POINT / COUNTERPOINT

Is Exposure to Secondhand Smoke Child Abuse? No.

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Children should be protected from the toxic effects of secondhand smoke. Cigarette smoking is dangerous for the fetuses of pregnant mothers and, as a growing number of studies show, environmental tobacco smoke (ETS) is a significant correlate with childhood illness and mortality.[1] As with any parental behavior that does not maximize child well-being, the question is not whether we should be concerned about children's exposure to ETS, but how to best respond to this troubling occurrence. Expanding definitions of child abuse to include ETS exposure, while understandable based on our desire to guard children from harm, is not the answer because it reinforces a punishment orientation towards addiction that harms both child and family.

The question of whether to refer a family to the child welfare system for an ETS-based allegation of child abuse depends on one's view of addiction—is it an illness that requires treatment or a moral fault that demands social control and sanction through a systemic response? For pregnant mothers, the Centers for Disease Control (CDC) recommends a nonjudgmental approach by health care providers that focuses on counseling the mother about the health effects of smoking and provides resources to assist her with stopping.[2] The CDC recommendations for pregnant mothers rest on an assumption that addiction is a treatable health condition. Viewing ETS as a form of child abuse presumes that children can better be protected by using child welfare to sanction and change parental behavior. A parallel effort was made in the late 1980s and 1990s to protect infants by punishing mothers who were engaged in illicit drug use (primarily the use of crack cocaine) by either prosecuting them criminally or mandating that these women be reported to child abuse authorities.[3] While also motivated by the desire to protect children, these efforts had dubious effects in terms of ensuring the safety of the children they were intended to protect.[4,5] Treating smoking as a form of child abuse may have unintended consequences such as causing people to hide information from their health care providers[6] and to potentially avoid health care altogether for fear of losing one's children.[3]

Taking children from their parents and placing them in out-of-home care based on a substantiated report of child abuse assumes that foster care is safer and healthier for a child than living with one's parents and family. This assumption may be true in some cases, but referral to the child welfare system also makes children vulnerable to other potential harms from their out-of-home care arrangement and the psychological stress that arises when they are separated not only from parents, but potentially from siblings and other extended family members.[7,8] The assumption underlying treating ETS exposure as a form of child abuse does not take into account the traumatic nature of out-of-home placement in foster care as another harm that needs to be weighed when considering how to intervene to keep children safe.

A punitive approach to ETS reinforces other patterns of systemic inequalities that affect both children and their families. Although smoking rates have been cut in half since the 1960s, about 20% of US adults continue to smoke.[9] Smoking is not equally distributed in society. As smoking-related stigma has intensified, fewer well-educated, high-income people smoke.[10] Almost twice as many adults who live below the federal poverty line smoke as those above the poverty line,[4] and this differential distribution of smoking has remained consistent for several years.[11,12] Research on poverty clearly demonstrates that women and people of color are more likely to be poor.[13] Making ETS exposure a form of child abuse is a policy recommen-

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dation that will fall primarily on the low income population and will disproportionately affect the children of people of color, reinforcing disparities in both child welfare and health care.

Evidence from the Adverse Childhood Experiences studies suggests that clinicians need to reformulate their understanding of smoking. People who experienced child maltreatment or other forms of dysfunction were much more likely to smoke in a dose-response relationship—those with the highest level of childhood trauma exposure were the most likely to smoke.[14,15] The parents who are smoking today are likely the traumatized children of yesterday[16]—this understanding, if truly embraced, would help us to address one of the root causes of smoking and provide support for smokers to change behaviors that are themselves the result of trauma.

Smoking cessation programs are more effective than doing nothing to help parents stop,[17-19] but not all people who need treatment are getting access to this help.[20] Effective care is not merely telling parents they should stop smoking. Research on addiction treatment suggests that people work through a process of change before stopping smoking, and that they are most effectively helped with interventions tailored to their current stage of change.[21] Clinicians who use evidence-based practices such as motivational interviewing[22] can successfully elicit the person's own ambivalence about stopping smoking, reinforce their desire to change, and help them negotiate barriers to smoking cessation. Unfortunately, very few parents who smoke are receiving these kinds of interventions from pediatric care providers. Until we know that parents have received adequate collaborative treatment, we should not resort to further sanctions by treating their behavior as a form of child abuse.

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