hoc comparisons from the same cohort, Griffith et al<sup>78</sup> found that children exposed to cocaine in addition to other substances scored significantly lower than unexposed controls on a verbal reasoning scale of the IQ test. However, these scores were not lower than the scores of children who had been exposed to the other substances but not cocaine and were not statistically controlled for tobacco exposure. Another study found no cocaine effect on IQ.<sup>89</sup> In the cohort studied by Hurt et al<sup>82,83</sup> there was no impact of prenatal cocaine exposure on children's cognitive test scores at 48 months. In the oldest prospectively recruited cohort studied to date, Richardson et al<sup>93</sup> found no effect of prenatal cocaine exposure on any IQ scales at age 6 years, including verbal reasoning, and no association with children's academic skills.

The literature on prenatal exposure to cocaine has not shown consistent effects on cognitive or psychomotor development. However, 7 studies show that environmental factors such as caregiver (biological mothers vs kinship care or foster parents),<sup>79,89</sup> whether or not that caregiver received case management or home visiting services,<sup>78,89</sup> quality of the home

environment,<sup>63,64,78,83</sup> and maternal IQ<sup>77</sup> were statistically significant correlates of test scores.

### Language Skills

Three studies of toddlers<sup>69,81,89</sup> showed no association between prenatal cocaine exposure and receptive or expressive language scores on standardized measures (TABLE 3). Using a naturalistic language sample, Bland-Stewart et al<sup>69</sup> found that cocaine-exposed children produced different semantic categories than matched unexposed children. However, there were too few subjects to permit confounder control.

### Motor Skills

Of 6 studies, 3 from 2 cohorts found less optimal motor scores in the first 7 months of life following prenatal cocaine exposure (TABLE 4).<sup>75,76,97</sup> No prospective study has identified a cocaine effect on motor development after age 7 months.<sup>75,76,89</sup> Dempsey et al<sup>74</sup> found mothers' prenatal tobacco use (quantified by urine assays of cotinine rather than by self-report), but not cocaine use (quantified by benzoylecgonine levels in meconium), was the major predictor of abnormalities in infant muscle tone at 6 weeks. No other prospective study of motor outcome<sup>75,76,79,89,97</sup> following cocaine exposure used biological markers to measure tobacco exposure. It is not yet clear whether previously reported positive associations between prenatal cocaine exposure and less optimal early motor development may be a misattribution of tobacco effects.

### Behavior, Attention, Affect, and Neurophysiology

Heterogeneous techniques used to evaluate behavior, attention, affect, and neurophysiology following prenatal cocaine exposure are not readily comparable across studies (TABLE 5). In the first year of life, visual habituation (an indicator of recognition memory and learning) was negatively associated with higher levels of cocaine exposure in 1 cohort<sup>85</sup> but not in 3 others.<sup>63,88,91</sup> No cocaine effect was found on toddler play<sup>80</sup> or on observations of behavioral style during an infant motor assessment.<sup>68</sup> Problem-solving abilities did not differ between cocaine-exposed and unexposed preschoolers.<sup>67</sup>

Differences in affective expression have been correlated with prenatal exposure to cocaine in 4 studies from 3 cohorts of infants younger than age 2 years. Alessandri et al<sup>62</sup> found that 4- to 8-month-old cocaine-exposed children showed less arousal, interest, joy, or sadness during the learning task. In the same cohort, Bendersky and Lewis<sup>66</sup> reported no differences in maternal behaviors, but less joy and more negativity among 4-month-old infants with heavy cocaine exposure following a perturbation of the face-to-face interaction between mother and infant. Roumell et al<sup>94</sup> reported a bivariate association between prenatal cocaine exposure and decreased facial emotion after immunization, uncontrolled for other prenatal exposures. In studies of face-to-face interaction between mothers and infants, Mayes et al<sup>92</sup> found heavy prenatal cocaine use correlated with less optimal maternal behavior and with decreased readiness for interaction among infants at age 6 months but not 3 months.

Diverse techniques have been used to assess neurophysiology in cocaine-exposed and unexposed infants aged 13 months and younger. Cocaine-exposed infants showed lower basal cortisol levels, but normal cortisol increase in response to the stress of venipuncture and no difference in amount of observed crying.<sup>86</sup> On electroencephalographic sleep studies at 12 months, cocaine-exposed children did not differ from unexposed children in sleep architecture, but infants whose mothers continued to use cocaine into the third trimester showed subtle reductions in spectral energies.<sup>95</sup> In 2 reports from a single cohort, assessments of heart and respiratory response to auditory, visual, and social stimulation at age 8 weeks found that cocaine-exposed children showed increased heart rate to social stimulation and a higher

baseline respiratory rate, but were not more dysregulated in arousal modulation or observed behavioral state.<sup>65,71</sup> Full-term cocaine-exposed infants showed better arousal modulation than their unexposed counterparts.<sup>65</sup>

Prenatal cocaine exposure, independent of exposure to alcohol, has not been found to be associated with levels of behavioral disturbances detectable by standard scoring of epidemiologic and clinical report measures by parents and teachers.<sup>64,72,73,77,78,87,93</sup> However, 2 studies in 1 cohort (1 study using a study-specific measure<sup>72</sup> and the other<sup>73</sup> using a new and as-yet-unreplicated method of scoring the Teacher Report Form of the Child Behavior Problem Checklist<sup>115</sup>) found less-optimal scores among cocaine-exposed children. Another research group<sup>90,93</sup> found, after covariate control, an association between prenatal cocaine exposure and increased errors of omission, but not commission, on a continuous performance task.

## COMMENT

Before summarizing our findings, we must acknowledge the limitations of our approach. Studies that meet our methodologic criteria may still lead to overestimation or underestimation of cocaine's impact. Prospective studies may yield biased results if there is differential attrition.<sup>99</sup> Less dysfunctional caregivers may be more likely to sustain study participation, creating differential retention of children with more favorable outcomes. Alternatively, caregivers of children with obvious impairments may be more willing to return for repeated assessments, leading to an overestimation of risk for poor outcomes.

Reliance on interviews alone to classify exposure, which was the state of the art when the cohorts reported here were recruited, entails unavoidable imprecision.<sup>14</sup> In the absence of cumulative biological markers some cocaine-exposed children may have been misclassified as unexposed. Conversely, women who do admit cocaine use in interviews tend to be heavier users than those who deny use but whose use is detected by hair assays.<sup>111</sup> Generalization from atypical cases at the highest levels of exposure will lead to overestimation of the impact of prenatal cocaine exposure in the broader population of users. However, if a sample contains very few infants heavily exposed to cocaine,<sup>77,93</sup> possible effects of heavier use may be statistically "diluted" by overaggregation of various levels of exposure into a single category.<sup>114</sup>

Four studies with positive<sup>69,75,76,94</sup> and 1 with negative<sup>68</sup> findings have small sample sizes and must be interpreted with particular caution since they may overestimate cocaine effects due to the impact of a few outliers or underestimate effects because of insufficient power or sampling variation.

While acknowledging these limitations, we conclude that after control for exposure to tobacco and alcohol, effects of prenatal cocaine on physical growth are not shown.<sup>64,70,71,79,84,89,93</sup> Researchers have not found a negative association of prenatal cocaine exposure, independent of environmental risk and exposure to other psychoactive substances, with developmental scores from infancy to age 6 years.\* However, sufficient information is not available to elucidate whether there are specific cocaine effects on developmental scores in the context of prematurity.<sup>96</sup>

Prospective data in the language and motor domains are only available for children up to age 3 years.<sup>69,74-76,78,79,81</sup> No effects on standardized language measures have been shown. Less-optimal motor development before age 7 months but not thereafter has been found by

\*References 63, 64, 70, 71, 77-79, 82, 83, 85, 89, 91, 93.

some investigators<sup>75,76,97</sup> but not others.<sup>74,79,89</sup> Recent research suggests that motor findings attributed to cocaine may in fact reflect heavy prenatal tobacco exposure.<sup>74</sup>

Except for the work of 1 investigator,<sup>72,73</sup> prenatal cocaine exposure independent of exposure to alcohol has not yet been found to be associated with levels of behavioral disturbance that are readily detected by standard scoring of epidemiologic and clinical report measures from parents and teachers.<sup>64,72,77,78,87,93</sup> However, sophisticated experimental and physiological paradigms of uncertain clinical importance have detected possible effects of prenatal cocaine exposure. Of these, only the finding of decreased emotional expressiveness has been replicated in more than 1 study.<sup>62,66,92,94</sup>

The differences between our conclusions and those of others show how methodologic rigor influences understanding of prenatal cocaine exposure. For instance, a respected research group recently concluded from a metaanalysis of 6 studies that prenatal cocaine exposure is associated with decreased competence in expressive and receptive language.<sup>98</sup> However, 5 of these studies<sup>29,37,43,46,51</sup> were retrospective; 2 did not use masked assessors.<sup>37,57</sup> In 2 samples, the majority of cocaine-exposed children were also exposed to opiates and methamphetamines.<sup>37,57</sup> Furthermore, none of these studies analytically controlled for the possible effects of prenatal tobacco exposure, an established correlate of language impairment.<sup>113</sup> Nevertheless, newspaper articles used the conclusions of the meta-analysis to declare that “because of cocaine-related receptive language impairments,” “crack babies” would cost taxpayers an additional \$42 to \$352 million per year in special education services.<sup>116</sup>

When prenatal cocaine and tobacco exposure are compared dispassionately, it becomes clear how sociopolitical forces shape discrepant interpretations of similar scientific data. The mechanisms of nicotine and cocaine effects on the developing brain are similar, involving vasoconstriction, hypoxia, and perturbations of neurotransmitter networks.<sup>117</sup> Prenatal tobacco exposure has been associated with infant mortality,<sup>118</sup> moderate impairment of cognitive functioning,<sup>119</sup> and a range of behavioral problems (which, unlike those associated with cocaine exposure, are detectable on relatively insensitive epidemiologic measures).<sup>120</sup> It has been calculated that low birth weight attributable to maternal smoking annually costs \$263 million (1995 dollars) in excess direct medical costs for neonatal care alone.<sup>121</sup> Despite increased health care costs imposed by their tobacco use, there are no sterilization campaigns for mothers who use tobacco. No pregnant women have been charged with child abuse for tobacco use in pregnancy. Teachers do not dread having a “tobacco kid” assigned to their class.

We have focused on cocaine as a suspected behavioral teratogen, since exaggerated views of its teratogenicity have provided the rationale for selectively targeting pregnant women who use cocaine for sanctions even more punitive than those imposed on women who use other illicit substances.<sup>3,8,122</sup> Our focus omits 2 important considerations beyond the scope of this review. First, even if cocaine were as hazardous to a child’s development as some claim, established teratogenicity (eg, that of heavy alcohol use) does not justify policies that violate the usual canons of medical ethics and civil liberties.<sup>3</sup> Second, health providers should not ignore that cocaine use in pregnancy is often a marker for a mother-child dyad at risk for poor health and impaired caregiving due to factors ranging from infectious diseases to domestic violence. Addiction to any intoxicant may so impair parents that they abuse or neglect a child.<sup>123</sup> However, presumptive punitive sanctions imposed in pregnancy or at birth do not reduce these risks to the child. On the contrary, fear of prosecution may discourage pregnant and parenting women from seeking prenatal care and drug treatment,<sup>8,124</sup> which have been shown to optimize infant outcome.<sup>125</sup> Stigma and negative expectations generalized from mothers to their children may in themselves impede the children’s academic progress.<sup>101</sup> Care of families affected by substance abuse should be comprehensive and not irrationally shaped by social prejudices that demonize some drugs and drug users and not others.<sup>123</sup>



Much is still unknown about the effects of prenatal cocaine exposure. Research on prenatal marijuana and tobacco exposure suggests that, even if no drug effects are found between the ages of 6 months and 6 years, the increasing cognitive demands and social expectations of school or puberty may unmask sequelae of exposure not previously identified.<sup>126,127</sup> Cumulative environmental risk and protective factors may also exacerbate or moderate negative cognitive and behavioral outcomes as children mature.<sup>128</sup> However, among children up to 6 years of age, there is no convincing evidence that prenatal cocaine exposure is associated with any developmental toxicity different in severity, scope, or kind from the sequelae of many other risk factors. Many findings once thought to be specific effects of in utero cocaine exposure can be explained in whole or in part by other factors, including prenatal exposure to tobacco, marijuana, or alcohol\* and the quality of the child's environment.<sup>†</sup>

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Table 1

## Physical Growth\*

Study	No.	Cocaine Effect	Outcome Measures	Assessment Ages	Tobacco Use	Alcohol Use	Marijuana Use	Selection/Matching Criteria	Controlled Variables	Other Effects
Azuma and Chasnoff, <sup>64</sup> 1993	92 + 25 poly 45 -	Both cocaine and polydrug exposed groups had lower OFC	Weight, height, OFC	3 years	R	C Analyzed as single category		All drug users in prenatal care by 15 weeks and in drug treatment		
Chasnoff et al, <sup>70</sup> 1992	106 + 45 poly 81 -	Both cocaine and polydrug exposed had lower OFC than unexposed at all ages measured	Weight, height, OFC	3, 6, 12, 18, and 24 months	R	C Analyzed as single category		All drug users in prenatal care by 15 weeks and in drug treatment	Sex, gestational age	
Coles et al, <sup>71</sup> 1999	25 preterm + 32 full term + 22 preterm - 26 full term	Full-term negatives longer; otherwise, no cocaine effect	Weight, length, OFC	8 weeks corrected for prematurity	R	R	R	Maternal age $\geq$ 19, English speaking, singleton or first-born twin, no O <sub>2</sub> > 28 days, no seizures, no grade III or IV IVH, not breastfed		
Hurt et al, <sup>79</sup> 1995	101 + 118 -	Cocaine associated with lower weight and OFC at all ages	Weight, OFC	6, 12, 18, 24, and 30 months	R	R	R	Medicaid, all > 34 weeks' gestation		
Jacobson et al, <sup>84</sup> 1994	86H 48L 330 -	Cocaine exposure associated with faster postnatal weight gain in first 13 months, no effect on length or OFC	Weight, length, OFC	6.5 and 13 months	DC	DC	DC	All black, low socioeconomic status, at least 2 prenatal visits, > 32 weeks' gestation	Maternal age, welfare, education, parity, prepregnancy weight, birth weight, height, breastfed, prenatal visits, infant age, sex, gestational age	Breastfeeding associated with faster postpartum growth
Kilbride et al, <sup>89</sup> 2000	111 + 41 -	No cocaine effect	Weight, length, OFC	2, 12, 24, 36 months	C	C	R	All from same ZIP code, 36 weeks' gestation, no NICU care, women referred for drug treatment excluded	Placement, gestational age, maternal age and education, OFC at birth, birth weight	
Richardson et al, <sup>93</sup> 1996	28 + 523 -	No cocaine effect	Weight, height, OFC	6 years	DC	DC	DC	All in prenatal care by 5 months of pregnancy	Age, sex, height, ethnicity, current drug/alcohol use	

\* Across tables, abbreviations are explained at first mention only. Plus (+) indicates exposed to cocaine; poly, exposed to multiple drugs; minus (-), not exposed to cocaine; OFC, occipitofrontal head circumference; R, reported; C, controlled; DC, dose controlled; L, lighter; DC, dose controlled; and NICU, neonatal intensive care unit.

Table 2

## Standardized Cognitive Assessments\*

Study	No.	Cocaine Effect	Outcome Measures	Assessment Ages	Tobacco Use	Alcohol Use	Marijuana Use	Selection/Matching Criteria	Controlled Variables	Other Effects
Alessandri et al., <sup>63</sup> 1998	15H 19L 78 -	No cocaine dose effect on PDI, no cocaine main effect on MDI, but interaction of heavy cocaine with age associated with lower MDI	BSID-II	8 and 18 months	DC	DC	DC	All with biological mothers	Environmental risk, neonatal medical risk, sex	Among lightly exposed, increased environmental risk associated with decreased MDI
Azuma and Chasnoff, <sup>64</sup> 1993	92 + 25 poly 45 -	No cocaine effect	SBIS	3 years	R	C Analyzed as single category		All drug users in prenatal care by 15 weeks and in drug treatment	OFC, HSQ, perseverance, CBCL	Poor HSQ and poor perseverance associated with lower IQ
Chasnoff et al., <sup>70</sup> 1992	106 + 45 poly 81 -	Cocaine exposed not different from other drugs, but lower on MDI and PDI at 6 months than unexposed	BSID	3, 6, 12, 18, and 24 months	R	C Analyzed as single category		All drug users in prenatal care by 15 weeks and in drug treatment	Sex, OFC	Smaller OFC correlated with MDI at 12, 18, and 24 months, OFC at birth associated with PDI at 6 months and MDI at 24 months
Coles et al., <sup>71</sup> 1999	25 preterm + 32 full-term + 22 preterm - 26 full-term - 30 + 20 poly 30 -	No cocaine effect	BSID	8 weeks corrected for prematurity	R	R	R	Maternal age $\geq 19$ , English speaking, singleton or first-born twin, no O <sub>2</sub> <28 days, no seizures, no grade III or IV IVH, not breastfed	Maternal IQ	Maternal IQ associated with MDI
Graham et al., <sup>77</sup> 1992		No cocaine effect	BSID	19.7 months	R	R	C	Tobacco, marital status, obstetric history, ethnicity, self-referred to Mother Risk Counseling	Maternal IQ	Maternal IQ associated with MDI
Griffith et al., <sup>78</sup> 1994	93 + 24 poly 25 -	Cocaine-exposed lower than controls on verbal reasoning	SBIS	3 years	R	C Analyzed as single category; associated with decreased abstract reasoning		All drug users in prenatal care by 15 weeks and in drug treatment	Caregiver, child's sex, OFC, CBCL, and Summative Attention Scale of SBIS	Drug-free environment associated with better scores on verbal reasoning among cocaine-exposed
Hurt et al., <sup>79</sup> 1995	101 + 118 -	No cocaine effect	BSID	6, 12, 18, 24, and 30 months	C	C	C	Medicaid, all <34 weeks' gestation, cocaine use in at least 2 trimesters	Congenital syphilis, maternal age and education, foster care	Foster care associated with lower MDI at 18 months
Hurt et al., <sup>82</sup> 1997	71 + 78 -	No cocaine effect	WPPSI-R	4 years	C	C	C	Maternal age and education, gravidity, parity, prenatal care, sex, foster care	Maternal age and education, gravidity, parity, prenatal care, sex, foster care	



Study	No.	Cocaine Effect	Outcome Measures	Assessment Ages	Tobacco Use	Alcohol Use	Marijuana Use	Selection/ Matching Criteria	Controlled Variables	Other Effects
Hurt et al. <sup>83</sup> 1998	72 + 78 -	Neither prenatal nor concurrent maternal cocaine use associated with full-scale IQ ≤90	WPPSI-R	4 years	C	C	C	Medicaid	HOME, PCIS, sex, child age, foster care, day care/Head Start attendance, parental education, gravidity, parity, prenatal care, current cocaine use	Higher HOME scores and better PCIS associated with full-scale IQs above 90
Jacobson et al. <sup>85</sup> 1996	86H 48L 330 -	No cocaine effect	BSID	13 months	DC	DC	R	All black, all received prenatal care	Maternal age, depression, prenatal visits, HOME, parity, examiner, sex, age at test, continued maternal drug use	Birth weight associated with MDI at 12 months; with case management, children cared for by biological mothers have higher SBIS verbal scores; children in care of relatives have highest overall scores
Kilbride et al. <sup>89</sup> 2000	111+ 41 -	No cocaine effect	BSID, SBIS	6, 12, and 24 months (BSID); 36 months (SBIS)	C	C	R	All from same ZIP code, 36 weeks' gestation, no NICU care, women referred for drug treatment excluded	Placement, gestational age, maternal age and education, OFC at birth, birth weight	
Mayes et al. <sup>91</sup> 1995	61 + 47 -	Cocaine univariately associated with PDI, but not after multivariate control	BSID	3 months	C	C	C	All with biological mothers	Maternal age and education, OCS, prenatal care, birth weight, birth length, and OFC at birth	
Richardson et al. <sup>93</sup> 1996	28 + 523 -	No cocaine effect	SBIS, WRAT-R	6 years	DC	DC	DC	All in prenatal care by 5 months	Maternal ethnicity, IQ, current maternal alcohol/drug use, self-esteem, HSQ, child's grade	
Singer et al. <sup>96</sup> 1994	41 + 41 -	Lower MDI and PDI among cocaine exposed	BSID	16 months corrected for prematurity	R	R	R	All black, all receiving AFDC, severity of BPD, all VLBW	Chronological age at testing, IVH, foster placement	

\* PDI indicates Psychomotor Development Index; MDI, Mental Development Index; BSID-II, Bayley Scales of Infant Development, 2nd ed; SBIS, Stanford Binet Intelligence Scale; HSQ, Home Screening Questionnaire; CBCL, Child Behavior Checklist; BSID, Bayley Scales of Infant Development; WPPSI-R, Wechsler Preschool and Primary Scale of Intelligence-Revised; HOME, Home Observation for Measurement of the Environment; PCIS, Parent Caregiver Involvement Scale; OCS, Obstetrical Complication Scale; WRAT-R, Wide Range Achievement Test-Revised; AFDC, Aid for Families of Dependent Children; BPD, bronchopulmonary dysplasia; and VLBW, very low birth weight.

Table 3

Language Skills\*

Study	No.	Cocaine Effect	Outcome Measures	Assessment Ages	Tobacco Use	Alcohol Use	Marijuana Use	Selection/Matching Criteria	Controlled Variables	Other Effects
Bland-Stewart et al. <sup>69</sup> 1998	11 + 11 -	Delays in early semantic development, no effect on SICD-R score	SICD-R language sample	24 months	NR	NR	NR	Age, sex, foster care, maternal age and education		
Hurt et al. <sup>81</sup> 1997	76 + 81 -	No cocaine effect	PLS	2.5 years	NR	NR	NR	Medicaid		
Kilbride et al. <sup>89</sup> 2000	111 + 41 -	No cocaine effect	REEL, SICD-R	6, 12, 24 months (REEL), 36 months (SICD-R)	C	C	R	All from same ZIP code, 36 weeks' gestation, no NICU care, women referred for drug treatment excluded	Placement, gestational age, maternal age and education, OFC at birth, birth weight	Case management of children cared for by biological mothers associated with higher SICD-R scores

\* SICD-R indicates Sequenced Inventory of Communicative Development-Revised; NR, not reported; PLS, preschool language; and REEL, Receptive Expressive Emergent Language Scale.

Table 4

## Motor Skills

Study	No.	Cocaine Effect	Outcome Measures	Assessment Ages	Tobacco Use	Alcohol Use	Marijuana Use	Selection/Matching Criteria	Controlled Variables	Other Effects
Dempsey et al. <sup>74</sup> 2000	40 + 56 -	No cocaine effect	Neurologic examination	6 weeks	DC High doses associated with hypertension	C	C	Birth weight >2000 g, English speaking, maternal age >18, no NICU care	Ethnicity, adequacy of prenatal care, OFC, gestational age, homelessness	
Fetters and Tronick, <sup>75</sup> 1996	28 + 22 -	Higher total risk on the MAI at 7 months, lower mean percentile on AIMS at 7 months	AIMS, MAI, PDMS	1, 4, 7, and 15 months	C	C	R	Maternal education, maternal age >18, health insurance, ethnicity, birth weight >2000 g, no NICU care	Hobel score, cumulative risk index, child hospitalization and poor health, maternal education, ethnicity	
Fetters and Tronick, <sup>76</sup> 1998	28 + 22 -	No difference on PDMS, significant differences on prone and standing subscores of AIMS and primitive reflex score of MAI at 7 months	AIMS, MAI, PDMS	1, 4, 7, and 15 months	C	C	R	Maternal education, maternal age >18, health insurance, ethnicity, birth weight >2000 g, no NICU care		
Hurt et al., <sup>79</sup> 1995	101 + 118 -	No cocaine effect	Tone and reflexes	6 and 12 months	C	C	C	Medicaid, all >34 weeks' gestation, cocaine use in at least 2 trimesters	Congenital syphilis, maternal age and education, foster care	
Kilbride et al., <sup>89</sup> 2000	111 + 41 -	No cocaine effect	PDMS	6, 12, 24, and 36 months	C	C	R	All from same ZIP code, 36 weeks' gestation, no NICU care, women referred for drug treatment excluded	Placement, gestational age, maternal age and education, OFC at birth, birth weight	
Swanson et al., <sup>97</sup> 1999	48 + COC3 72 + COC12 186 -	Higher full-scale MAI total risk, COC3 associated with less optimal volitional movement than COC12, COC3 at higher risk for neuromotor dysfunction than unexposed but COC12 is not	MAI	4 months	DC	DC	DC	Maternal age >17, gestational age ≥37 weeks	Prenatal visits, infant sex and age, parity, ethnicity, maternal age and education, marital status, income	Prenatal care decreased association between cocaine exposure and primitive reflexes and volitional movement to nonsignificant

\* MAI indicates Movement Assessment of Infants; AIMS, Alberta Infant Motor Scales; PDMS, Peabody Development Motor Scales; COC3, cocaine use in third trimester; and COC12, discontinued cocaine use before third trimester.

Table 5

## Behavior, Attention, Affect, Neurophysiology\*

Study	No.	Cocaine Effect	Outcome Measures	Assessment Ages	Tobacco Use	Alcohol Use	Marijuana Use	Selection/Matching Criteria	Controlled Variables	Other Effects
Alessandri et al, <sup>62</sup> 1993	36 + 36 -	Cocaine associated with fewer positive emotions, less arousal, and less instrumental responding No cocaine effect	Instrumental responses and facial expressions during learning	4, 6, or 8 months	R	R	NR	Sex, birth order, maternal age, all with biological mothers, all receiving AFDC, all black, all with <high school All with biological mothers	Beck Depression Inventory and Life Events Survey	
Alessandri et al, <sup>63</sup> 1998	37H 30L 169 -	No cocaine effect	Habituation	8 months	DC	DC	DC	All drug users in prenatal care by 15 weeks and in drug treatment		Smaller OFC associated with more externalizing behavior
Azuma and Chasnoff, <sup>64</sup> 1993	92+ 25 poly 45 -	No cocaine effect	CBCL externalizing scale	3 years	R	C	C			Term status associated with higher arousal and with arousal modulation of respiratory rate and arousal of heart rate
Bard et al, <sup>65</sup> 2000	27 preterm + 39 full-term + 23 preterm - 29 full-term -	None on behavioral state or heart rate; higher baseline respiratory rate and better arousal modulation in full-term infants, and poorer arousal modulation in preterm infants; preterm exposed are no more dysregulated than full-term unexposed	Arousal and arousal modulation in heart rate and respiratory rate	8 weeks corrected for prematurity	DC	DC	DC	Maternal age ≥19, English speaking, singleton or first-born twin, no O <sub>2</sub> >28 days, no seizures, no grade III or IV IVH, not breastfed	Quality of caregiving, maternal psychosocial resources, term status	
Bendersky and Lewis, <sup>66</sup> 1998	24H 17L 66 -	Heavily exposed showed less joy and more negative expressions during reengagement	Still face paradigm	4 months	DC	DC	DC	All with biological mothers	Maternal vocalization, maternal sensitivity, Environmental Risk Score, Contingent Responsivity Score, neonatal medical complications	Maternal sensitivity associated with both joy and negative expression; neonatal medical risk and maternal vocalization associated with joy
Betancourt et al, <sup>67</sup> 1999	7 + 81 -	No cocaine effect	Goodman Lockbox	3.5 and 4.5 years	C	C	C	Medicaid, all >34 weeks' gestation	Gestational age, birth weight, IQ, preschool experience	
Blanchard et al, <sup>68</sup> 1998	26 + 23 -	No cocaine effect	Qualitative behavioral ratings during motor testing	1, 4, and 7 months	C	C	C	Maternal education, maternal age >18, health insurance, ethnicity, birth weight >2000 g, no NICU care	Maternal age, parity	Child age associated with examiner's persistence and maternal parity with interruptions

Study	No.	Cocaine Effect	Outcome Measures	Assessment Ages	Tobacco Use	Alcohol Use	Marijuana Use	Selection/Matching Criteria	Controlled Variables	Other Effects
Coles et al, 71 1999	25 preterm + 32 full-term + 22 preterm - 26 full-term -	Increased heart rate to social stimulation	Heart rate response to auditory, visual, and social stimulation	8 weeks corrected for prematurity	C	C	C	Maternal age $\geq 19$ , English speaking, singleton or first-born twin, no O <sub>2</sub> >28 days, no seizures, no grade III or IV IVH, not breastfed	Caregiving potential, quality of caregiving	Caregiving instability explained more variance than cocaine exposure, preterm drug-exposed had least optimal response
Delaney-Black et al, 72 1998	27 + 75 -	1-Tailed cocaine effect on problem behaviors and daydreaming, but no effect on Conners Scale total	Conners Teachers Rating Scale and Problem Behavior Scale	72-90 months (6-7.5 years)	C	DC	NR	All black	Child's sex	Child's sex male, current lead level, exposure to violence, older age, custody change, caregiver marital status, and current caregiver drug use associated with less optimal scores
Delaney-Black et al, 73 2000	201 + 270 -	None with standard scoring method, but higher Externalizing-Internalizing Difference Score in cocaine exposed	Teacher Report Form of CBCL	6 years	DC	DC	C	All black, all with prenatal care, children with mental retardation excluded	Child's sex, custody changes, exposure to violence, current lead level, current caregiver drug use, socioeconomic status, marital status	Child's sex male, current lead level, exposure to violence, older age, custody change, caregiver marital status, and current caregiver drug use associated with less optimal scores
Graham et al, 77 1992	30 + 20 marijuana 30 -	No cocaine effect	Vineland Social Maturity	18 months	R	R	C	Marital status, obstetric history, ethnicity, self-referred to Mother Risk Counseling	Maternal IQ	
Griffith et al, 78 1994	93 + 24 poly 25 -	Similar to polydrug effects, but both show more aggressive and destructive behavior	CBCL	3 years	R	C	C	All drug users in prenatal care by 15 weeks and in drug treatment	Child's sex, drug-free caregiver	
Hurt et al, 80 1996	83 + 93 -	No cocaine effect	Free play	18 and 24 months	C	C	C	Medicaid	NICU admission, age at testing, foster care	
Jacobson et al, 85 1996	86H 48L 330 -	Heavy cocaine exposure associated with poor visual memory on Fagan Test at 6 and 12 months and faster responsiveness on Visual Expectancy at 6 months	Fagan Test of Infant Intelligence; Visual Expectancy Paradigm	6 and 12 months	DC	DC	R	All black, all received prenatal care	Maternal age, depression, prenatal visits, HOME, parity, examiner, infant's sex, age at test	
Jacobson et al, 86 1999	29 + 57 -	Cocaine exposed had lower basal	Cortisol levels before and after venipuncture	13 months	DC	DC	DC	All black, all received prenatal care	Milk, teething, pacifier, birth size,	New teeth, maternal

Study	No.	Cocaine Effect	Outcome Measures	Assessment Ages	Tobacco Use	Alcohol Use	Marijuana Use	Selection/Matching Criteria	Controlled Variables	Other Effects
Johnson et al, <sup>87</sup> 1999	53 + 37 -	cortisol prestress, but not poststress level	CBCL	24 months	NR	cortisol, heavy exposure to poststress elevation	NR	All Hispanic or black	maternal verbal ability, age at test, postpartum drug use, ego maturity, caregiver depression	depression, AFDC associated with higher basal cortisol; age at visit, maternal verbal ability with poststress cortisol Maternal stress and social support associated with total internalizing and externalizing behavior; depression with externalizing behavior problems CNS injury associated with neonatal pattern of attention Omission predicted by lower child SBIS IQ and age, and mother more hostile and not working; commission predicted by child's male sex, male in household, and lower SBIS IQ
Karmel et al, <sup>88</sup> 1996	46 + 147 - 162 - with CNS injury	No cocaine effect	Arousal modulated visual attention	4 months corrected for prematurity	NR	NR	NR	Cocaine-exposed had normal BAER and cranial ultrasounds	Arousal condition	
Leech et al, <sup>90</sup> 1999	26 + 582 -	Cocaine associated with increased errors of omission	CPT	6 years	DC	DC	DC Associated with more errors of commission, fewer of omission	All in prenatal care by 5 months	Ethnicity, child's sex, illnesses, hospitalizations, SBIS IQ, HSQ, maternal work status, life events, hostility, maternal age, male in household, current caregiver alcohol/drug use	
Mayes et al, <sup>91</sup> 1995	61 + 47 -	No effect on visual habituation, more cocaine-exposed too irritable to start procedure	Visual habituation	3 months	C	C	C	All with biological mothers	Maternal age, education, OCS, prenatal care, birth weight, length, OFC	
Mayes et al, <sup>92</sup> 1997	43 + 17 poly 21 -	Less readiness for interaction at 6 months	Face-to-face interaction	3 and 6 months	C	C	C	All with biological mothers	Maternal age and education, infant's sex, OCS, infant size at birth	
Richardson et al, <sup>93</sup> 1996	28 + 523 -	No cocaine effect	Teacher Report Form of CBCL	6 years	DC	DC	DC	All in prenatal care by 5 months	Ethnicity, child's IQ and grade, current maternal alcohol/drug use	

Study	No.	Cocaine Effect	Outcome Measures	Assessment Ages	Tobacco Use	Alcohol Use	Marijuana Use	Selection/Matching Criteria	Controlled Variables	Other Effects
Roumell et al, <sup>94</sup> 1997	14 + 16 -	Cocaine associated with less facial emotion Third-trimester exposure associated with reduced spectral $\theta$ energies; no sleep effects	Facial expression coding after inoculation	18 months	R	R	R	Hospital payment, maternal education, all black		
Scher et al, 95 2000	37 + 34 -		Quantitative EEG	Day 2, 1 year	DC Increased indeterminate sleep, increased arousal	DC Decreased indeterminate sleep and $\delta$ energies, increased REM and spectral correlation	DC Increased arousal, decreased $\beta$ energies	Full-term, Apgar score >5, mother in prenatal care by 5 months, no general anesthesia	Child's sex and age, ethnicity, number of hospitalizations, maternal age	

\* CNS indicates central nervous system; BAER, brainstem auditory evoked responses; CPT, Continuous Performance Test; EEG, electroencephalogram; and REM, rapid eye movement.