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ABSTRACT

This bulletin issue addresses the theme of drug-exposed infants and the services required by these infants and their families. "Cocaine-Exposed Infants: Myths and Misunderstandings" (Barbara J. Myers and others) comments on the negative accounts of drug-exposed babies presented by mass media and reviews the mix of positive and negative findings actually revealed by research. "Interventions To Strengthen Relationships between Infants and Drug-Abusing or Recovering Parents" (Jeree H. Pawl) presents case studies to illustrate that, to improve the lives of young children and parents affected by drug use, practitioners need to pay as much attention to the qualities of the relationship of parent and child as to the drug use itself. "Integrating Parent Support into Residential Drug and Alcohol Treatment Programs" (Cathie Harvey and others) describes inservice training for staff members and workshops for resident mothers who are addicted to alcohol and drugs. "Foster Parenting the Drug-Affected Baby" (Ellen White) examines the types of support that help foster parents care for drug-affected infants, sources of such support, and strategies to find supports that are not readily forthcoming. "Working with Addicted Women in Recovery and Their Children: Lessons Learned in Boston City Hospital's Women and Infants Clinic" (Margot Kaplan-Sanoff and Kathleen Fitzgerald Rice) describes a "one-stop shopping" model to offer health services for parent and child, developmental services, drug treatment, and case management for cocaine-exposed children and their drug-involved families. "Peer Support for Service Providers" (Sandy Sachs) describes a peer support group developed for early intervention providers in substance abuse treatment programs. "Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effects (FAE): A Lifespan View, with Implications for Early Intervention" (Heather Carmichael Olson and others) helps care providers shape realistic expectations and gives new ideas for their work with fetal alcohol-affected children and their families. "Tobacco Control Advocacy: Winning the War on Tobacco" (Michele Bloch) reviews the health hazards and demographics of tobacco use and discusses the tobacco industry's strategies to oppose health promotion. The bulletin also reviews publications and videotapes, describes activities of the Zero to Three/National Center for Clinical Infant Programs, and lists upcoming conferences. (JDD)

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National Center for Clinical Infant Programs

Volume 13 No. 1 August/September 1992

Cocaine-Exposed Infants: Myths and Misunderstandings

NANCY P. ALEXANDER

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What do we really know about cocaine-exposed babies? Are they terribly damaged from birth with disabilities that will affect them all their lives? Is cocaine a teratogen that affects the development of limbs, organs, brains, and emotions? Or is this picture a distortion of the small amount of available research findings? New research findings are emerging almost every day. It is hard to know what to think, for what we knew yesterday is changed in today's press, and what we read today is most likely already out of date. *The simple truth at this point is that we do not yet know what the effects are of prenatal cocaine exposure.*

What does the media publish?

The popular press has covered this emotional topic frequently for a public which is deeply concerned for the welfare of these children. In the effort to spread information widely, the media tend to present a simple, brief, and dramatic picture. This may be an effective way to motivate people into action, but a careful eye is needed to watch for oversimplification, especially since it is common in the media to present individual worst-case stories and then draw broad generalizations.

Most of the media presentations have been decidedly negative in their accounts of drug-exposed infants. Titles of articles sound an alarm before the story begins. Some capitalize on fears about crack cocaine: "Crack Comes to the Nursery" (*Time*, Sept. 19, 1988); "Crack in the Cradle" (*Discover*, Sept. 1989). Others point to an alleged addiction which the babies are born with (a hypothesis no longer supported by most studies of cocaine-

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exposed infants): "Cocaine Babies: Hooked at Birth" (*Newsweek,* July 28, 1986); "I Gave Birth to an Addicted Baby" (*Good Housekeeping,* April, 1990); "Kids Who Can't Say No" (*Readers's Digest,* February, 1991). Some articles stigmatize these children. *The Washington Post* referred to cocaine-exposed babies as a "bio-underclass", a "potential human plague almost too horrible to imagine" (Sept. 17, 1989).

Magazines and newspapers often begin their articles with heart-wrenching accounts of a single baby who is severely affected, presumably as a result of drug exposure. Those of us who work with infants with disabilities will recognize early signs of trouble and feel a sympathetic connection with the infants and what they face. We should be aware, though, of exaggerations. For example, "Guillermo, a newborn at Broward General Medical Center in Ft. Lauderdale, has spent his whole short life crying. He is jittery and goes into spasms when he is touched. His eyes don't focus. He can't stick out his tongue, or suck. Born a week ago to a cocaine addict, Guillermo is described by his doctors as an addict himself" (*Newsweek,* July 28, 1986). *(A baby who has spent his whole life crying? Does that seem accurate? Is this story really a typical one? Does this account stigmatize Guillermo?)* Or consider the account of an infant named Robert: "Most of the babies at Highland General Hospital in Oakland, California, are asleep at this hour. But little Robert, brought in by his mother, has been awake for days. He cries inconsolably, and his tiny limbs jerk and jitter constantly. Periodically, his hands fly back to the sides of his head and his large, dark eyes freeze wide in startled terror .... At birth, the infant plunged into a nightmarish withdrawal from drugs used by his mother" (*Readers Digest,* February, 1991). *(Is it possible for an infant to be awake for days? Is he seeing nightmares, or are his hands moving up in a simple Moro reflex?)*

In addition to watching out for oversimplification and exaggerations, readers of these articles should remember that study of drug effects is very complex. A first question to ask is how probable it is that disabilities, if and when they are found, are a result of the cocaine exposure. Certainly many babies who are born with disabilities were never exposed to drugs; often, the cause for the problem is never known. When cocaine-exposed infants show disabling conditions, we cannot be certain that prenatal cocaine was responsible. Cocaine-exposed infants, like any other infants, may have parents with previously undetected recessive genetic abnormalities. Their mothers may have avoided prenatal care to escape detection of their drug dependence, and so a variety of obstetrical complications and other health problems might have been left untreated. The mothers may have eaten poorly during the pregnancy and not taken their prenatal vitamins. Most cocaine-using mothers are polydrug users: They drink alcohol, or smoke cigarettes, or use marijuana, or use a variety of prescription or street drugs, cut with a variety of substances. And substance-using women, like any other group of women, can have babies with problems whose cause is unknown. Given this complicated

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course of prenatal history, it is premature to link every problem shown by a cocaine-exposed infant to the cocaine. Cocaine may indeed have played a role in an infant's problem, but cocaine is just one of the risks, known and unknown, to which these babies were exposed.

Many articles in the media focus on the long-term effects of cocaine exposure. At times it seems that articles are discussing events that have been well documented. Yet studies of cocaine-exposed infants have not followed these children past age three or four, and most studies are of newborn infants. In *The New York Times* (Sept. 17, 1989), for example, we read, "... studies suggest that without help, the children of addicted mothers may be unable to develop into adults with basic employment skills and unable to form close human relationships." *(Adults without basic employment skills? And unable to form close human relationships? These assertions cannot come from anyone's data, as nobody has followed children that far.)* On the same day, *The Washington Post* noted, "Already, a few [cocaine-exposed children] are turning up in first- and second-grade classrooms around the country, wreaking havoc on themselves and others. Severe emotional damage and even physical deformities not so readily apparent today may mushroom in the near future. The children's irritability and anger—along with their need for love and understanding—will surely grow." *(This article appeared before the group of cocaine-exposed children were old enough to enter school. Why are irritability and anger expected outcomes? Why should there be problems tomorrow—"emotional damage and physical deformities"—which are not apparent today?)* An education journal written for popular use also predicts the future for children exposed to cocaine: "In the typical classroom environment ... cocaine-exposed children tend to react in one of two ways. They withdraw completely, or they become wild and difficult to control" (*The Education Digest*, May, 1990). *(One must read this article carefully to pick up that the author is talking about her own predictions of the future.)* We need to be careful not to create ideas to fill the gaps in our knowledge, especially when we have strong feelings about the topic and want to know the answers now.

What does the research show?

In contrast to these disturbing popular accounts, available research on drug-exposed infants shows a mix of findings: In some studies, especially those published early on, cocaine-exposed infants were found to be different from (and "worse" than) comparison infants. But many studies detect no differences between cocaine-exposed and non-exposed infants, and that is important to know. These "no difference" studies are not readily published in professional journals or noted in the press. Indeed, Koren et al. (1989) documented that research studies which found that substance-exposed infants were *not* different from non-exposed infants were significantly more likely to be rejected for presentation at scientific meetings than were studies which found the substance-exposed infants *to* be different.

Editor's note;

In June, 1989, *Zero to Three* for the first time devoted an issue to drug-exposed infants and their families. In the introduction to that issue, we wrote:

> Our field and society have much to learn about supporting the optimal development of drug-exposed infants and their families. As in any work with children and parents, we need to be guided by careful, empathic attention to the unique experience of each infant and parent. This quality of thoughtful attention is, we believe, the hallmark of the articles in this issue.

We are equally impressed by the thoughtful attention of the contributors to this August/September, 1992 issue of *Zero to Three*. These writers document not only the experience of substance-involved young children and families, but also the quality of their own ongoing experience as foster parents, researchers, advocates, and front-line practitioners. They recognize how much we still have to learn about the developmental impact of substance abuse (and how difficult it is to act when new research findings emerge daily). They also say clearly that partnership and support of each other, as well as of infants and families, offer our best hope.

Two current research review articles give in-depth and readable examinations of the many research articles published through 1991 (Neuspiel & Hamel, 1991; Myers, Britt, Lodder, Kendall, & Williams-Petersen, in press). Both articles agree that the only finding which seems substantiated across many well-controlled studies is that babies who are prenatally exposed to cocaine are at risk for being younger and smaller at birth: This includes lower birth weight, birth length, head circumference, and gestational age. Cocaine-exposed babies were more likely to have shorter gestation (and thus to be premature); some were also found to be small for gestational age (SGA). Prematurity, SGA, and low birth weight are all risk factors for a variety of poor outcomes, whether or not cocaine has played a role. Thus, when cocaine-exposed children who were born too early or too small have problems, it is difficult to untangle what is the direct, and the indirect, cause. Certainly, cocaine plays at least an indirect causal role in this instance. Even though cocaine exposure places an infant at higher *risk* for prematurity and low birth weight, many exposed infants are born full-term and at appropriate weight. In fact, *the large majority of exposed infants are not premature and not low birth weight*, especially in programs which offer good prenatal care and nutrition education.

For many areas of infant development, one study shows infants exposed to cocaine to be different from comparison infants, while the next study finds no difference. We find this for areas as disparate as incidence of stillbirths, SIDS, anomalies of various organ systems, neurological abnormalities, newborn behavior as measured by the NBAS (Neonatal Behavioral Assessment Scale), social-emotional functioning, and parenting practices.

Why do scientists arrive at such different answers to straightforward questions? As researchers, we point to the methodological problems which accompany this difficult area of study. Although research design questions may seem boring and technical, they are at the heart of our difficulty in answering the complex questions posed by prenatal substance exposure.

Methodological problems in studying prenatal substance exposure

The answers we get about any research question depend in large part on how the research study is structured and conducted. The "ideal" for research is to conduct a true experimental study, with participants randomly assigned to one of several conditions. But random assignment to drug use or nonuse is obviously impossible and unethical. Some "less than perfect" methods are a necessity right from the start. Still, there are steps that can be taken to improve the validity and reliability of research in this area.

A first area of concern is who are the subjects in the study. Consider the following case: A 30-year-old white paralegal started using cocaine in the late 1970's because she thought it wasn't addictive. Concerned about her weight, she wanted to get high on fewer calories than alcohol supplied. Now a successful lawyer, she attends 12-step meetings at lunchtime and is in recovery. Although cocaine is used by people of all social classes and ethnic groups, this middle-class lawyer would not end up as a subject in a typical research project. There are currently *no* published studies of middle- and upper-class cocaine-using mothers and their infants. Rather, low-income women and their infants make up the study populations. This means that conditions of poverty get mixed up with effects of cocaine exposure. In addition, studies often use groups of women who are enrolled in ongoing drug treatment and recovery programs. These mothers are the healthiest, most stable, and most self-aware of low-income drug-using women. Thus we miss out on knowing about both upper-income women and the less motivated of the lower-income women—the two groups which are probably the "best" and the "worst" of the substance-using population in terms of health, stability, and personal resources. We cannot study babies whose mothers do not want to be studied or for whom no active research study is available.

Researchers have also learned that ascertaining drug use is a very challenging task. Drug users often deny their drug involvement (indeed, "denial" is one of the signs that the individual is in trouble with drugs or alcohol). In some states, admission of drug use is enough to prompt criminal proceedings, so denial may keep a mother out of jail or keep her children from being taken from her. Urine toxicology identifies traces of the drug or its metabolites from use only in the past 2-3 days, and so many users plan ahead and abstain prior to scheduled clinic appointments. Thus, many studies undoubtedly report data from a few drug users mixed in with the non-users. Even when drug use is admitted or discovered, it is difficult to establish the frequency, quantity, quality, type, and timing of substances used. Dose-effect relationships in the human fetus are nearly impossible to establish. Polydrug use, including opiates, marijuana, alcohol, nicotine and prescription drugs, is probably the most common pattern, yet this makes the job of untangling effects even more challenging. We know that smoking significantly reduces birth weight, and that alcohol is a teratogen. It is rare to find a woman who used cocaine during her pregnancy who did not also drink, smoke, or use other drugs; rarer still would be such a woman who also ate well, had good prenatal care, and had a stable and supportive home life. There are a thousand and one individual patterns, which underscores the need to treat each woman and her baby as a unique and individual dyad.

Should the professional who examines a baby know that drug exposure has taken place? While this knowledge may be valuable clinically, it can influence findings in a research study, and so the ideal is to have examiners who are blind to exposure status. Many studies fail to keep examiners blind, and so there is a threat of the examiners' expectations affecting findings. This implies that non-exposed infants are being studied at the same time and in the same setting. Many times there is no comparison group, or the comparison group is different on a number of factors other than cocaine exposure. Comparison groups need to be drawn from the same community as the cocaine-using sample, so that differences which really come from local customs, social class, health practices, and ethnicity are not unknowingly confused with the effects of the cocaine exposure.

After the baby is born and goes home, the caregiving environment becomes critically important. What is a cocaine-user's home environment like? It is no doubt a widely diverse picture, from suburban subdivisions to crowded apartments to shelters for the homeless, but our research at this point offers little information. From a research perspective, it is important not to confound results which stem from prenatal chemical exposure with results which come from how a baby is raised. This area is critical, but we know very little about how the caretaking environment(s) of substance-exposed infants impact their development.

Research with families in which substances are abused is expensive and difficult to do. Even the most well-seasoned and devoted team of researchers can become overwhelmed with both the scientific problems and the personal drain that this work presents. Cocaine-using mothers are a diverse group, and this diversity sometimes includes situations of extreme poverty, unstable lifestyles, and personal danger. Any critical assessment of research in this field should compliment those individuals who are doing the best they know how in a difficult situation.

Continued research in the area of perinatal substance exposure is needed, especially research which is well-designed and carefully conducted. The National Institute of Drug Abuse is currently funding such research. Twenty programs (referred to as the "Perinatal 20") are participating

in treatment-research demonstrations involving adult and adolescent pregnant and postpartum women and their children. These sites are working together to share ideas and techniques in an effort to provide sound answers to some of the questions about substance-exposed children and which treatment models are the most effective in producing favorable outcomes for both mother and child.

What is our model of cocaine effects?

With our current state of knowledge, most researchers in this area now view this group of children using a risk model, not a deficit model. That is, we recognize the various risks—biological, environmental, interpersonal—which individuals are subject to, and we also recognize the many strengths and protective factors which individuals may have available. Whether a risk factor such as cocaine exposure shows an impact upon a child's health or behavior depends on the complex interplay of all the risk factors and protective factors. Cocaine exposure is no doubt a biological risk factor, and many prenatally-exposed infants will have other risk factors at work as well. Certainly there are a great many such children whose prenatal care was inadequate, whose lives are chaotic, whose neighborhoods are dangerous, whose diets are terrible, and whose parents are emotionally unavailable to them. But most children also have some protective factors which can soften and relieve the stressors. These might include their general good health, easy temperament, a loving grandparent, a safe and appropriately stimulating home, a mother who loves and cherishes her child, or a community which provides adequate health and intervention services. Whether an individual child shows negative effects of cocaine exposure depends on the complex and ever-changing interactions among all the risk factors and protective factors in the child's life. This model is a graceful one that embraces each of us—every baby, every child, every adult. Not only is it philosophically satisfying, it also is supported by the data. Assessments of children which take into account a great many biological, environmental, and personal factors, and the ongoing changes in these forces, provide a more accurate prediction of child outcome than do static measures of isolated variables.

What can professionals who work with infants and young children do in the meantime? We cannot wait until all of the research is documented, because large numbers of infants prenatally exposed to drugs are born every day and some may be referred to us for evaluation or services. Here are some suggestions:

(1) Accept that the full picture is not yet known about substance-exposed babies.

(2) Remember the diversity of substance-using families, and be sensitive to the individual mother and her baby.

(3) Resist believing the stereotypes and participating in the stigmatization of drug abusers. Truly accept that it could be you, it could be your sister.

(4) Work from a risk and protective factors model, not a deficit model. Identify the positive factors in infants' and mothers' lives, as well as the problems.

(5) Think in terms of polydrug exposure, not just cocaine exposure. Be especially aware of alcohol effects and cigarette smoking.

(6) From what we know so far, the supports and interventions that substance-exposed infants need are no different from what other babies need. The interventions you offer need to be sensitive to the family's culture, but you will not need a special set of materials and activities for these babies.

(7) Chemical dependence adds new dimensions to what the family needs. As infant interventionists, we need to expand our own training to include knowledge and experience in the course of addiction and recovery. We need to become partners in our communities with agencies that provide substance abuse treatment if we are to be effective advocates for the infants and families we serve.

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Interventions to Strengthen Relation
Drug-abusing or Recovering Parent

Jeree H. Pawl, Ph.D.

From the significant relationships we have as we develop, we all learn about the world—what it's like, what we can expect, how benign and malevolent it is, and, equally important, what it thinks about us. The ways in which we are treated are messages about who we are and about how people in the world behave. It does not require the complication of drug abuse for a parent-child relationship to be troubled. Yet the abuse of drugs does interfere with a parent's ability to respond and care for a child in appropriate ways—moment-to-moment, and across the months and years of childhood. Just as parents who do not use drugs may have significant problems in taking appropriate care for their children, so do parents who are using or who are in recovery—not only because of the drug use but because of how they experience themselves and their children. If we hope to improve the life chances of young children and parents who are affected by drug use, we need to pay as much attention to the qualities of the relationship of parent and child as to the drug use itself.

Sharon and Larry

Some time ago, the Department of Social Services asked the Infant-Parent Program at San Francisco General Hospital to evaluate the nature of the relationship between a mother, Sharon, and her son, Larry. Sharon was a single mother who had lost custody of Larry when he was two years old as a result of leaving him with a friend of hers for a number of days—a friend who had agreed to keep Larry only for several hours. When, after five days, Sharon failed to appear to claim her son, Sharon's friend angrily called the Department of Social Services. A worker picked Larry up and placed him in an emergency shelter.

Sharon was located and found to have no stable living situation. She was using drugs, was functioning very poorly in general, and was utterly miserable. She felt hopeless and discouraged, but the one powerful, positive thing she felt was her love for Larry. She wanted her son back with her. Larry was a relatively well-functioning two-year-old, but was currently showing signs of depression and anxiety that seemed to stem in large part from the separation from his mother. He missed her.

Over the course of ten weeks, in which we met with Sharon and Larry to try to get a sense of their relationship, Sharon missed several appointments without explanation. At other times she arrived but was clearly under the influence of drugs. She was unable to make use of services that would help her find a stable living situation. But there was something else that was also strikingly true.

We had been asked to look at the quality of Sharon and Larry's relationship. It was strong, markedly resilient, and often a pleasure to observe. On those occasions when Sharon was not using, her moment-to-moment interaction

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Since no treatment facility existed where Sharon and Larry could be together, we and the Department of Social Services worked diligently both with the residential drug treatment center and with a potential foster home to ensure that Sharon could be with Larry for at least two hours, two times each week, from the beginning of her treatment. Initially these visits would be at the residential center and, later in her treatment, at the Infant-Parent Program.

Sharon spent one of the two hours of each visit with Larry and the Infant-Parent Program therapist and one hour alone with Larry. Mother and son needed private and uninterrupted time to be together, as well as treatment. In addition to working with Sharon to understand more about her drug abuse, we wanted to help her sort through her feelings about the separation from Larry. We also wanted to help her support and understand Larry's response to the continued separation which he needed to endure and his growing affection for his excellent foster mother. In addition, the Infant-Parent Program therapist supported the foster mother as she thought about how to respond to Larry in ways that would best provide understanding of his mother's absence and continuity for him through the week. He was helped to express his sometimes angry, sometimes sad feelings, and he was appropriately comforted by his mother and his foster mother. A framed picture of Larry and his mother, taken by the Infant-Parent Program therapist, was a central feature of his bedroom. The foster mother and Larry marked a calendar each night to help him develop some sense of time and clearer expectations about when he would be able to see his mother again. All of these efforts helped keep the sturdy relationship between Larry and Sharon alive, even as they were separated, and helped Larry know what to expect.

After 11 months, Sharon's transition back into the world and the actual reunification between Larry and Sharon received the same kind of careful attention. Mother and son continued to receive support and continued therapy until they had been functioning effectively together and Sharon had been managing well in the world for nine months more. At the time of termination, Sharon remained involved in several recovery programs. Larry was in child care, Sharon was working and taking classes, and follow-up has been consistently positive.

The effort was considerable on everyone's part. It was expensive. It was time-consuming. This was true even though Sharon was basically a competent and well-disposed parent. The drug use itself, its consequences, and the attendant separation from Larry necessitated enormous effort. But it was totally worth the cost. Sharon is self-supporting. Larry is well-functioning and is far more likely than not to become a self-supporting, productive adult. Certainly Larry feels good about himself. It is worth noting, too, that it was the infant-parent psychotherapy evaluation that led to Sharon's decision to seek serious drug treatment for herself.

Sally and Beth

Our experience with Sally was a different one. She was referred to us after she and her daughter, Beth, had been reunited following a separation of 10 months, beginning when Beth was two months old. Chronic neglect had been the issue. At the time of referral to the Infant-Parent Program, Sally had graduated from an out-patient drug program, attended Narcotics Anonymous regularly, and had completed two separate parent effectiveness courses. She had acquired a new set of friends, had a place to live, and was attending a computer training program. She was believed to be abstinent, continued to appear to be drug-free, and tested so. She had done everything she was supposed to do.

Despite all this, the Department of Social Services social worker felt uncomfortable about the relationship between Sally and Beth. Sally seemed to be constantly impatient with Beth, who was now 12 months old and very active. Sally had seen Beth only occasionally during their separation, since Beth had been placed out of the county and transportation was burdensome. Now with her mother for two weeks, Beth was either lethargic or protesting, and neither eating nor sleeping well. Her mother was not pleased.

The Infant-Parent Program therapist not only agreed quickly that the social worker's perceptions and concerns were correct, but felt that Sally and Beth's situation was worse and more complicated than the social worker had had the opportunity to observe. Although Sally was functioning quite well in many ways that were important, her relationship with her daughter was alarming. During the initial home visits, the therapist felt Sally's treatment of Beth was emotionally very abusive, and there were moments when the therapist wondered if it were really possible to leave Beth with her mother. Sally was abstinent. But achieving abstinence had not rendered her an adequate mother. She no longer neglected Beth. She was present, attentive, and active. But she was also rageful and totally unsympathetic to her one-year-old daughter.

Not only had the lack of contact between Sally and Beth during 10 months attenuated their relationship almost to the point of non-existence, but Beth was in deep mourning for the caregiver whom she had enjoyed for most of her life. She had lost her foster mother, whom she loved. And since her real mother was a far less adequate caregiver, there was no amelioration of this loss for Beth. Sally felt rejected and angry and at some level recognized that Beth, who had been happy and thriving when she was not with her, was miserable and languishing now that she was.

It was very important for the Infant-Parent therapist to appreciate with Sally the understandableness of many of her responses, and also to engage her gradually in discussion about how it is that babies develop their connections to people and why Beth was having some of the problems she was. As Sally's history began simultaneously to emerge in the course of these discussions, it was clear that many aspects of her own early relationships were impediments to her relationship with Beth.

Sally's expectations of Beth were hopelessly out of line with Beth's capacities. Sally often clearly experienced Beth as if she were one of a series of harsh, punitive figures

from her own past. If Beth could not refrain from touching something, Sally saw a purposeful design to provoke her mother, not a one-year-old's inability to inhibit her impulses. Sally felt that Beth really could, really knew better, and just wouldn't obey. Sally felt helpless and controlled by Beth. She became very angry and very punitive. To put it clinically, it was a mess.

It took a year and a half of very hard work to change this dynamic. Through a combination of carefully integrated developmental guidance and psychotherapy, the relationship between Sally and Beth did improve in important ways. It did not become ideal.

Drug use and the capacity to parent

The stories of Sharon and Larry and of Sally and Beth give us some concrete examples of how important it is that we understand the relationship, or lack of it, between drug use and the capacity to be a reasonably good parent. Most cases are not as clear-cut as these. We are useless in some cases, and many fall in some middle ground. Recently, for example, one-and-one-half years of work with a young woman who could not become abstinent resulted in good protection for her relationship with her daughter but an ultimate need for residential drug treatment for the mother. Without her work with the Infant-Parent program, the mother would not have made this choice. She and her daughter would be separated—as they are now—but the mother would be down the tubes.

This work is not easy. Nor is its course predictable. In a family with whom we are working currently, the central relationship between mother and child is fairly good, but the same impulsivity, irresponsibility, lack of patience, and need for a "quick fix" that characterized the mother's drug use remains a very important aspect of her relationship with her daughter—even though the mother is abstinent.

Thus the abuse of drugs is an interference in the parent-child relationship, though the quality of that relationship may vary. The impediment drugs present to appropriate care of children may be particularly apparent in families whose economic status cannot provide any buffer against harm, either in the form of ready substitute care or sufficient income to pay for drugs readily. Without such safeguards, drug use demands a lifestyle that places children at particular risk. More affluent drug abusers are more likely to be able to provide with more ease the rudiments of safety and attention from others for their child, and they have relatively uncomplicated access to their drugs of choice.

Since our interest at the Infant-Parent Program is in the quality of the relationship between the caregiver and the child, we try to understand all those things that affect the quality of the caregiving relationship. When drug abuse is involved, we can certainly wonder why this particular expectant mother has found herself dependent on drugs, and we want to understand why she is unable to free herself from their use, even as she sometimes recognizes and truly believes that drugs are a problem for her and a grave danger to the child she carries. We can also assume that if she understands intellectually some of the possible dangers to her fetus of the drugs she is taking during her pregnancy, and that if this understanding is not sufficiently compelling to help her overcome her dependence, then drug use is highly likely to remain a problem when the infant is born. Further, however, we can expect that many of the life experiences which have been a part of this mother's abuse of drugs will also have an influence on the mother-child relationship even in the absence of drug use.

Implications for intervention

Recognizing the need for treatment to pay as much attention to the qualities of the relationship between parent and child as to parental drug use itself helps us think about what might constitute appropriate treatment of parents who are addicted. When thinking about drug-exposed infants and their families (whatever structure that family has), we must realize that **families** must be the focus of intervention efforts that are too often targeted only to the drug-exposed child. In fact, those infants who manifest no effects of drug exposure may need no direct intervention at all, while their families (which include the child) need complex services.

Encouraging, understanding, and supporting families in which drug abuse is an issue demands a range of overlapping areas of expertise. Many years ago, Dr. Arthur Parmelee, at the University of California at Los Angeles, studied the sequelae of different intrauterine and perinatal assaults on children. He found that the "intervening variables "—that is, how the child was treated and cared for after she or he left the hospital—more often than not totally obscured any direct relationship between the original assault and the developmental outcome. This is also the issue with children who have been exposed prenatally to drugs. To help the infant, a range of overlapping services is needed, services that encourage, understand, and support families. Such an approach, in turn, requires cooperation among practitioners from a number of disciplines.

Counselors vs. therapists?

Unfortunately, it has often been my experience that many drug program counselors, dynamically oriented psychotherapists, and psychiatrists do not converse with ease. Their conceptual approaches and techniques can differ significantly. It is helpful to remember that peer counseling and group support were interventions that evolved initially to help people deal with drug addictions. Many interventions depended primarily on group support and many on group confrontation. In men's drug rehabilitation groups particularly, experiences tended to be somewhat abusive, guilt-inducing, and humiliating. These programs worked well for some people and not at all for others. Often, they have not worked well for women.

Meanwhile, the psychiatric literature has grown to include a large body of sophisticated studies and theory concerning psychiatric disorders and drug addictions. One can read about the relationship between street drugs of choice and psychiatric diagnosis, or about the propriety of

prescribing drugs for the treatment of recognized psychiatric disorders for patients addicted to street drugs.

There has been and continues to be sometimes fierce disagreement between drug counselors and the psychiatric community about the use of drugs to treat the psychiatric disorders of people who are also drug abusers. Many drug counselors feel that it is necessary to withhold any mood-altering drug from those who are attempting to stop abusing other drugs. Many drug counselors feel that psychotherapy for drug abusers is irrelevant and unhelpful; drug use is assumed to be the drug abuser's central, if not only, problem. It is true that psychotherapy has often proved ineffective in helping patients cease abusing drugs. All of this tension is surely compounded by the poor success rates of drug treatment of **any** kind, just as our society's failure to deal with social environments that support drug use does not help the situation.

Dual diagnosis and its implications for treatment

Increasing understanding of the concept of "dual diagnosis" has to some extent resulted in greater mutual appreciation among drug counselors, psychotherapists, and pharmacologically oriented psychiatrists. As the term "dual diagnosis" implies, psychiatric problems and drug abuse are clearly not readily separable. Family addictions, various kinds of abuse, and family chaos appear frequently in the histories of people who abuse drugs. Women suffering from chemical dependency very frequently have affective disorders, eating disorders, and histories of sexual abuse, early parental loss, and domestic violence. In general, drug abusers who have few psychiatric complaints can do rather well with drug abuse recovery programs alone. Individuals with drug problems who suffer from a medium to high number of psychiatric complaints do better when they have individual psychotherapy in addition to drug treatment. Given the high number of women addicts who have affective disorders, the combination of individual psychotherapy and drug treatment would seem particularly likely to be effective.

I would argue that the concept of dual diagnosis should include any person who is an addict who is also a parent. No parent who is addicted can afford to be without services that recognize both the potential and the dangers of that parenthood. Yet many drug-abusing women who have drug-exposed infants—often the sole primary caregivers for their children—are isolated. Many if not most of these mothers suffered as children from serious parental inattention and lack of protection. Without help, their drug-exposed infants will be subject to similar neglect. The impact of environmental relationship deficits will be added to whatever intrauterine damage they experienced.

Parents who are addicted need help both with their drug abuse and in understanding the effects of their past relationships, both negative and positive, on their ability to be adequate parents. One must not deprive women of the opportunity to become more adequate parents because they have a problem with drug use. Drug counselors, psychotherapists, and psychiatrists must listen to one another enough to appreciate what each has to contribute. Just as it does not help a child to have feuding parents, so it does not serve this population of parents to have feuding treatment providers.

Counselors and therapists: discussable differences

In a program for mothers in recovery and their infants in Contra Costa County, California, drug counselors (who facilitate recovery groups) and infant-parent psychotherapists (who make home visits, focusing on the infant-parent relationship) manage to cooperate well. In interviews with me, they described their perceptions of the tensions and differences between their treatment approaches, what their experiences had been with staff from different professional backgrounds, and how they achieved cooperation.

As they described their historical and current views and their perceptions of the "typical" practitioner of their own treatment approach, most staff members felt they differed in point of view from colleagues in their own discipline who had less experience with other treatment approaches. (Indeed, over time in this program, staff members who could not accommodate to differing perspectives left. The group consists currently only of those drug counselors and therapists who **were** able to learn to respect their differences and commonalities.)

Drug counselors felt that until abstinence was achieved, there was no foundation for recovery, there was therefore no shift in identity, and until that inner shift in identity occurred, no other treatments were possible or could be effective.Psychotherapists felt that working on the mother-infant relationships in the context of the traditional psychotherapeutic relationships was what would result in such a shift in identity, in higher levels of psychic defenses, and in sublimation rather than denial. They felt that psychotherapy would certainly achieve better results than a narrowly focused drug program.

The psychotherapists tended to see substance abuse as a symptom, like any other. They saw their goal as understanding with the patient the meaning of that symptom. Drug counselors felt that the drug use took on a life of its own, and that dependence on continued use would obscure any meaning of that use. More important, they believed that the patient had to stop struggling to find a way to be able to continue to use. Drug counselors felt that psychotherapists really didn't know what in the world they were dealing with when it came to drug use. They thought that therapists were often "suckers."

Psychotherapists felt that drug counselors asked people with drug addictions to "give themselves up" and felt uncomfortable with the religious aspects of many programs. They did not see drug counselors as true professionals, but as essentially untrained. Drug counselors experienced being seen exactly this way. They felt that psychotherapists had no respect for drug treatment. They also felt that therapists had an underlying anxiety about addicts and about drug counselors as recovering addicts.

Psychotherapists felt that drug counselors emphasized the sadism of "tough love," drawing tight lines, tolerating no aberrant behavior, and throwing people out of treatment who wouldn't surrender themselves. Drug counselors felt psychotherapists were "enabling"—in some sense co-dependent, and lacking in understanding of the nature of the problem of addiction, or certainly how to help with the addiction.

Both groups were aware of class issues. The mental health professionals were often more formally educated than the drug counselors, and often differed in class from both the particular population of people with addictions with whom they were working and from the drug counselors.

Such a set of differences, perspectives, and lack of mutual respect would constitute a tremendous impediment to anyone's working together. Some staff members couldn't manage it and left the program. Those who remain or who have come recently do manage, but marked differences among staff remain. Now, however, these differences have become discussable. They do not interfere with the mutual, supportive delivery of needed services to program families.

What makes cooperation possible?

Drug counselors and psychotherapists needed to achieve a few major understandings in order to work cooperatively:

- **First, drug counselors were persuaded that providing some immediate direct work in regard to the feelings involved in the parent-child relationship, in the context of psychotherapy, was necessary and possible without abstinence.**
- **Second, psychotherapists developed respect and understanding for the *actual* nature and dynamics of the group work done by counselors, and for its usefulness.** (These were women counselors treating mothers who were addicted. Their treatment was free of some of the qualities of punitiveness and guilt-induction of more traditional male-dominated drug treatment programs. It was very thoughtful, informed work.)
- **Third, drug counselors and psychotherapists all could observe that there were marked individual differences in what the parents/patients could use in the way of treatment.** Some parents seemed to respond to individual work when they couldn't make use of or even attend groups with any consistency at all. Some responded more readily to the groups and could only make good use of, or meet regularly with, infant-parent psychotherapists after using the recovery groups for some time.

Crucial to drug counselor/psychotherapist collaboration was their agreement that it was senseless and destructive to make patients' access to infant-parent psychotherapy a reward or punishment for clean or dirty drug tests, or for attendance at recovery group meetings. Surely, the psychotherapists had argued, the counselors would not have tolerated withholding recovery group meetings from patients who had missed their infant-parent psychotherapy appointments three times in a row. (In our experience, it is not unusual for drug treatment programs to withhold such things as parent training classes from a patient who has not been abstinent. Similarly, in residential centers for teenage mothers who are not abusing drugs, therapy may be withheld if young women accumulate demerits, as if therapy were similar to TV or late-night kitchen privileges.) The counselors and therapists came to agree that this kind of manipulation is a basic misuse of a program intended to help, representing an irrational deprivation and introducing a needless confusion. The current group of drug counselors and psychotherapists agrees that how the parent/patient is understood by, and is progressing in, both modes of treatment should be used by each treatment provider to expand his or her understanding, but it should have no other consequences.

This was the most difficult agreement for counselors and therapists to work out. It was primarily around this issue that staff departures occurred. Once an understanding was achieved, however, the counselors and therapists ceased to interfere with one another's work and began instead to appreciate each other's perspectives and learn from them.

Perhaps most important, drug counselors and psychotherapists have come to realize that although their treatment approaches are very different, many qualities of the relationships they have developed with parent/patients are the same. Both the drug counselors and the psychotherapists treat mothers with respect, concern, and sensitivity. In this way, the counselors and psychotherapists differ not at all. And when the counselors and the psychotherapists behave toward one another with the same respect and sensitivity which each shows toward mothers, then **everything** is possible.

The relationship between drug counselors and psychotherapists needs to be a respectful one. When it is, the range of treatments that can be available to people with addictions will begin to match their actual needs, whether the addiction is coupled with schizophrenia, an anxiety disorder, an affective disorder—or parenthood.

Drug treatment programs that ignore the relationships involved in parenthood are only insuring that they will be even busier in the next generation. Psychotherapy programs which ignore the help drug programs can offer to the patient/parent who is addicted are doing the same. Intervention with parents with addictions should begin when their children are infants and toddlers. Good intervention depends on cooperative treatment by a range of providers who are willing—and thus able—to learn from one another.

Integrating Parent Support into Residential Drug and Alcohol Treatment Programs

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Are men and women in drug and alcohol treatment (D/A) programs interested in support and education for their role as parents of young children? Do they have parenting needs that are specifically related to the process of recovery?

What skills do certified addiction counselors and case managers need in order to provide ongoing support and education for recovering parents of young children? Is the process of confronting addiction compatible with the process of nurturing the nurturer?

These are just a few of the questions Philadelphia Parenting Associates (PPA) raised in response to a 1988 request for consultation from the city's Diagnostic and Rehabilitation Center (DRC). The DRC had received a community demonstration grant from the National Institute on Alcoholism and Alcohol Abuse to establish Hutchinson Place, one of the region's first residential treatment facilities for homeless, drug-dependent women and their children. Aware of PPA's success in helping traditional shelters for homeless families become more family-centered, the Hutchinson Place staff wanted PPA to work with them, their administrators, and parents to define issues and develop strategies for integrating support and education for parents into all aspects of the residential treatment program.

Historically, residential drug and alcohol treatment regimens have been designed by adult men, for adult men. They involve confrontation, strict routines, and a full schedule of meditation, groups, and individual therapy sessions. The treatment emphasizes individual responsibility while encouraging the surrender of individual needs to the recovery process. Participants are required to focus tremendous energy on themselves. Staff of D/A programs are often men and women who are in the advanced stages of recovery from their own addiction. They are usually trained in the course of addiction, have good intuitive skills for supporting the process of recovery, and bring a strong personal commitment to their work. Although staff of a residential program for drug-dependent parents and their children generally accept the fact that they are responsible for parent **and** child, their focus is usually on the adult.

Given this history, PPA staff wondered whether drug and alcohol treatment programs were an appropriate area for collaboration. We first studied principles of addiction counseling with the DRC staff. Next we established ongoing communication with the Hutchinson Place administrative team regarding staff and resident needs and program policies and practices. This preliminary process of gathering information allowed us to tailor parent support and education to the requirements of the D/A staff and the recovering women. Finally, we provided inservice training for Hutchinson Place staff members and workshops for the resident mothers. The overall focus, for each level of planning and training, was on integrating parent support and education into the routine treatment program.

Consultation on policies and practices

Administrative guidelines in D/A programs tend to ignore the ordinary realities of parenting young children. For example, Hutchinson Place used curtains instead of doors at the entries to family sleeping cubicles. The curtains allowed for surveillance of the women by staff, but made it very difficult for mothers to monitor their children during sleep and quiet times. We suggested supplying child gates to families, in order to prevent toddlers from wandering off while parents slept. But gates are an expense that must compete against other program priorities for available resources. PPA staff had to make a clear, compelling case for the gates to administrators, explaining that they would provide parents with the means to establish a safe environment for their children--a major goal of the recovery process.

Consultation and training with staff members

When we circulated a child development knowledge survey among Hutchinson Place staff, we learned that staff members had a reasonable understanding of developmental milestones and age-appropriate behavior. However, the survey documented a tremendous diversity of opinion about childrearing practices such as feeding, weaning, and toilet training. (These findings have been confirmed in all the other drug and alcohol treatment programs where PPA worked.) Many staff members told us that they had experienced difficulties with their own parents during childhood and serious problems in parenting their own children. Others reported only minimal involvement with the rearing of their own children.

We found that before participating in training about principles of parent support, D/A staff members defined child care in terms of physical maintenance and discipline. Staff identified corporal punishment as the most effective technique for disciplining children (even though corporal punishment is not permitted in most residential treatment programs). D/A staff did not see play as a way for parents and children to build relationships and learn social and language skills. They knew only a few songs to sing with children and did not see value in reading stories with children.

Initially, D/A staff reacted to inservice training sessions on parent support and education with a mix of skepticism, curiosity, and apprehension. We learned to make every session experiential, rather than didactic, exploring staff

members' intuitive competencies and encouraging them to draw on the best in their personal parenting histories. Basic information about child development and child management is blended with problem solving around common concerns. In one session for example, Hutchinson House staff and Cathie Harvey together developed a list of questions to consider when working with parents on setting limits with young children:

- **What does the parent want the child to learn?** A skill? Information? Fear?
- **Can the child learn this? What clues can you get from the child that helps you to know if the child is ready?** How does the child do in other situations? With other adults? When she isn't tired? When other children are around?
- **Is the child clear about what is expected of him? Has the parent been clear with the child?** Does the parent walk over to the child? Look her in the eye? Use words the child can understand? Stay with one idea at a time? Check to see if the child really did understand?
- **Are there too many limits for this child? Or is the child demonstrating a need for more limits?**
- **Does the parent allow the child to use opportunities to explore on her own?**
- **Has the child had enough time to adjust to the new limits?**

Judgmental attitudes about parent/child relationships, conflicts between staff values and program norms, and erroneous information about child development can only be challenged after considerable trust is established and staff members begin to feel confident in some areas of parent support.

In addition to group training sessions on parent support, PPA staff facilitate case conferences to discuss individual parenting situations. These sessions allow for additional informal education and result in action plans that involve the whole staff working as a team to use a comprehensive, supportive approach.

A basic paradigm shift is usually required before a D/A staff member can see parent support as an integral part of his or her work with women in recovery. When this shift does occur, staff members begin to observe parent-child interaction more sensitively, to nurture the women residents as mothers, to provide anticipatory guidance around parent/child and child development issues, to model appropriate behavior with the children, to sit with mothers and review problematic parenting situations, and to use teachable moments with parents.

Understanding the parenting support needs of mothers in recovery

As part of the evaluation plan for Hutchinson Place, videos were made of each woman resident playing with one of her children. Under the controlled circumstances of a playroom—where the mother was with only one child and a variety of age-appropriate toys was available—women were generally responsive to activities that the child initiated, played actively, and handled their children gently. But daily communal life in Hutchinson Place was full of unattended children, parents shouting commands to children across the dining hall, and frequent evidence of parents' inappropriate expectations of their toddlers and preschoolers.

Mothers at Hutchinson Place had the kinds of parenting support and education needs that one finds among any group of parents of infants and toddlers. Some wanted help in developing bonds with their newborns. Others simply needed to increase their repertoire of age-appropriate activities for young children. For all the women, however, their normal needs were complicated by their stage of recovery from addiction. Women in the early stage of the recovery process were often fatigued, malnourished, and depressed, and had difficulty concentrating. Returning physical stamina did not necessarily make parenting easier, since as women began later in recovery to come to terms with their sense of guilt regarding their children, they often established unrealistic standards for themselves as parents. As they proceeded in therapy after detoxification, women started to work on issues of self-control, managing feelings of anger, and establishing routines for daily living. The fact that, ironically, these were the same issues that they needed to address with their toddlers and preschoolers complicated the challenges they faced as mothers and as functioning adults.

It is important to recognize that the children at Hutchinson Place themselves presented special challenges for their parents. Many had symptoms of malnutrition, had a low resistance to infection, and were irritable. They tested their mothers frequently, as though they were not ready to trust their parents' new sober status. Many children had difficulty accepting new bedtime, mealtime, and bathtime routines, and limits on their behavior. One could sympathize with a mother's question, "Now that I'm clean, why can't my kid act right?"

Workshops with mothers in recovery

To address the variety of parent support and education needs of parents in residential drug and alcohol treatment, we have found that weekly workshops are optimal, offered in at least a six- or eight-week series. We recommend having eight or fewer women in workshops of one hour or less. Realistic objectives for parent workshops are to create opportunities for participants to have positive experiences with their children, to practice child care skills, and to create an environment in which mothers can safely raise questions and share concerns about their role as parents.

As workshop facilitators, we use a variety of techniques that encourage mothers to discover and exercise their power as parents. Exercises are structured to build on the system of mutual support that exists within the residential treatment facility. Each group needs to establish a set of ground rules for managing manipulative behavior, intense feelings carried over from other parts of the treatment program, and difficulties between individual mothers.

Our workshops at Hutchinson Place and in other D/A programs are a blend of discussion and problem-solving sessions, parent activities, and parent-child activities. PPA staff elicit concerns from parents and then use those concerns as a framework for weaving in critical information about child development and child care. We select activities for parents and for parents and children together with three criteria in mind: They must promote physical contact between mother and child, encourage mothers to observe and interact with their children, and be fun! Infant massage, making and using playdough, making finger-food snacks, and making simple toys are popular choices that meet the criteria.

Moving on

Since beginning our work with parents and staff at Hutchinson Place, PPA has established collaborative relationships with five other drug and alcohol treatment programs and drug-free shelters. Our experience with each program confirms that parent support and education is an essential element in the recovery process, and one which can be integrated into routine D/A program activities. We have demonstrated that D/A staff effectiveness is improved through training in child development and techniques of parent support. Next steps include securing more stable funding for collaboration between family support programs and drug and alcohol treatment programs; interesting the research community in describing and documenting the critical paradigm shifts that allow D/A staff to become more family-centered in their practice; and disseminating successful strategies for integrating parent support and education into drug and alcohol treatment programs for mothers and fathers of infants and young children.

Foster Parenting the Drug-affected Baby

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Imagine a tiny baby whose high-pitched, intense screaming, induced by withdrawal from whatever variety of legal and illegal substances his mother used during pregnancy, goes on hour after hour. Imagine yourself, sitting in a darkened room, trying to feed this underweight newborn, who cannot coordinate sucking, swallowing, and breathing and who therefore gags and chokes after every few sips of fluid. The baby cannot tolerate the stimulus overload of having your arms hold him as he tries desperately to eat. He screams in frustration and fury. Every bit of what he swallowed ends up in your lap.

You try rocking, singing, stroking, swinging, bathing, swaddling, and riding in the car. Nothing seems to comfort or soothe this baby for more than a few minutes at a time. He sleeps fitfully in 15 to 20 minute snatches throughout the day and night, his sleep interspersed with more screaming and battles to ingest some nutritious liquid. He cannot begin to calm himself down. He startles at every sound and touch, goes from sleeping to screaming in a matter of seconds, and arches and stiffens away from you every time you try to console him.

The baby has thrush, a yeast infection, diarrhea, and severe diaper rash. His breathing is very rapid, and his nose is always stuffed up. He suffers from severe gas pains and vomits with every meal. He sweats profusely in any temperature. His skin exudes a peculiar, unpleasant odor which is not removed by regular bathing.

The baby has developed seizures and apneic spells that require intense monitoring, medication, and documentation of the occurrences and effects of various doses of medication. Perhaps he requires a heart monitor, prone to false alarms, especially in the middle of the night.

This goes on for months. This is the care foster parents are called on to provide for drug-affected babies.

Foster parenting requires a deep emotional commitment in the face of conflicting pressures and demands from a social welfare system that is straining at the limits of endurance to serve families whose intense needs beggar description. In recent years, foster parents have taken on even greater challenges. They have become in-house therapists to babies who may be born addicted, medically fragile, premature, developmentally compromised, and separated from their parents and other family members at a crucial time of life. Taking a drug-affected infant into one's home means facing demands little imagined by parents of typically developing, healthy children. In addition to seeing that the child's medical, nutritional, and physical needs are met, we foster parents of drug-affected babies are also expected to become *de facto* case managers, arranging and participating in screening and therapy; seeking appropriate resources for developmental concerns; providing transportation to medical, therapy and family visits; sharing information with a wide variety of professionals; documenting behavior; and planning for the eventual transition of adoption or return to the child's birth family.

We are the experts on the children we serve, but seldom are we given the recognition, support or resources we need to do our job. The team concept is much vaunted, but rarely realized. This article will examine the types of support that help foster parents care for drug-affected infants, sources of such support, and strategies to find supports that are not readily forthcoming.

Formal sources of support

Foster parents who care for drug-affected infants and toddlers need both formal and informal supports. Formal support resources include social service agencies, medical resources, and early intervention services. All too often, systems and institutions that should offer support fail to do so unless foster parents demand services.

Social service agencies

Social service (child welfare) agencies traditionally provide support in the form of financial subsidies and training, both initial and ongoing, for foster parents. The agency caseworker is the designated link between foster parents and the resources of the child welfare system as a whole. Unfortunately, many foster parents have to fight for basic supports, including information. The children we care for provide enough stress, heartache, and exhaustion—having to fight the system as well is demeaning and debilitating.

Financial subsidy for foster care of drug-affected children is provided in Oregon through monthly payments for standard care, medical costs subsidies, and a system of higher reimbursement for children with special medical needs. The standard monthly support rate for children under three years of age in the Portland area is $285. Specially trained registered nurses, using specific criteria, may determine that some children have significant medical or therapeutic needs; these children may be eligible for a special supplemental care rate of four dollars per hour, up to maximum specified amounts for various categories of need. Most costs of medical and dental care for foster children are covered by Medicaid (although, as discussed below, this arrangement limits the choice of providers to those willing to accept Medicaid.) In some cases, foster parents may be reimbursed for mileage costs involved in taking children to required medical and therapeutic appointments.

Although this system may seem relatively straightforward on paper, the reality is complex. Social service workers volunteer information to foster parents about little beyond the **standard** reimbursement rates, so foster parents who are caring for children with special needs, especially foster parents new to the system, spend considerable time and effort just finding out what their child may be entitled to. Then the struggle begins to make sure that the payments actually occur, and in the correct amounts.

In my own case, when I called to ask why I had not received the expected payments one month, I was told that this was due to the expiration of my certification as a foster parent. I explained that my certification had expired because the agency had failed to assign a new certifier after my former certifier had been transferred—four months ago. I was told that nothing could be done until my home was recertified. When I commented on the dubious logic of the agency's allowing foster children to be cared for in my uncertified home yet denying me payment for services to those children, I was informed that my case seemed to have fallen into a crack. A series of intemperate phone calls on my part resulted in a supervisor placing a note in my file to the effect that I was now "recertified." Payments resumed. Nine months later, a new certifier was assigned to me.

Initial training, for foster parents in the Portland area who choose to take infants, involves specialized training

Drug- and alcohol-affected young children in Oregon's child welfare system

According to the Director of Oregon's Department of Human Resources, "Child welfare agencies ... are in the middle of a major war for the lives and safety of children across our country because of drug and alcohol use" (Oliver, 1990, p. A20.)

In Portland, Oregon, the number of children who spend part of their earliest years in foster care is growing. In 1989, 10,067 children were in foster care statewide, with 3,162 in Multnomah County (Portland and environs) alone. This represented an increase of nearly 31 percent in a four-year period (Oliver, 1990). Substance abuse is inextricably intertwined with this increase. According to a July, 1990 article in *The Oregonian,* almost two-thirds of children in foster care in the state are the children of suspected drug and/or alcohol abusers, and about half of all foster children will never return to their parents. Of 29 child abuse deaths in Oregon in 1989, 14 involved drugs or alcohol, including nine deaths of drug-affected babies (Kaufman, 7/15/90).

Statewide in Oregon, 532 drug- and alcohol-affected newborns were reported to the Children's Services Division (CSD) in 1989, a rate of 1.2 per 100 births. But not all hospitals provide drug and alcohol screening, and even a positive drug screen on mother or newborn is not automatically grounds for CSD gaining custody of the child. More than 60 percent of all reported drug-affected babies go home with their mothers. Some are visited by community health nurses, but CSD follows few of them (Kaufman, 7/15/90).

Increasing complexity of family problems, including those of substance abuse and domestic violence, combined with severe budget cuts has meant that child welfare workers in Multnomah County are seldom able to respond personally to reports of neglect unless the child is in immediate danger. Caseloads are double or triple the size of a decade ago. County workers write up about 450 cases of suspected abuse or neglect each month, but investigate only about 100 cases in person (Oliver, 7/22/90).

Only the most severely affected children make their way into foster care in the Portland area. Foster parents are now being asked routinely to cope with children who a few years ago would have been deemed candidates for residential treatment. The number of foster homes has not increased significantly over the past several years. Thirty-eight percent of new foster parents drop out during their first year (Hochman, 1990).

in techniques for medically compromised and drug-affected babies, in addition to regular foster parent training. The 15 hours of initial training provided through Oregon's Children's Services Division includes basic principles of child development; specific information on the population of children coming into foster care; and agency structure, policies, and procedures. A comprehensive manual accompanies the training. The training agenda portrays foster families and agency workers as a team working together, but acknowledges the reality of the need for foster parents to act as advocates for the children in their care. More advanced and specialized training is offered for foster parents interested in three levels of specialized care: dealing with mild to moderately drug- and alcohol-affected babies; caring for children who require monitors or gavage feeding; and caring for children who are severely compromised developmentally or terminally ill.

Continuing training for foster parents is required in Oregon. Current regulations mandate 10 hours per year of continuing training for all foster parents (30 hours for medical foster parents) in order to maintain certification. Reading books and watching videos count as continuing training, as does attending support group meetings and more formal classes or conferences. Topics of agency-sponsored workshops may include behavior management, attachment issues, agency procedures, and manifestations of abuse and neglect.

The relationship between foster parent and agency caseworker is, theoretically and logically, the support link for foster parents to the child welfare system as a whole. Foster parents care for children who challenge even the best trained and motivated professionals and do so twenty-four hours a day for months or years—and then watch these children move on to another family. We foster parents must become attached to the children we serve, and yet preserve enough objectivity and emotional distance to support children's transitions and our own reattachment to the next needy child. Foster families who take in drug-affected infants learn that not only is the child likely to be affected adversely by parental substance abuse in the past, but there is often little real possibility of the child's forming or maintaining a bond with the birth parent(s). Even if parents cooperate to the extent of scheduling visits with the child, missed appointments and/or their inability to respond to the agency-directed structure for regaining stability frequently result in no meaningful contact between the baby and his or her birth family for long periods. For babies in these circumstances, foster parents are likely to become psychological parents as well.

The psychological complexity and emotional intensity—added to the extraordinary physical and technical demands—of foster parenting babies from substance-abusing families make clear the need for skilled professional support for foster parents. But in a system that is overloaded and underfunded, caseworkers are seldom able to provide foster parents with emotional support, expertise, or even information. Paperwork consumes great amounts of caseworkers' time, and yet placement desk workers calling potential foster parents are sometimes mistaken about even the age and sex of the child to be placed. Foster parents also encounter a prevailing (though mistaken) belief among caseworkers that keeping foster parents ignorant of certain aspects of the child's situation (using rules of confidentiality as a rationale) will increase the likelihood of making a placement.

Foster parents value caseworkers who:

- return phone calls promptly;
- follow through on promised services or information;
- show respect for the foster parents' knowledge and expertise;
- are honest;
- offer support when foster parents express a concern;

Ways to comfort a drug-withdrawing baby

1. Wrap or swaddle your baby in a soft blanket.
2. Keep the lights dim to decrease sensory stimulation.
3. Drape the crib with a blanket or sheet to decrease light and noise.
4. Keep the noise level low.
5. Play soft, soothing music.
6. Hold the baby frequently.
7. Use a pacifier.
8. Use unstarched, soft blankets, sheets, etc., to prevent rub marks.
9. Hold baby firmly.
10. Rock gently and slowly.
11. Speak softly and calmly.
12. Give gentle massage.
13. Avoid bouncing and rapid patting.
14. Place the baby on his/her stomach over a soft ball (beach ball type) to ease abdominal pain.
15. Use a front pack to carry baby.
16. Make sure medication is given on time, at regular intervals.
17. Plan for respite care.
18. Stay calm.
19. Ask for help when you need it.

Some signs of overstimulation

avoiding eye contact
tension
sucking on hands, fingers
frowning or grimacing
yawning

Adapted from material by Ruth Stroemple in the *Medical Foster Parent Handbook.* (unpublished).

- seek appropriate—rather than merely expedient—placements; and
- listen!

Medical resources

The staff of the hospital nursery that has cared for a drug-affected newborn can give a foster parent important information when the baby is released into foster care. Foster parents have learned to ask for the results of sleep and abstinence studies, Apgar scores, any non-routine medical tests, and for the attending pediatrician's discharge summary. We try to speak with a nurse who has cared personally for the baby we will be caring for. Her impressions, especially about feeding and sleep behaviors, may be even more valuable than official reports. She can answer the critical question, "What helps to soothe this particular baby?" Foster parents have learned not to rely on the chart phrase, "Shows no withdrawal symptoms"; these can take weeks to appear.

Some foster parents try to pick up a child from a hospital nursery during the evening rather than the daytime. There may be more time to talk with medical personnel, there is less chance of a confrontation with birth parents, and the environment at home is likely to be calmer and more subdued as well.

Public health or other visiting nurses are professionals who can visit the child in the foster home, observe behaviors of concern, and offer practical help and resources. However, foster parents are likely to have to search to find nurses with expertise in the effects of drug exposure.

A relationship with a knowledgeable and supportive pediatrician is necessary for ongoing medical care for the drug-affected foster child. Again, finding a physician with a specialized knowledge of drug effects is challenging, as is finding a pediatric practice that will willingly accept Medicaid payments for care. Foster parents have learned to recognize that the pediatrician's respect for their own expertise is a good criterion for judging the relationship. We are wary of the doctor who provides lots of false reassurance ("Oh, she'll grow out of it") or the one who attributes every symptom to drug exposure. It is important to be aware that some tests, procedures, and medications that a physician may recommend may not be covered by Medicaid. One must try to determine whether medical judgment or payment structures are the major factor in recommendations. Once again, foster parents must advocate for the needs of the child.

Quasi-formal sources of support

Support groups and respite care are two very important resources for foster parents caring for drug-affected babies—as they can be for birth parents as well. However, foster parents are on their own to seek out and pay for such help.

The Oregon Foster Parent Association, a statewide non-profit group that is partially funded by United Way and an affiliate of the national Foster Parent Association, provides a variety of training opportunities, ongoing support groups, and peer consultation. It also sponsors an annual conference, fund-raisers, social events, clothing exchanges, and a monthly newsletter. A special project offers handmade, monogrammed quilts for babies in foster care.

Respite care is not a consistent or reliable resource. It is difficult to find, expensive, and likely to be available at the provider's convenience rather than the foster parent's. As a result, many foster parents try to provide respite care for each other. Respite care offers an example of how an issue that confronts all parents—finding temporary child care—is especially difficult for foster parents. The resources available to parents of healthy, typically developing children are limited, and not always of appropriate quality. Imagine trying to find child care for a baby on a heart monitor, who screams for hours on end, and who doesn't respond to ordinary soothing and comforting techniques. And many foster families have a number of hard-to-manage children in their homes, not just one.

Informal supports

Informal support for foster parents begins with caring for ourselves, and includes family and friends as well. Stress management is vital. If we do not nurture ourselves, we will not be able to nurture the child. Knowing our own limits and, more important, recognizing and accepting those limits, allows us to do our job as foster parents. Some specific areas where a sense of limits is important include:

- **Attachment**—The foster child does not belong to the foster parent. The child will not become a permanent part of the foster family's life. Remembering and accepting this reality is difficult, but crucial. Someone who cannot deal with the inherent incongruities and emotional upsets engendered by this core aspect of foster care should not become a foster parent.
- **Documentation of experience**—In addition to their value for court proceedings and medical and therapeutic encounters, written records can help the foster parent retain a sense of reality and gain distance from stress. Observing and recording a child's routines and upsets can help a foster parent gain a more accurate sense of how the child's behavior affects family life and what progress occurs over a period of time. If nothing else, written records can help others understand the intensity of the foster parent's struggles.
- **Respite**—A foster parent should take a break from the child, and allow her to have a break from the foster family. A network of alternate caregivers who can cope successfully with a child's needs can offer a foster parent some time for self-renewal.

Most foster parents rely extensively on extended family and friends for respite care, supplies (such as children's clothing and furniture), and the social support needed to

balance the stresses of this job. Church membership, neighborhood and school organizations, and other traditional family support systems play a role as well. None of this is unique to foster care. What may be unique is the degree to which foster parents are subject to the scrutiny and judgments of people in the community. We are reviled as money-seeking laggards who fill our houses with children we don't care for, or exalted as saintly creatures who selflessly lavish devotion on the rejects of society. Eager hands reach for the charming foster baby at church services, while the voice of the person attached to the hands declares she could never do this job because "I could never give a child up that I'd gotten attached to." (So foster parents have hearts of stone?)

Foster parents are no more saints or sinners than anyone else, just people committed to providing a service that others will not.

A chain of support

In the same way that social service agencies struggle to meet the needs of a burgeoning population of families overwhelmed by their circumstances, they struggle to support the foster parents they depend on so heavily. And we foster parents come to realize that their job entails gathering support for ourselves, as well as for the children in our care.

We are rewarded by small, and sometimes fleeting successes. We know that we have provided the very best foundation we could for a child's future, a loving start to whatever his or her life holds.

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Working with Addicted Women in Recovery and Their Children: Lessons Learned in Boston City Hospital's Women and Infants Clinic

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Working with drug-abusing women and their young children is extremely hard. It is different from working with children with special needs or with families struggling with poverty. Indeed, drug use and the life style that accompanies drug addiction may have had much to do with the inability of infant/family practitioners to connect with some "hard to reach" families—we just didn't understand this at the time.

In 1992, providers of services to infants, toddlers, and their families need to understand addiction. We need to understand addiction as a disease, its impact on the family system, and the way it triggers our own feelings about drugs, alcohol, women, and childrearing. This article shares what we and our colleagues have learned since 1989, when we opened the Women and Infants Clinic at Boston City Hospital. Our transdisciplinary team of pediatricians, early childhood specialists, a substance abuse specialist, public health nurses, students, and volunteers use a "one-stop shopping" model to offer health services for parent and child, developmental services, drug treatment, and case management for cocaine-exposed children and their drug-involved families. We have learned valuable lessons about addiction, intervention strategies, and the need for clinical support and supervision for providers.

Addiction and women

"For me, it came down to a choice. It was either the drugs, or my life and my child."—Barbara, two years into recovery from cocaine addiction

When women are addicted to drugs or alcohol, they focus primarily on their drug of choice, not on their children. They organize their lives around getting drugs, not getting their children to health care visits or educational services. Women who are addicted often use drugs to numb their own intense anxiety and shame. Trying to feel nothing, they cannot relate emotionally to their young children, or respond to their children's needs (Brooks, Kaplan-Sanoff & Zuckerman,1992).

Addiction is a chronic, progressive, and potentially fatal disease, with characteristic signs and symptoms. An addict uses substances compulsively, experiencing an increasing loss of control over the substance and continuing to use despite adverse consequences. In the late stages of addiction, addicts are preoccupied with getting and using substances to the exclusion of all other needs and responsibilities, including self-care and parenting their children. Addiction is not confined to any ethnic, cultural, or socioeconomic group. It affects all ages and both sexes.

Addiction is not caused by lack of morals. People do not become addicts because they are bad people. But parents who are addicts have a primary relationship with their drug, not with their child. To pay for drugs, addicted parents will use money that they and their children need for food, clothing, shelter, and health care. Addicted women view

themselves as bad mothers. This perception is frequently reinforced by social services designed to help them, as well as by the popular media. Professionals must understand addiction as a disease.

Most addicted women have experienced severe trauma and loss. Their parents are likely to have abused drugs or alcohol, and siblings are usually involved in drug use as well. Growing up in substance-abusing families, women who become addicts have often witnessed or participated in criminal behavior to support parental drug use and have witnessed violence, including drug-related deaths. They have experienced early and frequent disruptions in education and in appropriate social and peer relationships. Childhood sexual abuse is pervasive; studies have reported rates of 75 to 90 percent among women in inpatient drug treatment (Rohsenow, Corbet & Devine, 1988). Professionals working with substance-involved mothers must understand what they experienced as they were growing up, and who they were before they became mothers.

As adults, women often repeat these earlier traumatic experiences of loss and abandonment. Not surprisingly, they have little ability to trust or to develop healthy relationships. They feel neither control over life events nor a sense of being worthy of love. They are isolated, with few if any social supports. In women with histories of severe trauma, persistent feelings of depression, low self-esteem, anxiety, rage, and panic surface frequently. Yet such women have tremendous difficulty identifying the feelings they experience, or in coping appropriately with these feelings. Substance-abusing women are very often so disconnected from themselves that their ability to recognize their own needs and care for themselves is severely impaired.

Women use drugs to alleviate pain. They use drugs to self-medicate painful emotions and extreme anxiety associated with past experiences of loss and trauma. They use drugs to avoid the pain of their chaotic daily reality. Achieving abstinence alone cannot do away with chaos, trauma and loss, for women or their children. During recovery from drug addiction, mothers may be extremely fatigued, depressed, and preoccupied with themselves. They may feel guilty, isolated, and overwhelmed by the stress of remaining sober while experiencing painful emotions. Drugs and/or alcohol have been so much a part of life for some women that they have limited ability to live without drugs. They have rarely experienced success in school or in relationships. When asked to describe things that make them happy, some women cannot answer without referring to drug- and alcohol-related behaviors. Mothers in early recovery may seem to have no vision for their own future and to see little future for their children. The family dysfunction we see in drug-abusing homes is not only attributable to drug use itself. We must understand that the women we see have often had very poor models of parenting themselves; we should anticipate that they may have difficulties in parenting, not only when they are using drugs but also during the period of early recovery and beyond.

Outcomes for children of addicted mothers

Maternal addiction to drugs takes a toll on children. Although the popular press has painted an overwhelmingly dismal and alarming picture of these children in a rush to judgment about outcomes (Mayes, Granger, Bornstein & Zuckerman, 1992; Zuckerman and Frank, 1992), the research suggests that prenatal exposure to drugs does not cause permanent brain damage. Studies of two-year-old children who were exposed prenatally to opiates do not show statistically significant differences in developmental scores from social class matched controls (Zuckerman and Brown, 1991). The single published developmental study of children who were exposed prenatally to cocaine, and not opiates, shows no mean differences on the Bayley Scales of Infant Development between cocaine-exposed two-year-olds and socially matched controls (Chasnoff, Griffith, Freier & Murray, 1992).

Standard measures of infant behavior may not be sensitive to the specific aspects of young children's development and behavior which are likely to be compromised by prenatal exposure to specific chemical agents. Global measures of "developmental outcome" may not provide critical information on how prenatal drug exposure truly affects children. In a preliminary study using more behavioral measures of development, drug-exposed 18-to-20-month-old children were assessed as more insecure, disorganized, and more avoidantly attached to their primary caregivers than a group of premature infants. In unstructured play assessments that required initiation, goal-setting, and follow-through, drug-exposed toddlers

One-Stop Shopping at the Women and Infants Clinic

The Women and Infants Clinic is a comprehensive early intervention program for cocaine-exposed children and their drug-involved families. In operation since 1989 at the pediatric primary care clinic at Boston City Hospital, the Women and Infants Clinic offers:

- **Health services for parent and child**—pediatric, family planning, HIV testing
- **Developmental services**—mother-child groups, play therapy for children, child care
- **Drug treatment**—relapse prevention group, individual/group therapy, 12-step groups
- **Case management**—connection to housing, legal services, GED, job training.

The transdisciplinary staff includes two pediatricians, two early childhood specialists, a substance abuse specialist, several public health nurses, students, and volunteers. Clinical supervision to all professional staff is provided by the substance abuse specialist. Approximately 10 mothers and 20 children are served each year. Relationships with families begin shortly after the target child's birth and have continued for over two years.

demonstrated greater difficulty than they did during structured assessments. Marked differences were evidenced in children's performance on the unstructured tasks, while only modest differences were seen between the drug-exposed and premature groups in structured tasks (Rodning, Beckwith & Howard, 1990).

How much of these subtle behavioral differences is due to prenatal drug exposure and how much to the postnatal caregiving environment is unknown. Living in the chaotic, traumatic environment of a drug-abusing home can have a major impact on development (Zuckerman and Bresnahan, 1991). A study of infants exposed prenatally to heroin and opiates showed that the home environment, and not the amount of drugs the mother used during pregnancy, was the most important predictor of children's developmental outcome at age two (Lifschitz, Wilson & Smith, 1985).

Although we have much to learn about the developmental impact of prenatal exposure to drugs, a "main effects" model of development that identifies prenatal exposure to one or more substances as the sole cause of such developmental outcomes as language delay or impulsivity seems clearly inadequate. Such a model does not take into account such critical factors as maternal nutrition, quality of prenatal care, or aspects of the postnatal caregiving environment. We find more useful Sameroff and Chandler's transactional model of development (1975), which considers the pattern of mutual regulation between caregiver and infant. In this model, experiences of mutual regulation between caregiver and child during infancy and early childhood help children gradually achieve the ability to regulate their behavior themselves. But when the caregiver's ability to regulate her own behavior is impaired, mutual regulation between infant and caregiver is difficult to establish. This lack of mutual regulation between mother and child can lead to a lack of self-regulation and impacts the developmental and behavioral problems that researchers are finding among young children who were exposed to drugs prenatally and who have been reared by drug-abusing caregivers.

Barbara and Robert

Two years ago, Barbara and her son Robert joined the Women and Infants Clinic a few days after Robert was born at Boston City Hospital, with a positive urine toxicology screen for cocaine.

A typical week for Barbara and Robert begins on Monday when they arrive at the clinic for a well child check-up and a 6-month follow-up developmental assessment. Barbara will also check in with the substance abuse specialist, who is her primary case manager. Robert, a feisty toddler, enters the familiar waiting room confidently, looking for toys or a snack. Barbara is depressed today. She had a difficult weekend, is worried about relapsing, and needs assistance with housing and food. As the pediatrician and substance abuse specialist talk with Barbara, Robert plays quietly at his mother's side. When the visit ends, Barbara and Robert leave with food and taxi vouchers, housing information, and an appointment for Barbara with the substance abuse specialist for some individual counseling.

On Tuesday, Barbara meets with the substance abuse specialist. They discuss her recovery and also make some phone calls about housing together. As Barbara leaves, the substance abuse specialist reminds her gently that attendance at Thursday groups—a parent/child group and a relapse/recovery group—is mandatory for both Robert and Barbara.

On Thursday, Barbara and Robert begin the afternoon parent/child group session by singing "Hello" with the other mothers, children, and the early childhood specialists. After making play dough together, Barbara sings "Good-bye" to Robert and leaves him in child care while she and the other mothers participate in their relapse/recovery group.

The one-stop shopping model of services allows for coordination of services, close case monitoring, and comprehensive service delivery. But perhaps most important, the model provides a safe, non-stigmatizing, nurturing environment for women that sets the stage for developing a relationship of trust with providers. Two-year-old Robert expresses his feelings about the clinic with confident exploration and a smile; Barbara says, "I know someone will be there when I call."

Intervention strategies for women and children

The strategies we recommend to support infants exposed prenatally to drugs are not unlike those already recommended for all "fragile" children who need help with self-regulation because of neurobehavioral dysfunction that may be due to prematurity, lead poisoning, intrauterine growth retardation, or prenatal drug exposure (see Zuckerman, Bamforth, Cole & Kaplan-Sanoff, 1992). What is different for drug-exposed children is the likelihood that their caregivers may be unable to correctly read and respond to early indications of poor regulation in the child.

Mothers who are using drugs, and even mothers in early recovery, have impaired ability to read and regulate their own behavior, much less promote their children's development toward self-regulation. One woman who has attended our program for over two years sucks her thumb whenever she feels distressed. Although this is a primitive self-regulating strategy, it is an effective one for her, and one of the few mechanisms she has for regulating her own behavior without drug use. Yet mothers must be able to regulate their own behavior before they can promote their child's development towards self-regulation. The expectation that this mother can support her child's self-regulation through mutual strategies is unrealistic without help from a program, such as ours, which supports her attempts at self-regulation and guides her efforts to mutually regulate her child's strivings towards self regulation.

We believe that the best way to help the child of a mother who is using drugs is to help the mother recover. We work to support the mother's attempts at self-regulation

and guide her efforts to promote her child's self-regulation. Recovery is a developmental process, during which women can grow and mature, learn to experience and cope with feelings, feel positive regard, and learn how to develop positive, meaningful relationships (Brown, 1987). To be effective, we frame our interventions in a way that allows for growth and change in the parent as well as the child. Several specific strategies are central to our approach:

- *Denial busting:* Breaking through the denial used to maintain drug use is the first step toward recovery. Infant/family practitioners must be very clear with mothers about the effects of their drug use on themselves and their children. Most of us have been trained to be "supportive of parents," but if that support ignores the obvious effects of drug use, it can enable the mother's continued drug use. If we professionals take a child for medical or educational services without the mother, or if we do not tell the mother that she and/or her child need to attend to their physical care and appearance, we enable her continued drug use.
- *Limit setting:* Providers should set clear, firm limits with mothers, as with children. We must make the rules of the intervention program explicit and follow through on those rules. For example, we never meet with a parent when she is drunk or high. We reschedule the appointment and write down the time, with the assumption that the mother will not remember without this written reminder.
- *Building a therapeutic relationship:* Denial busting and limit setting are only effective if they occur within the context of a therapeutic relationship between the mother and provider. Such a relationship is built on both the mother's and provider's common concern for the best interests and well-being of the child. It must also involve active nurturance of mothers, many of whom have never been nurtured adequately themselves. The trusting, consistent relationships we seek to establish are likely to be unfamiliar for both mothers and providers. Mothers are likely to have experienced loss, exploitation, or abandonment when they have trusted others before; many staff members in emerging programs for drug-involved families will lack experience in therapeutic work with adults, or with parents.

Regular meeting times and a quiet, private place for mothers and providers to meet are essential. They demonstrate the value placed on the relationship. Active listening, including reflecting back in her own words what the mother has said, helps the provider understand and helps the mother feel understood. Expressions of concern about the mother's behavior must be balanced with words of praise and encouragement. More concretely, activities planned for mothers without their children demonstrate the provider's care and support of mothers as individuals. Through these adult field trips, adult art activities, and cooking projects, mothers find out what they can feel and accomplish—without needing to share the attention of the provider with their children.

Helping mothers to identify and label their feelings is a major part of nurturing. Because many mothers have used drugs to numb painful emotions, they can be completely out of touch with their own feelings, often substituting somatic complaints for the anxiety or depression that they are experiencing. Legitimizing the mothers' right to feel these emotions and helping them to label them constitute a critical first step toward helping children cope with their own growing emotional awareness. Mothers cannot tell children that it is all right to feel angry, sad, or confused until they have experienced and felt safe expressing their own anger, sadness, and confusion.

- *Assuring family safety:* Since both the parent and child are our clients, the boundaries and obligations of the therapeutic relationship are complicated, requiring attention and clarification. Although it is our job to support a woman in her recovery so that she can parent her child, it is also our job to assure the safety of the child. Most women are likely to relapse at some time during recovery. Substance abuse therapists use relapse as a learning experience for a woman, asking questions to help her identify why she felt compelled to use again and to develop alternate approaches when the need recurs. But for a young child, a mother's relapse can threaten physical safety and emotional security. When a mother relapses, we need to protect the child while the mother attends to her recovery. This stance need not involve "taking the child's side" over the mother's. Mother and child are a complex system, and often the best way to help the child is to help the mother. Supporting her parenting includes helping her protect her child from the kind of early experiences that caused her pain. This may mean using social services to keep the child safe while the mother enters a treatment program. It may mean providing extra treatment time for mother and child so that the mother herself can keep her child safe, continue her recovery, and avoid the trauma of separation for the child. Balancing identification between parent and child is always a challenge in work with infants and families, although not always one that is acknowledged. When anxiety about the family's safety adds to the level of stress, good clinical supervision is an essential support for the worker.

Caring for the caregivers: the need for clinical supervision

"I feel so helpless. It's really hopeless."—Addicted mother? Or provider working with addicted mothers?

Feelings of helplessness and hopelessness are common in people struggling with addiction. These feelings are also familiar to professionals working with addicts and their families. Why is this work often the most stressful and difficult

challenge we face as professionals? What can we do as professionals to keep ourselves healthy in order to work successfully with the families in our care?

The challenge of working with addicted families lies in the reality of addiction, addictive behavior, and the associated family dysfunction. Tragically, the intensity of families' needs is often coupled with barriers to serving families. For professionals, these barriers are formidable and, at times, overwhelming. Barriers to successful work with drug-involved families include: the lack of appropriate educational, social, and drug treatment services for families; lack of professional training and support; and our own feelings, attitudes, and beliefs about drug and alcohol addiction. We can overcome some of these barriers as individual professionals; others are beyond our individual control. Professionals can protect themselves from feelings of hopelessness and helplessness by recognizing what is in their control to change, and what is not. As the Alcoholics Anonymous serenity prayer suggests, we should remember in our work with families to "accept the things I cannot change, have courage to change the things I can, and the wisdom to know the difference."

- *Lack of treatment services:* Both the lack of appropriate intervention services and the lack of collaboration among agencies that do exist place an undue burden on professionals working with addicted families. It is hard enough for a professional to identify drug use in an individual. Having no place to refer the person or not knowing whom to call adds to frustration. As a result, some professionals may be tempted to retreat from, or overstep, the boundaries of their roles. They may ignore evidence of a drug problem, or indulge in rescue fantasies about crusading against City Hall on a family's behalf or stealing a child away in a shoulder bag. The real key to helping families, however, is knowledge of resources that are available in the community and networking with other professionals and agencies. Meeting with others around a challenging family not only allows for case coordination, close case monitoring, and professional support; it also offers the opportunity for professionals to advocate collectively for families. A collective voice offers professionals a renewed sense of hope and commitment to families.

- *Lack of professional training:* Professionals who work with drug-abusing families seldom lack commitment or concern, but rarely have they been prepared in their professional training for what they are likely to encounter in this work. One of my most distressing experiences as a young teacher occurred when I (KFR) arrived for a scheduled home visit, only to find both parents intoxicated and combative. Nothing in my training as a special educator had prepared me for that moment.

When professionals question their abilities and are unsure of their role with families, they become extremely anxious. A not uncommon response is to withdraw from involvement with families. "I became a teacher because I like **children**; I want to work with **them**" is a comment heard repeatedly in conversations with early childhood professionals. Yet professionals can feel helpful, hopeful and competent when they have the training and information they need. Education about the disease of addiction and training in family-focused intervention are **both** essential to provide professionals with a solid knowledge base from which to develop skills in recognizing addictive behavior, offering appropriate intervention strategies, assessing realistically a family's ability to change, and acknowledging that recovery is a life-long process. This kind of training takes time. Professionals who can set realistic goals for themselves as professionals, as well as for families, establish a climate of hopefulness for all involved.

- *Feelings, attitudes and beliefs:* Providers' feelings, attitudes, and beliefs about drugs and alcohol, derived from our personal experiences as well as our cultural and societal backgrounds, can impair our effectiveness with drug-involved families. The work can generate intense feelings of anger and resentment toward addicted families (especially toward women who are addicts) as well as feelings of helplessness and despair. In order to approach families in respectful, nonjudgmental ways, professionals need to recognize their own feelings, where they come from, and how to understand them.

One of the most significant lessons learned in our work with addicted families is the critical need for process-oriented clinical supervision for professionals. The process-oriented supervisory model used by the transdisciplinary team in the Women and Infants Clinic provides a safe arena for processing the intense feelings and associated stress that arise in our work with families. Clinical supervision combines information exchange and problem solving with self-exploration. Supervisors are less concerned with providing answers (often there is no one answer to a treatment question) than with empowering providers by encouraging them to think about a situation differently and come up with their own solutions or strategies.

Clinical supervision offers the professional a safe place to recognize, express, and accept a range of emotions—in herself and in others. Addicted individuals who are unable to recognize or manage painful emotions may project their feelings onto a "safe" caregiver, often the professional involved with the family. Professionals can use supervision to identify feelings of confusion and anxiety that they may themselves "pick up" from families. The supervisor can help the professional to distinguish clearly between her own needs and those of families, to realize that efforts to "rescue" needy families can undermine relationships and interventions, and to continue to work in a respectful, nonjudgmental way with parents even when a child is in trouble.

Supervision validates professional skills, supports professional growth, and recognizes the importance, as well

as the difficulty, of work with at-risk families. Professionals who seek and offer peer support give themselves and others a powerful gift. In caring for themselves, they model for other professionals the importance of receiving the nurturance they give so freely. Clinical supervision is not a luxury; it is a necessity in working with at risk families.

Keeping the vision

To work effectively with drug-using women and their children, we must have a vision of recovery for the mother and healthy developmental outcomes for the children. We must measure success in small steps and take "one day at a time." Helping a mother achieve sobriety is the first step toward the vision, but it does not guarantee success, either for mother or child. Just as we support a mother's efforts at sobriety, so we must support her efforts to become a better parent. Changing chaotic and crisis-oriented approaches to life cannot be a short-term goal, but issues can be addressed in small steps, within therapeutic relationships based on a shared desire for quality care for children.

Professionals who work with drug-involved mothers are not responsible for keeping women sober. It is our responsibility to share with each mother a vision of the future for herself and for her children, one which allows her to have hope and respect for the enormous efforts that recovery and parenting require. As providers, we must also have a vision for ourselves, one that allows us to sustain our professional growth and to fight the feelings of helplessness, hopelessness, and rage that we all can feel when combatting the effects of addiction upon children and families.

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Peer support for service providers

Sandy Sachs, MEd, LCSW

Boston area Early Intervention Providers join other providers across the country in seeing a dramatic increase in the need for services for families and children affected by substance abuse.

Caring for this diverse group of families brings many EI providers to their first contact with substance abuse treatment providers, to the need for an instant indepth understanding of the process of addiction and recovery, for additional clinical supervision from substance abuse specialists and for peer support around a variety of weighty and sensitive issues presented by families.

In September of 1991, with the staff of the Steps for Kids: A Family Recovery Outreach Project at Boston City Hospital, we began a peer support group for EI providers (particularly for educators and social workers) and child specialists in substance abuse treatment programs. Our goal was to begin to learn this new body of knowledge together, to define our special role in these programs, to break isolation for ourselves, to give ourselves a chance to explore our own feelings about themes presented to us on a daily basis. Our format is a peer support group which meets off sites one evening a month. Direct care staff have attended from 15 Boston area sites with staff from 4 sites participating on a regular basis.

During our open meetings, we began to take small risks, sharing our common learning-by-doing experiences, assisting in ongoing and everchanging program development for each of our sites, supporting each other and processing our own "transference" experiences and feelings. We discuss such topics as how to address the impact of domestic violence, gangs and community violence on families; how to assist parents in noticing their strengths, welcoming the return of the role of parenting to their lives in early recovery; and speaking to older children about their past drugging behaviors; how to work effectively with collateral agencies; and what "perks" draw parents to attend a parent and child program on a regular basis so that the program becomes a part of their newly structured life in the period of early recovery. The group also addressed the requests from parents for opportunities to have FUN for themselves and the need for humor in our day-to-day work life.

We also discovered a unique role that EI providers can play with this diverse group of families during the window of opportunity presented by early recovery. With parents, we can identify and address the overlapping needs and shared strategies of parenting in early substance abuse recovery. Many families come to the Early Intervention Program at a time when they are receiving their children back from relatives or from foster care. Parents may need to address their own feelings about their parenting behaviors while they were using substances while at the same time set firm limits on behaviors they see in their children.

Parents may need to boost their child's self image while they boost their own self esteem. Many parents have not had the opportunity to learn parenting skills or to parent sober before and are now addressing the diverse needs of an infant, a toddler and two school-age children for the first time. Though some parents do relapse and then come back to the EI program, many parents take advantage of the opportunity to share new parenting experiences, to learn about child development and day-to-day child care, to share coping strategies for themselves and their children and to learn how they can work with EI staff to get the services they need for themselves and for their children.

Our peer support group has learned a tremendous amount from the parents themselves. Parents from one Boston EI Program shared these ideas about the overlapping tasks of parenting and early recovery:

- Join a parenting group
- Deal with children's behaviors
- Accept the children for who they are
- Be patient
- Pat yourself on the back
- Have tolerance
- Don't expect
- Accept surprises
- Reward the good deeds
- Set and carry out a routine
- Be consistent
- Communicate with children
- Use trial and error
- Teach responsibility—walk your talk!
- Set limits—put your foot down
- Make clear messages
- Say thank you, appreciate children for their deeds and for themselves
- Ignore when needed, praise often

Tasks of early recovery (defined by the group as 0-5 years from the last drink or drug use and the beginning of changing your life):

- Put the drug and/or alcohol down
- Go to Narcotics and/or Alcohol Anonymous meetings regularly
- Change old behaviors
- Walk into fears
- Pull up your self esteem
- Change your attitudes
- One day at a time
- Get a relationship with a higher power

Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effects (FAE): A Lifespan View, with Implications for Early Intervention

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Alcohol is a legal drug. It remains widely used during pregnancy, both by women who use other drugs in addition to alcohol and by women who use no other drugs. Twenty years of following children exposed to alcohol before birth, as they move through adolescence into adulthood, have taught us that a significant level of prenatal alcohol exposure can have serious effects upon human development.

The impact of prenatal exposure to alcohol is long-lasting, raising challenges at each stage of development, and continuing beyond puberty. In the most heart-breaking situations, alcohol-affected children are raised with no awareness of their disabling brain damage. Parents and other caregivers may see these children's disobedience as willful; professionals can view the distraught parents as inept. But we do not yet know the best possible outcomes possible for fetal alcohol-affected children. Some may do well. Family experiences and expectations, cultural practices, schooling, and peer contact are all important; a good environment can foster development and buffer alcohol effects. Alcohol-affected children who do well may not have come to the attention of researchers, who have mostly studied clinical groups.

We believe that informed early intervention can bring hope to all parents and children dealing with prenatal alcohol exposure. This article is designed to help care providers in early intervention programs, developmental centers, and medical facilities shape realistic expectations and give new ideas for their work with fetal alcohol-affected children and their families.

Fetal Alcohol Syndrome (FAS) and possible Fetal Alcohol Effects (FAE)

What we know about prenatal alcohol exposure comes from both animal and human research (a selection of research data is given at the end of this article). An excellent overview of human data can be found in the National Institute on Alcohol Abuse and Alcoholism's *Seventh Special Report to the U.S. Congress* (1990). A listing of all recent (1990 to early 1992) animal and human studies on the issue of "alcohol and pregnancy" can be found in the National Institute on Alcohol Abuse and Alcoholism's bibliography on alcohol and pregnancy from the alcohol and alcohol problems science database (NIAAA, 1992). More research is upcoming.

The Centers for Disease Control are focusing increased attention on the incidence and prevalence of Fetal Alcohol Syndrome (FAS) and are supporting more research on community education, identification, and intervention.

Alcohol is a teratogen—a substance which can cause birth defects by affecting the growth and proper formation of the fetus' body and brain. When a pregnant woman drinks alcohol, it crosses the barrier of the placenta. The brain and central nervous system of the unborn child are especially sensitive to disruption by the effects of prenatal alcohol exposure.

Exposure to large quantities of alcohol before birth can lead to long-term developmental disabilities in the form of fetal alcohol syndrome (FAS). A medical diagnosis, FAS is characterized by: intrauterine growth deficiency; a pattern of specific physical anomalies, including characteristic facial features; and central nervous system dysfunction, evidenced by developmental delay, hyperactivity, problems in attention or learning, intellectual deficits, and/or seizures. FAS has been called one of the leading known causes of mental retardation in the western world. What is less well-known is that only about half of the children with FAS can be defined as mentally retarded, and not every child affected by prenatal alcohol exposure will show sufficient features for a firm diagnosis of FAS. Research is underway concerning "possible fetal alcohol effects (FAE)," a partial expression of the characteristics seen in FAS in cases where there is no strong alternative diagnosis. FAE can also cause developmental disability. We do not yet know why one child exposed to alcohol before birth shows FAS, another FAE, and another remains unaffected. The developmental effects of alcohol, like those of other teratogens, depend on the amount, timing, and conditions of exposure. Researchers are investigating genetic susceptibility to alcohol effects and are studying intensively the consequences of relatively lower levels of exposure to alcohol before birth.

In the *Seventh Special Report to the U.S. Congress on Alcohol and Health,* the incidence of FAS is estimated at 1 to 3 per 1000 live births. This incidence is nearly double that of Down syndrome, and almost five times that of spina bifida. But researchers are debating incidence figures, given how difficult it is to establish the frequency of a birth defect that is hard to pick out at birth, can be confused with other medical problems, and must be diagnosed by careful history and physical examination rather than by a laboratory test. Drinking levels and demographics of populations must be kept in mind when estimating ratios. It is even harder to estimate the incidence of the clinical category of FAE. Possible FAE may be three times as common as FAS.

Long-term prospects for people with FAS and FAE

To help a child made vulnerable by prenatal exposure to alcohol, it is wise to remember that these children have a biologically based disability and to know the possible long-term consequences of their condition. Then the early interventionist can puzzle out what places each child at risk, and what will help protect these children as they grow older.

For the past 20 years at the University of Washington in Seattle, we have followed the progress of individuals with FAS from childhood, through adolescence, and into

adulthood. The following description of characteristics at different ages of those with FAS and possible FAE is based on research with children who have come to the attention of clinicians and are thus likely to be more severely affected. Prenatal alcohol exposure can have many outcomes, perhaps because the central nervous system damage appears to be diffuse. It is important to remember that there are children with FAS/FAE who do not have all of these characteristics, and that all the characteristics described are not unique to the developmental disability of FAS/FAE. It is equally important to remember that the broad range of intellectual capabilities and other individual differences among children with fetal alcohol effects, as well as the impact of the caregiving environment, makes it difficult to predict how they will function as adults. Nevertheless, a general profile of "untreated" developmental skills at different ages can help to guide our thoughts about intervention with individuals with FAS/FAE.

Infants with FAS/FAE are usually small for height and weight. They may show jitteriness, tremulousness, weak suck, hyperexcitability, and fitful sleeping. There may be additional problems such as hypotonia (low muscle tone) and increased irritability. Infants exposed to alcohol may have more difficulty "habituating," or getting used to stimulation in their environment. It is important for children with FAS/FAE to be identified at birth, since they are high risk children in high risk environments. More severe cases of FAS can be identified in the newborn period but are often missed, just as alcohol use is unfortunately not often discussed with mothers. A recent report (Little, Snell, Rosenfeld, et.al., 1990) noted a 100 percent failure rate to diagnose FAS at birth at a large teaching hospital.

In the preschool years, children with FAS/FAE are often alert, talkative, and friendly. They have been described as typically short and skinny, with butterflylike movements but a generally vigorous appearance. Children with FAS/FAE may have severe temper tantrums and difficulty making transitions. More than half show hyperactivity, and many are over-sensitive to touch or other stimulation. Attentional deficits, fine motor difficulties, and developmental delays are also seen. Possible otitis media, eye problems and congenital anomalies must be monitored. In our clinical experience, preschool-aged children with FAS/FAE are often rewarding but tiring to those around them. Since children with FAS/FAE are small, adults often treat them like younger typically developing children, even when testing suggests delays. Their apparent skill level is often higher than their tested level of ability, especially in IQ and verbal skills. During early childhood they may appear to be progressing toward normalcy, but then problems may arise later in life.

In middle childhood, the behavioral profiles of children with FAS and FAE are marked by hyperactivity, distractibility, impulsivity, and memory difficulties. These youngsters are usually affectionate and interested in those around them, but often lack the social skills to make friends or stay away from strangers. In school, they often have trouble making transitions and predicting the consequences of their behavior. In the primary grades, these children's developmental deficits may result in academic problems. Their tendency toward concrete thinking interferes with learning abstract concepts, especially math. Behavior problems are often labelled by parents and teachers as intentional stealing, lying, or defiance. One parent of a boy with FAS found it more helpful to think of her son as a "stretched toddler": this image helped her to understand why, in middle childhood, he still had temper tantrums, didn't like to share, and needed simple, concrete rules, with clear consequences.

Adolescent and adult development of groups of individuals with FAS/FAE has been reported only recently. After puberty, the characteristic facial features and growth deficiency of individuals with FAS/FAE are harder to recognize, although they usually remain short in stature and often have small head size. Testing of adolescent and adult patients with FAS found an average IQ in the mildly mentally retarded range, with a wide range of functioning from severe retardation to intelligence within normal limits. Teenagers and adults with FAS or FAE seem to "plateau" academically and in daily functioning, but their problems grow more serious as attention deficits, poor judgment, and impulsivity create obstacles to employment and stable living. Adolescents and adults with FAS/FAE have been described as "innocent," immature, and easily victimized. They are at risk for serious life adjustment problems, including depression, alcohol abuse, and pregnancy.

"Reframing" our understanding of the behavior of individuals with FAS and FAE

Children with FAS/FAE vary considerably in their skills, in how they respond over time to treatment, and in whether they use feedback to regulate their behavior. They have a wide range of deficits, especially in how they process both object-related and social information. To understand needs and design intervention for children with FAS/FAE, care providers must be open to new ways of looking at the problems involved.

Lacking an understanding of fetal alcohol effects, parents and caregivers may say about children with FAS/FAE:

- "She has tantrums because she's *stubborn*, that's all!"
- "He could sit still if he just *tried hard enough!*"
- "She forgot to put away her toys *just to get on my nerves* . . ."
- "You know it's just that his *parents don't know how to handle him* . . ."

The first three "explanations" imply that the youngster with FAS or FAE is choosing to exhibit problem behaviors such as temper tantrums, forgetfulness, or overactivity. The final statement suggests that difficult behaviors occur because the parents are not skilled enough, or perhaps don't care enough, to learn good management techniques.

These explanations miss a very important point: brain damage or central nervous system (CNS) dysfunction underlies the problems of people with FAS or FAE. Understanding this point can allow behaviors to be

"reframed," or looked at in a different way. For example, informed early interventionists can help parents take a new look at the persistent temper tantrums often seen in preschool aged children with FAS. Instead of blaming children's tantrums on their own "bad parenting" (as neighbors, other family members, and some professionals are wont to do), parents can understand persistent temper tantrums as difficulties in making transitions, regulating mood, or handling outside stimulation. All of these problems arise from dysfunction of the central nervous system. Reframing can be especially important as children with FAS/FAE grow, and the consequences of their behavior problems become more serious. For instance, stealing by a youngster with FAS/FAE can be understood as an inability to understand that one can't just take something one wants because it might belong to someone else. "Reframing" does not excuse inappropriate behavior, but rather allows interventions to be based on the real cause of the problem: CNS dysfunction.

School systems, early intervention agencies, and communities can also rethink their handling of the problems of FAS and FAE. Individuals with genetically transmitted disabling conditions are not blamed because they have difficulty functioning day-to-day, and their parents are not blamed because these children have difficulty learning. We make attempts to provide these individuals with appropriate education and training for successful job placements. We can do the same for the teratogenic disability of FAS/FAE.

A framework for early intervention for children with FAS and FAE

Taking a long-term view of FAS/FAE can help parents and care providers shape realistic intervention early in life. Help for families should begin when fetal alcohol-affected children are young, with the understanding that intervention may continue throughout the child's life. Early intervention may not overcome the vulnerability of a child with FAS, but it can be a key to reducing family stress in the present and to improving later outcome.

Since much human neurological development occurs after birth, alcohol-affected children can make considerable progress given adequate nutrition and caregiving (Coles, 1991). Appropriate services may be more available and accessible to the young child with FAS/FAE and his family than to an older youth with FAS/FAE. Informed early intervention professionals may be able to break down systemic barriers to services for older children, by helping to qualify a child for later services, such as special vocational training or alternatives to the juvenile corrections system, even if the child does not have "low enough" test scores at a particular time to meet eligibility requirements.

Good early intervention for children with FAS/FAE depends on early identification. Early interventionists may be in a position to alert families to the possibilities of fetal alcohol effects, but actual diagnosis requires a trained health professional (such as a specialist in birth defects). FAS should be considered when infants are diagnosed as "failure to thrive," since growth deficiency and problems in sucking are characteristic of both diagnostic classifications. Asking families about alcohol and drug use during pregnancy requires care and training, and should be done according to agency guidelines by a staff member chosen and trained to ask about these issues. A resource guide published by the Northwest Regional Perinatal Care Program (1990) lists questions to ask and pointers on what to do once an answer is given.

In working with FAS/FAE, service providers should assess family stress and coping strategies, as well as the family environment. If the problem has been identified early, it is during their children's infant and toddler years that families realize that FAS and FAE will present lifelong problems. This means dealing with guilt, anger, and sorrow over past alcohol use and the fact that their children's problems could have been prevented. Early interventionists can tailor assistance to the needs of adoptive, foster, or biological families as they adapt to the idea of raising a child with developmental disabilities. All families can use information about normal development and fetal alcohol effects, and help in looking toward the future. Many will appreciate connection to resources including Supplemental Security Income (SSI), parent support groups, respite care, and counseling.

Since children with FAS/FAE will face long-term developmental challenges, their parents, and indeed all care providers, must learn to advocate for the child and work with other systems to provide the comprehensive services needed. Just as no teacher or parent alone can cope with the problems of FAS/FAE, no single service system should be expected to serve people with FAS and FAE. It takes time and persistence to handle the successive challenges these children offer.

Guidelines for intervention with families and children with FAS/FAE

A good environment for the child with FAS/FAE can foster development and offer protection against the effects of prenatal alcohol exposure. We believe that early intervention, especially, can make a difference, and a great deal is already known about what constitutes appropriate intervention for young children with FAS and FAE.

Parents of children with FAS and FAE may have problems with substance abuse or themselves have disabilities resulting from fetal alcohol effects. In consequence, children with FAS/FAE are likely to experience ongoing substance abuse within the family, poverty, parental depression, abuse and/or neglect within the home, or multiple out-of-home placements because of parental alcohol use. In our clinics, we are starting to see "second generation" fetal alcohol effects—adolescents with FAE who show poor judgment, become involved in substance abuse, and then find themselves parenting a drug- or alcohol-affected child.

Recognizing FAS or FAE in a child can bring help to the biological mother by uncovering her drinking problem, and perhaps preventing future alcohol-affected children.

Ongoing substance use may require referral for treatment, along with careful attention to the stability and quality of the child's home placement. We have found several guidelines helpful in working with substance-using or alcohol-affected parents of children with FAS/FAE:

- Understand that these parents may be less skilled than they appear.
- Keep parenting advice concrete.
- Set up structured parent support.
- Have modest expectations about what these parents can do on their own.
- Refer these parents for needed treatment and help agencies be sensitive to the needs of individuals with fetal alcohol effects.

For infants with FAS or FAE themselves, the most important initial intervention is enrollment of the baby in a high-risk infants' monitoring system that follows the child's developmental progress, home environment, and health. Warm and nurturing parent-child relationships can be strengthened by helping parents pay attention and respond to the cues of babies with FAS/FAE. Infancy is a good time to build a caregiving network, including respite care, that can support parents or be activated if the parent cannot care for the child.

In addition to warmth and nurturance, careful behavior management is important early in the lives of children with FAS/FAE. One set of parents raising a daughter with FAS described early childhood as the time to learn how to "walk the delicate balance between allowing control and setting limits." Early interventionists can help families achieve this balance by showing them how to "reframe" behaviors they see in their children with FAS/FAE. Parents can also learn that it may take much more time than they expected, or different parenting strategies, for their child with FAS/FAE to learn better ways of coping with change and stimulation.

Well-established principles of therapeutic child care also apply to early intervention programs serving young children with FAS/FAE. These include: a low staff-child ratio, changing the environment to help structure the child, and setting up daily routines. A focus on communication can help: trying to understand what children are communicating through misbehavior, providing language for feelings, and working on language delays. Sources of information about specific intervention strategies in this evolving field are listed at the end of this article.

Recommendations for early intervention agencies

We recommend four chief strategies for early intervention agencies dealing with the problems raised by fetal alcohol effects:

- **First, set up pediatric care, high-risk monitoring systems, and screening within early childhood agencies to identify (but not stigmatize) children with FAS and FAE.** Some of these children need early intervention but may not exhibit the severe deficits that in many jurisdictions constitute eligibility for service. An effective identification system means that staff must be trained and directed to ask questions about children's alcohol and drug exposure. Guidelines for responsible sharing of information must be developed and enforced.
- **Second, set up systems to identify parents who may be substance-using or who may be fetal alcohol-affected or otherwise developmentally disabled.** Set up systems to refer these parents as needed for alcohol/drug treatment and parenting education and support. In work with these parents, keep in mind the guidelines mentioned earlier in this paper.
- **Third, train health professionals, early childhood care and education providers, and other personnel about fetal alcohol effects and substance abuse.** Personnel who should be trained include neonatal and pediatric hospital staff; public health nurses; community obstetricians and pediatricians; center-based, family, and therapeutic child care providers; Head Start and family resource center staff; personnel in drug/alcohol treatment programs for pregnant women; and providers of service to abused and neglected children.
- **Fourth, ensure continuing care in infancy, early childhood, and beyond.** Early interventionists can provide continuity of care by setting up a referral system for children identified with FAS/FAE and by developing comprehensive plans with families and in the community to meet the needs of children with known or suspected fetal alcohol effects.

Prevention and early intervention

Fetal Alcohol Syndrome and Fetal Alcohol Effects are **preventable** forms of developmental disability. We can encourage prevention of FAS and FAE by raising public awareness, providing alcohol/drug treatment services to pregnant women, and educating professionals about alcohol effects. But for children born with fetal alcohol effects, prevention is no longer possible. Hope begins with early intervention. The keys to appropriate early intervention for children with FAS/FAE are: developing and maintaining realistic expectations; thinking long-term; learning to "reframe" child behaviors; and keeping an open mind about goals and strategies for working with children and families.

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Clearinghouses, parent newsletters, and slide show on FAS

Clearinghouse for Drug-Exposed Children, Division of Behavioral and Developmental Pediatrics, University of California, San Francisco, 400 Parnassus Avenue, Room A203, San Francisco, CA 94143-0314, tel: (415) 476-9691

Fetal Alcohol and Drug Unit, University of Washington School of Medicine, Department of Psychiatry and Behavioral Sciences, 2707 Northeast Blakeley Street, Seattle, WA 98105, tel: (206) 543-7155

Fetal Alcohol Education Program, Boston University School of Medicine, 7 Kent Street, Boston, MA 02146

ICEBERG Newsletter—a quarterly educational newsletter for

people concerned about FAS and FAE . . ." because the problems we readily see are only the tip of the iceberg"; $5/year for families, $15/year for professionals. Available from P.O. Box 4292, Seattle, WA 98104

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National Clearinghouse for Alcohol and Drug Information, P.O. Box 2345, Rockville, MD 20852, tel: (301) 468-2600 or 1-800 729-6686

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Tobacco Control Advocacy: Winning the War on Tobacco

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Anyone who works directly with infants, toddlers, and their families or considers herself an advocate for their well-being should be concerned about controlling tobacco use. Tobacco use is one of the most significant threats to fetal and infant health, as well as being the single most important preventable cause of premature death in the United States. While past efforts to control tobacco use have focused on helping individuals to quit smoking or motivating them not to begin, more recent efforts to prevent smoking are population based. These efforts aim to change community norms and standards about smoking and often involve advocacy to influence public opinion, and through it public policy.

Tobacco control advocates soon find that the major obstacle to their work is the tobacco industry, which seeks to continue to promote tobacco use. The stakes are high, and simply expressed: tobacco industry profit vs. the public health. Fortunately, promising comprehensive tobacco control programs are beginning. These include antismoking education and tobacco control research made possible by California's Proposition 99, and ASSIST (American Stop Smoking Intervention Study for Cancer Prevention), a 17-state collaborative effort between the National Cancer Institute and the American Cancer Society, along with state and local health departments and other voluntary organizations.

This paper will review the health hazards and demographics of tobacco use, and provide an introduction to the techniques of tobacco control and media advocacy. It will also discuss the tobacco industry's strategies to oppose health promotion, and what advocates can do to overcome them.

Health hazards of tobacco

Tobacco takes a terrible toll on our nation's health. Each year, nearly one-half million Americans die from tobacco-induced illnesses; these represent approximately one in every five deaths in the United States.[1] Of tobacco related deaths, approximately one-third are due to cardiovascular disease, one-third to cancer—mainly lung cancer—and one-third to chronic lung disease and other diseases.[2] Tragically, most tobacco deaths are premature; men and women who die between age 35 and 69 from smoking related diseases, will lose, on average 22 years of life.

Tobacco is an extremely addictive substance, and it is the nicotine in tobacco that causes addiction. Nicotine is psychoactive or "mood-altering", and can produce pleasurable effects. It also causes physical dependence; withdrawal from nicotine produces a withdrawal symptom. Addiction to tobacco is similar, pharmacologically and behaviorally, to addiction to drugs such as heroin and cocaine.[3]

Smoking during pregnancy can cause numerous pregnancy complications, including abruptio placentae, placenta previa, bleeding during pregnancy, premature and prolonged rupture of membranes, preterm delivery, and low birthweight. Studies have shown a 25 to 50 percent higher rate of fetal and infant deaths among women who smoke during pregnancy, compared with women who do not smoke. Smoking has also been linked to SIDS.[4]

The U.S. Surgeon General has concluded that smoking is probably the most important modifiable cause of poor pregnancy outcome among women in the United States. On average, babies born to mother who smoke weigh 275 grams less than babies born to mothers who do not smoke; babies born to smokers also show decreased head circumference and birth length. Eliminating smoking during pregnancy could prevent 3000 (5 percent) of perinatal deaths, about 20 percent of low birthweight births, and about 8 percent of preterm deliveries. Among groups with a high prevalence of smoking, such as women without a high school diploma, eliminating smoking during pregnancy could prevent about 10 percent of perinatal deaths, about 35 percent of low birthweight births, and about 15 percent of preterm deliveries.[5]

More recently, the health hazards of environmental tobacco smoke (ETS), sometimes called passive or involuntary smoking, have become apparent. ETS is a cause of lung cancer in non-smokers and may cause as many as 40,000 deaths from heart disease in non-smokers.[6] Although ETS is responsible for acute and chronic respiratory disease in children up to 14 years of age, its impact is most pronounced in the first year of life. Infants of parents who smoke have a significantly increased risk of bronchitis, pneumonia, chronic middle ear effusions, Respiratory Syncytial Virus infection, and respiratory symptoms. Exposure to ETS increases the incidence and severity of asthma in children. ETS impairs post-natal lung development, complicating the *in utero* damage to the lung thought to be caused by maternal smoking during pregnancy. In addition, children of smokers have been found to have cognitive deficits of a magnitude similar to that seen with chronic lead exposure.[7]

Demographics of tobacco use and exposure

In 1988, 49.4 million (28.1%) of Americans were current smokers, including 30.8% of all men, and 25.7% of all women. The overall prevalence was higher among blacks (31.7%) than whites (27.8%) and Hispanics (23.5%). Now and for the foreseeable future, the best demographic predictor of smoking status will be level of educational attainment, with smoking far more common among those with lower levels of educational attainment. In 1988, 15.9% of college graduates were smokers, whereas 34% of those without a high school diploma were smokers.[8] Indeed, if current trends continue, by the year 2000, the prevalence of smoking among college graduates may be as low as 5%, while the prevalence of those with a high school diploma or less may still be in the 30% range.[9] In the future, tobacco-related illnesses will occur, disproportionately, in the less educated, and serve to further widen the already huge gaps in American society.

The National Center for Health Statistics estimated that one out of five pregnant women smoked throughout her pregnancy in 1989. Smoking during pregnancy was more common among white women (20%) than among African American women (17%) or Hispanic women (8%). Again, educational attainment is a critical predictor of maternal smoking: the prevalence of smoking among mothers with four or more years of college was 5%, while that of those without a high school diploma was 35%.[10] Quitting smoking completely in the first 3 to 4 months of pregnancy appears to protect the fetus from pregnancy complications. However, of those women who quit smoking during pregnancy, 70% resume smoking after delivery.[11]

Infants' and children's exposure to environmental tobacco smoke largely mirrors the smoking patterns of the U.S. population. In 1988, nearly half the children 5 years of age and under had significant exposure to ETS, as through smoking by the mother or other household member, since their birth. Exposures are highest among children from families with low income, and low education. 67% of children from homes where the mother had not completed high school were exposed to ETS, as compared with 35% of children whose mother's had 1 or more years of college.[12]

The tobacco industry's role in promoting tobacco use

Growth and development of the tobacco industry

How did we get where we are today? For the answer, we must study the growth and development of the United States tobacco industry, which was reviewed extensively in the 1992 Report of the U.S. Surgeon General, *Smoking and Health in the Americas*.[13] Tobacco is native to the Americas, and was used by the indigenous people for thousands of years for ceremonial and religious purposes. The European explorers brought tobacco to Europe from the New World; over the next few centuries, tobacco use was popularized around the world. Tobacco grew well in the southern U.S., and quickly became an important cash crop for the developing colonies. Over the next few centuries, tobacco growing became entrenched, economically and politically, well before its health hazards were known—the underlying reason for our current problem.

Despite its long history of cultivation, per capita tobacco consumption was low until the 20th century, when cigarettes largely replaced pipes and cigars. Consumption rose steadily throughout the 20th century, peaking in 1963, because of:

- the invention of a machine to mass produce cigarettes in 1881.
- the invention of a safe, portable match, which eliminated the need to light tobacco products using a live fire.
- urbanization—the fast-paced urban environment seemed more suitable to a fast cigarette, than to the more leisurely paced pipe or cigar.
- the development of modern means of mass communication, which spurred the development of modern advertising and promotion techniques.

Unfortunately, knowledge of the health hazards of tobacco lagged far behind the increase in tobacco use, because tobacco-related diseases take several decades to appear, and do not appear in all tobacco users. Although initial studies linking tobacco to disease were published in the 1920s, public attention to the issue began only in the 1950s, when several retrospective epidemiologic studies provided scientific evidence strongly linking smoking to lung cancer. The *Reader's Digest* is credited with playing an important role in informing the public about the possible dangers of smoking, by publishing such articles as "Cancer by the Carton."

Under strong pressure from the medical and voluntary health organizations, the U.S. federal government established the Surgeon General's Advisory Committee on Smoking and Health in 1962. The 10 participants, selected in consultation with representatives of the tobacco industry, reviewed over 7,000 publications before issuing their landmark report in 1964. The report determined that cigarette smoking is the most important cause of lung cancer and chronic bronchitis, and that male cigarette smokers had a 70 percent excess mortality rate over men who had never smoked. It concluded that "Cigarette smoking is a health hazard of sufficient importance in the United States to warrant appropriate remedial action."

The report established a strong position for the federal government, generated tremendous publicity and unleashed a firestorm of controversy. In the ensuing decades innumerable organizations and individuals would take up the cause of decreasing tobacco use. The resulting tobacco control movement, one of the largest and most important public health efforts ever conceived, has reduced the prevalence of smoking each year since 1964, and saved hundreds of thousands of lives in the process. Its has educated much of the American public about the health hazards of tobacco, has helped enact hundreds of laws designed to protect non-smokers from ETS, made smoking

unacceptable in many social circles, and convinced fully one half of all persons who have ever smoked to quit.

Unfortunately, the tobacco control movement has been much less successful in preventing youth from initiating tobacco use, and has not reached all sectors of the U.S. population, particularly women and those with lower levels of education. Increasingly, a population or community based approach to tobacco control is favored, because it will reach these segments of the population most efficiently and effectively.

The tobacco industry's role in promoting tobacco use.

In order to protect its highly lucrative investment, the tobacco industry operates in direct opposition to the tobacco control movement. It is important to reflect historically on the response of the tobacco industry, then a multimillion dollar enterprise, to the earliest reports of possible health hazards of cigarettes. It is clear, in retrospect, that the industry adopted a strategy to deal with reports of tobacco's health hazards, from their earliest appearance. That strategy was to reassure the public that evidence of any health hazard was merely circumstantial, unproven and unresolved. In short, at an early juncture, the tobacco industry decided to lie to the American public. They have been lying ever since.

The industry has both a legal and philosophical need to deny any health hazard of tobacco. An admission that smoking is hazardous would be used to the industry's disadvantage in the many tobacco liability lawsuits, and would make impossible the industry's charade of portraying smoking to its customers as a pleasurable and innocent "habit" or behavior.[14]

The tobacco industry has many ways to promote tobacco use, of which the most visible is advertising and promotion. Expenditures for advertising and promotion, which have risen steadily since 1964, totalled $3.2 billion in 1988. Advertisements encourage youth to initiate smoking, discourage quitting by current smokers, and encourage both brand loyalty and brand switching among current smokers. Cigarette advertisements are "Alive With Pleasure", and portray smoking as sexy, healthy, glamorous, and fun. Additionally, because cigarette smoking decreases body weight, "diet terms", such as thin, long, slim, and superslim, are commonly used in brand names and advertisements directed at women and girls. Many believe these appeals to weight control to be the most effective means by which these groups are targeted to smoke.

Tobacco advertising also impairs the public's knowledge of tobacco's health hazards, because publication's which accept tobacco advertising are loathe to cover the health hazards of tobacco to avoid offending tobacco advertisers. It is not a coincidence that the *Reader's Digest*, which first alerted the public to the health hazards of tobacco in the 1950s, does not accept tobacco advertisements. Women's magazines, many of which rely heavily on tobacco advertising, rarely discuss tobacco.[15] The effect of this "self-censorship" should not be underestimated, as many of the most vulnerable women and girls rely heavily upon women's magazines for health information.

Promotional activities are also important for tobacco marketers. As defined by the Federal Trade commission, non-advertising promotional activities include sample distribution, promotional allowances, public entertainment, and direct mail. Examples of such promotions include the familiar Marlboro Grand Prix, Virginia Slims Tennis, and the promotion of many music and art events. Promotional activities, which frequently receive broad television coverage, promote smoking in general, as well as particular brand names. They also portray the sponsoring tobacco manufacturer as a good corporate citizen and serve to "buy respectability".

The tobacco industry also employs a more insidious type of promotion which receives little public attention—philanthropic donations to community organizations. It is little recognized that the tobacco industry is a generous corporate donor to many women's leadership and political organizations, including the National Women's Political Caucus, the American Association of University Women, the League of Women Voters Education Fund and the Women's Campaign Fund.[16] The industry is also a strong supporter of African-American and Hispanic-American organizations. Such pro· ·tions help ensure the political silence of these organizations and enable the industry to continue to target the constituents of these organizations for tobacco sales.

The tobacco industry is recognized as one of the most effective and powerful lobbyists at the federal level, and has been such for many decades.[17] Indeed, it is the political clout of the industry which is largely responsible for the dearth of federal regulation of tobacco products. The tobacco industry lobbying has persuaded Congress to exempt the industry from all federal safety and health legislation, not to increase excise taxes, not to restrict advertising, and not to inaugurate tobacco education and prevention programs.[18] The industry also maintains an active lobbying profile at the state and local level.

Traditionally, health advocates have focused on enacting legislation at the local level, where citizen's groups have their greatest leverage, and where attempted tobacco industry influence is easiest to expose. As a result, the tobacco industry has resorted to lobbying for state-wide legislation aimed at pre-empting local legislation. Increasingly, health advocates will be required to work at the state level, to protect their hard won ordinances, and to make further progress in enacting tobacco control legislation.

The efforts to enact and protect California's Proposition 99 are a case in point. In 1988, California voters approved a 25 cents-a-pack tax on cigarettes, despite a $21 million tobacco industry campaign against the measure. One quarter of the proceeds were designated to antismoking education and tobacco control research; in 1991, this amounted to $115 million dollars. The centerpiece of Proposition 99 is a series of antismoking ads, appearing on television and in print media. The ads, which portray smokers as being duped by the scheming of the tobacco industry, have been

remarkably effective. Smoking among California adults decreased a dramatic 17%, over a three year period. In 1990, of those who quit, half cited the ads as a reason, and one-third said they were the main reason. Despite this remarkable success, California's Governor Pete Wilson has worked determinedly to abolish the anti-smoking program, especially the ad campaign.[19] It is widely speculated that Wilson is beholden to the state's well financed tobacco lobby. Today, the future of this remarkable program hangs in the balance.

Diversification has been an important strategy for the tobacco industry since the 1950s; the most familiar linkages are that of Philip Morris-Kraft, and the R.J. Reynolds-Nabisco. Diversification provides an outlet for the phenomenal cash flow and profitability of the cigarette industry. It also provides greater power and leverage to protect the cigarette business from regulation, legislation and liability suits, and has broadened the political coalitions against anticigarette legislation.[20] The public often views diversification as an indication that the tobacco industry is decreasing its reliance on tobacco products. In reality, this a misconception; in each case, tobacco remains the basis of the firm's profitability.

The declining market for cigarettes in the United States, and the potential for sales to populations with a low smoking prevalence, has motivated cigarette companies to promote sales overseas. Two of the four largest transnational firms are based in the United States: R.J. Reynolds and Philip Morris. These firms are among the largest U.S. manufacturing firms, and among the largest in the world, exerting considerable economic influence worldwide. Abroad, these firms employ practices no longer permitted in the United States, such as television and media advertising, selling cigarettes with a higher tar and nicotine content, and selling cigarettes without warning labels.

Furthermore, the federal government has aided the efforts of the cigarette manufacturers, through its U.S. Trade Office. The Trade Office's threat of trade sanctions succeeded in opening cigarette markets to U.S. companies in Japan, Taiwan, and South Korea.[21] Two years ago, vice-President Dan Quayle told a Republican audience in North Carolina that "Tobacco exports should be expanded aggressively, because Americans are smoking less."[22] Abroad, as at home, cigarette manufacturers target "growth markets", groups such as women and children, which have not traditionally smoked.[23] If present trends continue, the efforts of the U.S. cigarette manufacturers may effectively reverse the tremendous contribution the U.S. has made to improving international health. This is an evolving tragedy.

Tobacco control advocacy

Traditionally, health professionals have dealt with the problem of tobacco by addressing the needs of individuals, be they people who smoke who must be motivated to quit, or young people who must be influenced not to initiate smoking. Increasingly, however, the tobacco control movement has turned to advocacy, to influence public opinion, and thereby the social environment and public policies regarding tobacco.[24] Advocacy, in contrast to lobbying, does not involve specific legislation, although it may deal with issues which should be addressed legislatively. The distinction is important, because public funds may not be used to lobby, and because non-profit organizations may use only a small proportion of their tax-exempt funds for lobbying.

Advocacy efforts are most often directed at the general public. They may utilize "events", such as press conferences, petition drives, rallies, or demonstrations. They may also involve personal visits, letters, or telephone calls to decision makers, such as elected officials, business owners, or school principles. Most often, however, advocacy efforts involve gaining the media's interest because of the media's power to influence large numbers of people and command the public's attention.

Effective use of the media requires both gaining access to the media and properly framing a story for public consumption.[25] To the media, the issue of tobacco is an "old story". Nonetheless, because of its tremendous public health importance, tobacco receives renewed attention each time a new or fresh angle can be drawn upon it. However, not all stories help advance tobacco control; some are of no use, others may even be counterproductive. It is the advocate's job to both provide a fresh angle and to shape the story to advance a particular goal.

The local media will often cover both the local and national aspects of a story. Advocates must be prepared to localize and personalize a story for the media, and need to be knowledgeable about the local and national "scene". Placing a story may involve preparing and distributing a press release, writing a letter to the editor or an op-ed piece, or meeting with an editorial board. Most often, it is as simple as a call to a reporter. *Smoke Signals,* prepared for the American Cancer Society by the Advocacy Institute; identifies four important means of gaining access to the media:

Opportunism: Seizing an opportunity to tie a tobacco issue to a current news story.

Health news: The public's insatiable appetite for health news ensures the coverage of a "scientific breakthrough," a national statistic given a local angle, the monetary cost of a health hazard, and other stories.

Shaming the tobacco industry and their allies: The public's derisory view of the tobacco industry and its allies can be used to place stories focusing on the industry's irresponsible behavior.

Using Public Service Announcements and paid counter-commercials: PSA's and judiciously used paid advertisements allow maximum control of a story's content.

"Creative epidemiology", digesting and dramatizing scientific facts and figures for public consumption, is an important advocate's tool. Creative epidemiology translates large or obscure figures into more readily understood terms. For example, the fact that almost one-half million Americans die each year from tobacco can be illustrated by saying that number is equivalent to two jumbo jets crashing each

day, with no survivors. Advocates must always be thinking for novel ways to interpret what are, to much of the public, dry and dusty figures.

Shaping or framing a story to maximize its benefit is another important part of working with the media. Advocates must recognize the tobacco industry's primary tactic: to shift attention from its own efforts to sell a lethal and addictive drug. For example, the industry will portray the tobacco "problem" as a fight between smokers and non-smokers, it will assert that youth begin smoking because of peer influence or social pressure—not because of tobacco advertising—it will contend that advocates are patronizing in their efforts to protect women and minorities from targeted advertising, and it will hide behind the advertising industry which contends that so long as tobacco is legal, it should be legal to advertise without restrictions. It is critical to ensure that the blame falls where it belongs—squarely in the lap of the tobacco industry and its allies.

Tobacco control advocacy is best learned by doing, and by examining both successful and unsuccessful advocacy efforts. In some cases, advocates have lost because they were outspent, or outmaneuvered. In other cases, they have lost because of flaws in their own plans.

Tobacco control in the 1990s

A major force in shaping tobacco control in the 1990s will be the American Stop Smoking Intervention Study (ASSIST), sponsored by the National Cancer Institute and the American Cancer Society. ASSIST will focus on promoting progressive tobacco control policies in the public and private sector. Seventeen states were awarded 24-month ASSIST planning contracts in September, 1991: Colorado, Indiana, Maine, Massachusetts, Michigan, Minnesota, Missouri, New Jersey, New Mexico, New York, North Carolina, Rhode Island, South Carolina, Virginia, Washington, West Virginia, and Wisconsin. During the five-year intervention phase, beginning in September, 1993, each state will implement a comprehensive tobacco control intervention, through locally based coalitions and use of the health care system, schools, the worksite, and other channels to reach target groups.The National Cancer Institute has committed $115 million to this seven-year project; additional funds will be provided by the American Cancer Society to its local divisions.

ASSIST will focus primarily on four subject areas: tobacco advertising, youth access to tobacco products, clean indoor air restrictions, and tobacco pricing. Action in these four areas, occurring simultaneously in so many states, will drive similar activities in neighboring states and, perhaps, at the federal level.[26] ASSIST is expected to dramatically decrease domestic tobacco use, although the states can expect to battle the tobacco industry, a formidable enemy, each step of the way.

Summary

Diminishing tobacco's toll on infants and children, as well as on the general population, remains one of the highest public health priorities. In difficult financial times, it should be noted that, in contrast to many public health needs, addressing tobacco requires mainly public will, not public expenditures. Addressing tobacco will come at significant cost, however, to the tobacco industry, a well financed and formidable foe. Nonetheless, the experience of the last two decades demonstrates that winning the tobacco segment of the "war on drugs" is possible. Successful advocates will remember the words of Paul Ehrlich—"pessimism has no survival value."

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26. For information about ASSIST, including the names of project directors and media contacts in each participating state, contact the National Cancer Institute, Applied Tobacco Research Section, at (301) 496-0273, fax: (301) 496-8675.

The OSAP National Resource Center

The Office for Substance Abuse Prevention (OSAP) in conjunction with the Maternal and Child Health Bureau (MCHB) established the **OSAP National Resource Center for the Prevention of Perinatal Abuse of Alcohol and Other Drugs** in June 1991. The OSAP National Resource Center serves as a focal point for prevention and addressing the problem of maternal alcohol, tobacco, and other drug use and the resulting consequences for the fetus and other children. The Center's activities include: leadership development, increased coordination and collaboration in the field, knowledge base development and information dissemination, training, and technical assistance for professionals in the field.

Through its **information and referral services** the Center seeks to provide professionals in the field with the most accurate, up-to-date information and useful resources on the problem and effective prevention, intervention, and treatment strategies. The Center's library and information resource base contains over 2,000 resources and documents on a variety of subjects including: prevention and early intervention strategies and programs; identification, assessment and referral tools; recruitment and retention strategies for AOD treatment clients; caring for drug-exposed infants and medical management of pregnant alcohol and drug abusing women; and, legal and confidentiality issues. The Center's information and referral services can be accessed from 9:00 A.M. to 5:00 P.M. EST at 1-800-354-8824 or locally in the Washington, D.C. area at 703-218-5600.

The OSAP National Resource Center's computer modem accessible **Perinatal Research and Education Management Information System (PREMIS)** has been developed to serve as a major repository of easily accessible information on all aspects of maternal addiction prevention and intervention. The on-line system houses the Center's library database and an experts/resource persons database. PREMIS also includes profiles of programs, organizations, resource persons, funding sources, and legislation. The system can be accessed by modem through an on-line account.

The Center's primary training initiative is the **Community Team Training Institute (CTTI)** which provides an opportunity to support community-based efforts to engage multidisciplinary, cross agency, and community leadership in efforts to prevent the problem. CTTI recruits and trains interagency teams composed of local leadership from drug abuse treatment, maternal and child health, child welfare, social services, health care, education, judicial/legal, government, housing, religious, and grass roots organizations. CTTI will provide these teams with a customized program of structured community assessment, problem identification and strategic planning. Teams are selected through a competitive application process and awarded funding to cover travel, lodging, and per diem expenses for the five-day training event in the Washingotn, D.C. area.

The Center provides practical, hands-on **technical assistance** to States, communities, and professionals to foster the development of innovative strategies and programs. Experts and resource personnel in the field are available to provide on-site and off-site technical assistance. For more information on any of these services please contact the Center's information and referral line at 703-218-5600 or 1-800-354-8824 from 9:00 A.M. to 5:00 P.M. EST.

Videotapes:

Note: **With this issue of *Zero to Three*, we begin a regular column on videotapes related to work with infants, toddlers, and their families. We will feature primarily tapes designed to train practitioners and parents or raise their awareness about some aspect of infant/family development. Producers who are interested in having their videos reviewed should contact Emily Fenichel, Editor, *Zero to Three*, tel: (703) 528-4300, fax: (703) 528-6848.**

Straight from the Heart: Stories of Mothers Recovering from Addiction (1992) - Vida Health Communications (Vida Health Communications, 6 Bigelow Street, Cambridge, MA 02139) $275. Free previews can be arranged by calling (617) 864-4334.

Produced in partnership with NAACOG (the National Organization for Gynecologic, Obstetric and Neonatal Nurses), this 28-minute video portrays a culturally diverse group of six mothers in various stages of recovery from alcoholism and drug addiction. Each woman tells her story in her own way. Topics covered include: personal histories of women with substance abuse problems; what it is like to "hit bottom"; ambivalence about treatment, and overcoming denial; the impact of substance abuse on children; how to ask for help; treatment options; the rewards of getting and staying clean; and relapse prevention.

Straight from the Heart is designed for showing in prenatal settings as well as in the hospital during post-partum stays, offering chemically dependent women the chance to receive information in privacy. A national hotline number at the program's conclusion gives viewers a source for further information about treatment options. The video is also designed for use in training care providers.

A Challenge to Care: Strategies to Help Chemically Dependent Women and Their Children - Vida Health Communications and NAACOG (Vida Health Communications, 6 Bigelow Street, Cambridge, MA 02139). $275. Free previews can be arranged.

This 38-minute video is designed to help health and social service providers understand more about addiction and learn specific, practical interventions to use in caring for women during pregnancy and women and infants after birth. Using graphics and interviews with a range of experts, four video chapters demonstrate: methods for approaching women at risk; how to conduct a non-judgmental substance use history; the impact of drugs on fetal development; signs of concern at labor and delivery; behaviors of newborns exposed to drugs or alcohol; how to comfort and handle substance-exposed babies; a Brazelton Neonatal Behavioral Assessment of a cocaine-exposed baby; postpartum teaching of chemically dependent mothers; and pediatric follow-up combined with substance abuse therapy for mothers. Legal issues, public policy, and health care protocols are also discussed.

ZERO TO THREE Notes

by Eleanor S. Szanton

In keeping with our ongoing interest in intensive, multidisciplinary models of training individuals who work with infants and toddlers and their families, we have developed a 1992-93 City TOTS (Training of Teams) initiative, supported by the Prudential Foundation. Teams of 4-6 individuals from Atlanta, Boston, Chicago (two teams), Houston, Jacksonville, Los Angeles, Minneapolis, Philadelphia, and Phoenix were chosen to participate in City TOTS after a recruitment period that generated some 175 inquiries from 12 target cities. Each team submitted a proposal for a project designed to improve the training of practitioners who work with inner-city infants, toddlers, and their families. Proposed projects include strategies to:

- increase the knowledge of infant/family development and community organizing among paraprofessionals and professionals working with families at the neighborhood level;
- integrate infant mental health concepts and skills into training programs;
- improve practitioners' sensitivity to families and cultural competence; and
- improve the supervision available to professional, paraprofessional, and other direct service staff in infant/parent programs.

In November, 1992, all 10 teams will join City TOTS faculty, resource consultants, and staff for a week-long seminar at a retreat setting near Atlanta, Georgia. Seminar sessions will be based on the four elements of training for infant/family practice identified by **ZERO TO THREE**'s TASK (Training Approaches for Skills and Knowledge) Project. These are: 1) a knowledge base built on a framework of concepts common to all infant/family disciplines; 2) observation of a variety of infants, toddlers, and families; 3) reflective supervision; and 4) collegial support. Material will be presented in a variety of formats and from the perspectives of a range of professional disciplines. Meeting in their city teams and in larger groups, participants will begin to consider the content and training approaches most appropriate for the training initiative they are planning in their own cities.

Each team has planned together in advance its City TOTS objectives. For example, one group will plan for the development of a neighborhood-based group of "health advisors." Another will plan the content and approaches to a series of training sessions for staff working with children prenatally exposed to drugs or HIV positive.

Faculty for the City TOTS seminar are: **Rebecca Shahmoon Shanok**, Ph.D., M.S.W., chair of the faculty and Director of the Early Childhood Group Therapy Program, Child Development Center, Jewish Board of Family and Children's Services, New York City; **Blanca Almonte**, M.S., Director, Family Focus Nuestra Familia, Chicago and

Instructor, School of Social Service Administration, University of Chicago; **Evelyn Hausslein,** Coordinator, National Network of Parent Centers, Inc, Boston; **Brenda Jones,** M.S.W., Fellow, Bush Center on Child Development and Social Policy, Yale University and Lecturer, Howard University College of Medicine and Schoo' .f Social Work, Washington, D.C.; **Teresa Kohlenberg,** M.D., Director, Teen-Tot Clinic Boston City Hospital; **Jeree Pawl,** Ph.D., Director, Infant-Parent Program, San Francisco General Hospital, University of California San Francisco; and **G. Gordon Williamson,** Ph.D., OTR, Director Pediatric Rehabilitation Department, Johnson Rehabilitation Institute, John F. Kennedy Medical Center, Edison, NJ.

Five individuals who participated in **ZERO TO THREE**'s 1990-91 Training of Trainers Intensive Summer Seminar (TOTISS) are Resource Consultants to the City TOTS project, helping to plan and implement the curriculum and activities of seminar week. They are **Annette Axtmann,** Ed.D., Adjunct Associate Professor and Director, Center for Infants and Parents, Teachers College, Columbia University; **Trudy Latzko,** M.A., R.N., Project Coordinator, Continuing Education Consortium for Early Intervention Providers, (CECEIP), Eunice Kennedy Shriver Center, Waltham, MA; **Barbara Moss,** M.S., Director, Parent Infant Training Center, Dallas County Mental Health Mental Retardation, Dallas, TX; **Arlene Restaino-Kelly,** M.A., Director, The DART Center, Kean College of New Jersey; and **Barbara Wightman,** MPA, Occupational therapist, Institute for Human Development, Indian Children's Program, Flagstaff, AZ.

In the nine months following the seminar week, the 10 City TOTS teams will implement their planned training projects in their home cities. Teams will be able to consult with City TOTS project staff at **ZERO TO THREE** and to use City TOTS implementation funds to cover some expenses of their training projects.

An independent evaluation will address all phases of the City TOTS project, including recruitment, the seminar week, and the implementation of teams' training initiatives.

The City TOTS project, co-directed by **Linda Eggbeer** and **Emily Fenichel,** operates under the auspices of **ZERO TO THREE**'s Training of Teams Intensive Seminar Committee, which includes **Rebecca Shahmoon Shanok,** chair, and **Evelyn Hausslein, J. Ronald Lally, Jeree Pawl, Jack Shonkoff, and Gordon Williamson.**

For more information about City TOTS, or to discuss ideas for future training of teams initiatives, call or write Linda Eggbeer or Emily Fenichel at **ZERO TO THREE.**

We wish to thank readers who send contributions to **ZERO TO THREE,** the organization, along with their subscription renewals to *Zero to Three,* the bulletin. These contributions help in three important ways. First, they represent unrestricted funds that can be used for program planning and innovation. Second, they demonstrate to institutional funders that we have support from a committed constituency. Most important, they encourage us to think that you appreciate both **ZERO TO THREE** and *Zero to Three*—and that you are cheering us on.

Publications:

Can They Hope To Feel Safe Again? The Impact of Community Violence on Infants, Toddlers, Their Parents, and Practitioners (1992) - A report from the final plenary session, Seventh Biennial National Training Institute, **ZERO TO THREE**/National Center for Clinical Infant Programs (**ZERO TO THREE,** 2000 14th St. North, Suite 380, Arlington, VA 22201-2500) $5.00.

This booklet contains the edited transcript of the final plenary session (December 8, 1991) of **ZERO TO THREE**/National Center for Clinical Infant Programs' Seventh Biennial National Training Institute. It includes presentations by Clementine Barfield, founder and Executive Director of Save Our Sons and Daughters (SOSAD), Detroit, Michigan; Elizabeth Simpson, Project Director at the East Bay Activity Center, Oakland, California, and Betsy McAlister Groves, social worker in the Division of Developmental and Behavioral Pediatrics, Boston City Hospital. Data presented by Joy Osofsky, Professor of Pediatrics and Psychiatry, Louisiana State University Medical Center, New Orleans, are also included in the booklet, the publication of which is the first activity of an ongoing **ZERO TO THREE**'s Violence Study Group, chaired by Dr. Osofsky.

Although most current research efforts on the impact of community violence on children focus on children of school-age or older, the material in *Can They Hope To Feel Safe Again?* speaks specifically to the experience of infants, toddlers, their parents, and practitioners working in violent communities. Describing a two-year-old whose father was killed by gunfire as she rode with him in a car, Barfield writes:

> This little girl is afraid to ride in a car... She has night terrors—she can't explain or articulate to anybody what she is seeing or fearing, as an older child might... She is a "terror" in the group—it is almost impossible to help her keep still. She is acting out her sense of loss. She can't talk about it; she doesn't know how to explain it; so she acts it out.

Elizabeth Simpson describes symptoms frequently seen in young children growing up in a violent environment: anxiety, lack of impulse control, poor appetite, poor concentration, and flat affect; sleep disturbances; somatic complaints and stress-related syndromes; school phobia and school avoidance, linked to fears about parents' welfare; and issues of abandonment, separation, and loss. Betsy McAlister Groves describes work that she and her colleagues, Laura Taylor and Barry Zuckerman, are doing at Boston City Hospital. This includes direct clinical intervention with young children who have witnessed violence, consultation with day-care centers and child care providers in violent neighborhoods, and interventions with parents, many of whom are making "heroic and creative efforts to keep their children safe and to protect them from fear and worry about their own safety."

As a further step toward addressing the impact of

violence on children and families, **ZERO TO THREE** will sponsor a symposium entitled "The Impact of Violence on Infants, Toddlers, and Their Families: Epidemiology and Intervention," to be held in Washington, DC on December 4, 1992. For information on the symposium, contact Beverly Roberson Jackson, Director of Public Policy and Public Education, **ZERO TO THREE**, 2000 14th Street North, Suite 380, Arlington, VA 22201 2500, tel: (703) 528-4300, fax: (703) 528-6848.

Children in Danger: Coping with the Consequences of Community Violence (1992) - James Garbarino, Nancy Dubrow, Kathleen Kostelny, and Carole Pardo (Jossey-Bass, Inc., 350 Sansome Street, San Francisco, CA 94104) $24.95.

Finished in the fall of 1991, this book is a companion to the authors' 1991 volume, *No Place to Be a Child: Growing Up in a War Zone* and was written as part of their work with the Erikson Institute for Advanced Study in Child Development.

Children in Danger notes that our Western concept of childhood hinges on safety and special protection, and that when danger (both objective, and the feeling of impending harm) replaces safety as a condition of life for a child, children are increasingly susceptible to developmental harm and post-traumatic stress. All this is compounded in inner-city environments by poverty, family disruption, and community disintegration. In addition to using an ecological perspective to analyze the experience of children exposed to chronic violence, the authors explore four themes related to children's experiences in both actual war zones and inner-city neighborhoods in this country:

- The resilience of children subjected to chronic brutality *if* they have sufficient psychological and social resources;
- The enormous challenges faced by adults (often traumatized themselves) who care for children in situations of community violence;
- Alternative concepts of revenge that flow from the cultural and spiritual resources of children and adults caught up in situations of community violence; and
- Ideology as a motivator of children during times of crisis and stress.

Garbarino and his colleagues see psychologically oriented schools and child care centers as caregiving environments and centers for community organization that can protect children at risk of exposure to violence, help children cope with their experiences of violence, and serve as catalysts for mobilizing adult resources. They would like to see school emphasis on resilience and coping complemented by an elaborate program of individualized, therapeutic interventions, but recognize that for the present, traditional individual or family interventions "must be conserved as precious adjunct services ... saved for the most difficult cases."

Children at the Front: A Different View of the War on Alcohol and Drugs (1992) - The Child Welfare League of America (CWLA) North American Commission on Chemical Dependency and Child Welfare, Final Report and Recommendations (Child Welfare League of America, Inc. 440 First Street, NW, Suite 310, Washington, DC 20001-2085) $14.95.

This volume is the final report of a 70-member multidisciplinary commission convened in the fall of 1990 to discuss the nature of addiction and the best interests of children at all stages of development and within the context of the family and community. Individual chapters of the report examine chemical dependency and the child welfare system; address specific populations, including pregnant and parenting women and drug-exposed infants and toddlers; describe the current responses of the child welfare system to these populations; review related human service systems; and suggest strategies for improving services to children and chemically involved families at the local community level. A final Call to Action offers a "12 step" approach to child-centered public policies on abuse of alcohol and other drugs. Recommendations for the President, the Congress, the Department of Health and Human Services, governors, and state legislatures include the following:

- Place children and families at the forefront of our nation's alcohol and drug strategy by targeting additional funds to alcohol and drug education, prevention, treatment, and aftercare.
- Provide universal access to preventive, primary, and pediatric health care services which include alcohol and drug prevention and treatment services as mandated benefits for all children, adolescents, and families.
- Authorize and fund home visiting services for pregnant and postpartum women and their children, and make home visiting services an integral part of all programs targeted to chemically involved families in the child welfare system.
- Include alcohol- or drug-exposed children in the category of children who are at risk and eligible for early intervention services. Permit differential rates under the Child Care and Development Block Grant for the provision of services to meet the special needs of children exposed to alcohol and drugs.
- Increase funding for alcohol and drug training and cross-system skill building so that child and family service providers and direct caregivers can more effectively prevent and respond to alcohol or drug abuse in children and families.
- Improve decision making by the courts and the legal system through training and supportive services that ensure the legal system's understanding of child welfare laws and alcohol and drug issues, and sensitivity to the needs of children and chemically involved families.

Perinatal Substance Abuse: Research Findings and Clinical Implications (1992) - Theo B. Sonderegger, editor (The Johns Hopkins University Press, 701 West 40th Street, Suite 275, Baltimore, MD 21211) $95.00.

All drugs—therapeutic, legal, or illegal—affect a developing organism in many ways, observes the editor of this volume. For human infants as well as the young of other species, drug exposure early in life may produce a broad spectrum of changes that range from short-term physiological and behavioral effects to long-term morphological, physiological, and behavioral alterations. Changes may not manifest themselves until later in childhood or young adulthood. Some may persist throughout life or, in some instances, into the second generation. The combined efforts of clinicians and researchers, using all available research models, are needed, argues Theo Sonderegger, to understand the complexity of drug-exposure effects in order to plan interventions for and possible ameliorations of the detrimental effects of perinatal drug exposure. It is equally imperative that correct information about the extent and consequences of exposure to drugs during the perinatal period (including the limitations of research findings) reach the public, particularly legislators and judges.

Growing out of meeting presentations and exchanges during the past decade, the chapters in this book are intended to present state-of-the-art data on several common drugs of abuse—alcohol, marijuana, cocaine, PCP, amphetamines, and tobacco. Animal and clinical findings are presented. Three chapters are devoted to alcohol, the substance of abuse which has been studied for the longest period. These include information from longitudinal studies that show the consequences of exposure to alcohol early in life in children who have now reached adolescence or early adulthood, as well as new information about the consequences for offspring of paternal alcohol abuse. Contributors to the volume include Ernest Abel, Ira Chasnoff, Susan Dalterio, Diana Dow-Edwards, Loretta Finnegan, Peter Fried, Dan Griffith, Gaylia Harry, Judy Howard, Karol Kaltenbach, Sam Kepfield, Robin LaDue, Patricia McLaughlin, Joan Martin, Sandra Randels, Robert Sokol, Ann Streissguth, Alan Tomkins, Joanne Weinberg, Geraldine Wilson, Ian Zagon, and Betty Zimmerberg.

Recent Developments in Alcoholism, Volume 9 - Children of Alcoholics (1991) - Marc Galanter, editor (Plenum Publishing Corporation, 233 Spring Street, New York, NY 10013) $72.50.

This 9th volume of *Recent Developments in Alcoholism* includes sections on genetic predisposition, fetal alcohol syndrome, vulnerability to disease in relatives of alcoholics, and social and environmental issues. In a chapter on multilevel intervention for prevention of fetal alcohol syndrome and effects of prenatal alcohol exposure, Iris Smith and Claire Coles report that secondary prevention with reduction of alcohol intake in mothers during the second trimester of pregnancy resulted in infants who were superior in motor tone and behavior and reflexive behavior and were less tremulous, compared to infants of mothers who drank throughout pregnancy. This treatment team also demonstrated that the best predictors of drinking throughout pregnancy were the length of drinking history, reported history of tolerance to alcohol, a history of alcohol-related illness, drinking by siblings, and being more likely to drink with other family members—all factors likely to enable identification of women at risk early in pregnancy.

Other contributors to this volume writing on aspects of fetal alcohol syndrome include Stata Norton, Lois Kotkoskie, Ernest Abel, Robert Sokol, Claire Ernhart, Kathy Smith, Michael Eckardt, and Donald Gallant, Section Editor.

Handle with Care: Helping Children Prenatally Exposed to Drugs and Alcohol (1992) - Sylvia Fernandez Villarreal, Lora-Ellen McKinney, and Marcia Quackenbush (ETR Associates, P.O. Box 1830, Santa Cruz, CA 95061-1830) $17.95.

The situation for children born drug- or alcohol-exposed is not a hopeless one, say the authors of this book, designed to offer useful information for a broad spectrum of teachers, counselors, caregivers, parents, health care workers, and others working with children. The authors note that there is no single "profile" that will describe the circumstances or needs of all children with prenatal chemical exposure, and they recommend that schools and other service agencies should avoid labeling children as "drug-exposed" except where there is a specific clinical benefit to such labeling (in a medical setting, for example, or in formal developmental assessment).

Familiarity with cultural attitudes towards substance use and chemical dependency, note the authors, can be useful in prevention, treatment and recovery efforts. A chapter on cultural issues discusses: the "cultures" of substance use as differing by region, community, and neighborhood; ethnic trends and traditions in substance use; women and drugs; the drug culture; and the family as a key to recovery. A chapter on taking care of infants and toddlers with drug or alcohol exposure discusses medical care, developmental assessment, out-of-home placement, signs of neglect and abuse, and day-to-day care techniques. A chapter on helping families describes the advantages of multiservice family centers in areas with high levels of drug use and dependency. Case vignettes throughout the book describe several infants and toddlers, as well as older children. Appendixes provide background information about abusable substances; the effects of substance use on pregnancy, newborns, and children as they grow; tools for assessing development; and resources for information and treatment.

Fetal Alcohol Syndrome and Pregnant Women Who Abuse Alcohol: An Overview of the Issue and the Federal Response (February, 1992) - Barbara Anderson and Emily Novick (U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Office of Human Services Policy, Division of

Children and Youth Policy, Office of the Secretary, Washington, DC 20201) Free of charge.

Despite 20 years of research, treatment, and prevention efforts related to fetal alcohol syndrome (FAS) and alcohol related birth defects (ARBD), current knowledge about FAS is limited, the existing service system is fragmented, and too many of the population at-risk for alcohol abuse and FAS do not receive the services or benefits they need, conclude the program analyst authors of this report.

The report estimates the total annual cost of treating the birth defects caused by FAS as $1.6 billion in 1985. The authors identify gaps in appropriate services, treatment options, data collection systems, and knowledge about FAS. They note the need for treatment protocols to help professionals respond to changing needs of individuals with FAS as they mature, as well as a pressing need for treatment models that address the needs of pregnant women and mothers for prenatal care, child care and transportation. Data collection could be improved by better surveillance for FAS, more accurate and consistent diagnoses of FAS and ARBD by medical professionals, and a national reporting system for substitute dare and child protective services which includes information on parental substance abuse.

Conference call:

October, 1992

October 17-19: *Kids in Motion, Inc.* will sponsor a short course on "Assessment and Management of Developmental Visual Dysfunction" in Oak Lawn, Illinois. Rhoda P. Erhardt will be the instructor. Contact Maryann Maher or Mary Maiolo, Kids in Motion, Inc. 4721 W. Midlothian Tpk., Suite 25, Crestwood, IL 60445, tel: (708) 371-7007.

October 20-25: The *American Academy of Child and Adolescent Psychiatry* will hold its 39th annual meeting in Washington, DC. Topics of workshops and symposia will include depression in families, managed care/continuum of care, and bipolar disorder in preschoolers, children, and adolescents. Contact AACAP Annual Meeting, 3615 Wisconsin Avenue, NW, Washington, DC 20016, tel: (202) 966-7300.

October 23: *Boston University School of Medicine* and *Albert Einstein School of Medicine* will co-sponsor a seminar on "Dilemmas in nfant Growth and Nutrition," to be directed by Howard Bauchner, M.D. and held in New York City. Contact Boston University School of Medicine, Continuing Medical Education, 80 E. Concord Street, Boston, MA 02118, tel: (617) 638-4605.

November, 1992

November 5-10: The *National Council on Family Relations* will hold its 54th annual conference, entitled "Families and Work," in Orlando, Florida. Featured speakers will include Sheila B. Kamerman, Joseph H. Pleck, Arlie Russell Hochschild, and Brent C. Miller. Contact National Conference on Family Relations, 3989 Central Ave. NE, Suite 550, Minneapolis, MN 55421, tel: (612) 781-9331, Fax: (612) 781-9348.

November 12-14: *The Council for Exceptional Children* and *The Division for Culturally and Linguistically Diverse Exceptional Learners* will present a topical conference on culturally and linguistically diverse exceptional children in Minneapolis, Minnesota. Keynote speakers will be Li rong Lilly Cheng, Asa G. Hilliard, III, and Hiram Zayas. Contact Dao Tran, The Council for Exceptional Children, 1920 Association Drive, Reston, VA 22091-1589, tel: (703) 264-9450, TDD: (703) 620-3660.

November 15-19: The *National Association for Perinatal Addiction Research and Education (NAPARE)* will hold a seminar on Perinatal Addiction Issues and Interventions Development in Chicago, Illinois. A national training forum will be held **December 12-15.** For information on the seminar, forum, and other NAPARE educational events, contact NAPARE, 11 E. Hubbard Street, Suite 200, Chicago, IL 60611, tel: (312) 329-2512, Fax: (312) 329-9131.

November 19-22: The *National Perinatal Association* will hold its annual conference in Lake Buena Vista, Florida on the theme, "Vision of the Future—Changes and Challenges in Perinatal Care." Contact NPA, 3500 E. Fletcher Ave., Suite 525, Tampa, FL 33613, Tel: (813) 971-1008.

November 20-21: *The Boston Institute for the Development of Infants and Parents (BIDIP)* will hold its 17th annual conference, on infants and young children facing disabilities, in Boston, Massachusetts. Major topics will include genetic counseling, public policy and children with disabilities, and the parent perspective. Contact Nancy M. Terres, BIDIP, 26 Trapelo Road, Belmont, MA 02178, tel: (617) 484-6603.

December, 1992

December 4: ZERO TO THREE will sponsor a symposium in Washington, DC entitled "The Impact of Violence on Infants, Toddlers and their Families: Epidemiology and Intervention." For information, contact Beverly Roberson Jackson, Director of Public Policy and Public Education, **ZERO TO THREE**, 2000 14th Street North, Suite 380, Arlington, VA 22201-2500, tel: (703) 528-4300.

December 14-18: The *First Eilat International Symposium on Pediatric Developmental Science* will be held in Eilat, Israel on the theme "Early Childhood Intervention and Family Support Programs—Accomplishments and Challenges." Faculty will include Nicholas Anastasiow, Sara Friedman, Abigail Golomb, Shaul Harel, Pnina Klein, Deborah Lieberman, Samuel J. Meisels, Miriam Rosenthal, Abraham Sagi, Jack P. Shonkoff, Emanuel Tirosh, G. Gordon Williamson, and Rachel Yifat, among others. For information, contact Jack Shonkoff, fax: (617) 856-4287 or Carmel Organizers of Conferences and Events, P.O. Box 1912, Ramat Gan, Israel, tel: 972-3-5754040, fax: 072-3-5753107.

ZERO TO THREE is published 6 times per year. Subscriptions cost $29 per year, $55 for 2 years and $77 for 3 years. Subscribers may order additional copies of **Zero to Three** for distribution to staff or students at a rate of $14.50/ auxiliary subscription/year.

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