Resources to address the Unique needs of Rural communities for Availability/accessibility of Local services

The R.U.R.A.L. Project

Working With Drug-Abusing Families

Reference Guide

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The R.U.R.A.L. Project

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Introduction

What is Different About Rural Social Work?

Seventy-six percent of America's counties are rural, including all of the 28 poorest counties. Because rural communities rely more on minimum wage jobs and service sector employment, rural children are more likely to be poor (15.9%) than are children overall (12.6%). And yet, most child welfare programs are designed to fit the needs of urban and suburban families.[1] That is why this course was created: to better prepare child welfare professionals to meet the needs of rural clients and cope with the challenges presented by rural environments.

The following information about these challenges is from the Child Welfare League of America (CWLA).

Challenges Rural Communities Face

The needs of children and families in rural communities are related to a range of conditions that typify rural communities as a whole, such as poverty, barriers posed by cultural and racial differences, and geographical and social isolation. Some of these conditions include:

- Economic disadvantage: Higher poverty levels among rural families are tied to specific economic disadvantages: lower average incomes, low or seasonal employment, and out-migration of the better-educated.

- Health: Poverty is tied to significant health risks, such as higher rates of infant mortality, childhood illness, and nutritional deficits

- Disability: According to 1995 data, the 12.5 million people with disabilities who live in non-metro areas (23%) make up a higher proportion of the total than those who live in metro areas (18%).

- Housing: In rural areas, 23% of poor homeowner households and 27% of poor renter households were inadequately housed, compared to 17% and 22% in urban areas. Poor rural people cannot afford their housing because they lack necessary income, not because rural housing is expensive.[2]

Some statistics from the Economic Research Service on Rural Communities:

- The unemployment rate is 16% higher in rural areas than in urban areas (1st quarter 1997).

- 3.2 million rural children live in poverty.

- Child poverty rates in US rural communities increased 76% between 1973 and 1992.

- 23% of rural poor were either full-time workers or were in families with one or more full-time workers.

- 6.3 million rural households have household incomes under $15,000.

- More than 60% of rural people in poverty worked at least part-time or had a family member who worked at least part-time.[3]

The 40 million Americans who live in rural communities often lack access to critically needed social services. Sparse populations generally rule out the economies of scale that urban services can realize. Without vital human and material resources, many rural communities have not been able to develop effective infrastructures, train enough social service practitioners, or plan and deliver social services that take into account the general characteristics of rural populations. Since advocacy expressly focused on the needs of rural communities has been lacking, there has been little concerted, nationwide effort to mobilize resources for rural social services provision.[4]

Cultural and Racial Barriers

Many rural communities are composed of ethnic and racial minorities with language, cultural traditions, and family structures that differ from the dominant culture and from one another. According to 1998 US Census Bureau data, African Americans comprised only 9% of the rural population but make up 20% of the population which lives below the poverty level.[5]

- 48% of rural African-American children live in poverty.[6]

- 46% of rural Latino children live in poverty.[7]

- 41% of Native American children live in poverty.[8]

Poverty data indicates that these individuals may be employed but not earning enough to sustain themselves, let alone a family.[9]

References

1. *Challenging the One-Size-Fits-All Myth: Findings and Solutions from a Statewide Focus Group of Rural Socal Workers*, by Templeman, Sharon B., Mitchell, Lynda, Child Welfare, 00094021, Sep/Oct 2002, Vol. 81, Issue 5.

2. *Shaping Responsive Social Services for Rural America, Phase I: National Action Agenda* CWLA Draft, Child Welfare League of America, March 20, 2001, Washington, DC

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4. *Shaping Responsive Social Services for Rural America* CWLA Draft, CWLA

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7. Shadburn, Jan E., Statement , Rural Development Congressional Testimony, 2000 Congressional Session, Washington, DC

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9. Ibid

Senate Bill 636: Child Welfare Services Redesign

Senate Bill 636 has caused Child Welfare Services (CWS) to fundamentally change the ways in which child welfare services are administered in California. Practices being changed are based in part on successful efforts already underway in a number of counties throughout California and in other parts of the nation. The following is a summary of the key elements of this redesign.

Traditional System	*Reformed System*
• Is based on intervention, which is often seen as punitive and adversarial	• Based on prevention and early intervention, before problems occur or become intractable
• Is built on "one-size-fits-all" intervention model	• Through a new intake process, shifts to customized assessment of need and appropriate response
• Measures effectiveness as a reflection of compliance with process-oriented service plans	• Measures effectiveness in terms of children's safety, permanence, and well-being
• Minimizes exercise of professional judgment	• Promotes collaboration and non-adversarial relationships
• Focuses on processes and timeframes	• Focuses on results and meeting the needs of the family as a whole
• Establishes the Child Welfare agency as the single entity in charge	• Calls on a network of agencies, service providers and families within the community (with built-in accountability)
• Tends to regard reunification in either/or terms – either reunify or place in adoption or other settings	• Underscores the value of reunifying by maintaining and enhancing connection between children in care and their birth families
• Provides limited support for foster children transitioning out of system	• Adds support for young people as they leave foster care
• Does not systematically incorporate evidence-based practices	• Creates a process for infusing evidence-based practices into work with families and children
• Is restricted to funding mechanisms that are tied to specific strategies	• Allows flexible funding based on what is necessary for the well-being of children and families

About the RURAL Project

This Reference Guide is an element of The RURAL Project: Effective Child Welfare Practices in Rural Communities. It was created through a grant by the U.S. Department of Health and Human Services Administration on Children, Youth, and Families, to address issues relevant to social work in California's rural areas, and help rural practitioners use available resources more effectively in serving their clients.

About this Reference Guide

This Reference Guide contains information and resources pertaining to the topics covered in the seminar *Working with Drug-Abusing Families*. It includes summaries of some of the information for your review, articles that provide greater depth on topics that were covered briefly, and various tools and resources we hope you will find useful on the job.

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Impacts of Drug Abuse on Families

Introduction

Drug abuse in families has far-reaching effects on the emotional and intellectual development of children. You deal with its consequences at your jobs every day, and with parents who are unaware of or unwilling to acknowledge how their drug use affects their children. You are probably already aware of the drugs are being used in your own community, and how they are being used. This section provides information about commonly-abused drugs. It includes articles on prenatal effects by Dr. Ira Chasnoff and on effects on child development by Dr. Bruce Perry.

Overview of Commonly-Abused Drugs

The following drug information comes from the Police Department of the Village of Rockton, Illinois (www.rockton.org).

Methamphetamine

Street Names

> Crystal
>
> Ice
>
> Glass

Description

> Methamphetamine was created as an artificial chemical substance. Methamphetamine is a powder, sometimes made into capsules or pills.

Use

> Amphetamines are taken orally or injected. However, the addition of "ice," the slang name for crystallized methamphetamines has promoted smoking as another mode of administration. Just as "crack" is smokable cocaine, "ice" is smokable methamphetamine. Intravenous use of methamphetamines is abused by a subculture known as "speed freaks."

Dangers and Effects

> Chronic abuse produces a psychosis that resembles schizophrenia and is characterized by paranoia, picking at the skin, preoccupation with one's own thoughts, and auditory and visual hallucinations. Violent and erratic behavior is frequently seen among chronic abusers of amphetamines, especially methamphetamine. Methamphetamine, in all its forms, is highly addictive and toxic.

NOTE: *Methamphetamine abuse may be a particular problem in your area. For greater depth of information on this drug, please see the National Institute on Drug Abuse (NIDA)* Research Report on Methamphetamine Abuse and Addiction, *in the Appendix.*

Marijuana

Street Names

Weed

Grass

Chronic

Description

Marijuana is a green or gray mixture of dried, shredded flowers and leaves of the hemp plant Cannabis sativa.

Use

It can be eaten in certain foods or smoked. Marijuana is usually smoked in the form of loosely rolled cigarettes called "joints" or hollowed out commercial cigars called "blunts."

Dangers and Effects

Smoking marijuana may impair short-term memory while people are using the drug. This happens because all forms of marijuana contain THC (delta-9-tetrahydrocannabinol), the main active chemical in marijuana, which alters the way the brain works.

Heroin

Street Names

Tootsie Roll

Smack

Junk

Description

Heroin is produced from opium, which is obtained from seedpods of the oriental poppy. In its pure form it is a white to dark brown powder. Heroin is one of the most widely feared drugs. Another form of heroin, "black tar," has also become increasingly available in the United States. The color and consistency of black tar heroin results from the crude processing methods used to illicitly manufacture the substance in Mexico. Black tar heroin may be sticky, like roofing tar, or hard, like coal, and its color may vary from dark brown to black.

Use

Most users dissolve it in water, and then use a needle to inject it directly into a vein. Many users just snort the powder, which is equally dangerous.

Dangers and Effects

Because people who are high on heroin, or craving the next fix, don't use good judgment, they often share needles with other users. And sharing needles means

massive risk for HIV infection and hepatitis...two incurable diseases, which can kill.

Inhalants

Street Names

Rush

Poppers

Climax

Description

Inhalants are common household and workplace substances that are sniffed or huffed to give the user an immediate head rush or high. They include a diverse group of chemicals that are found in consumer products such as aerosols, plastic cement, fingernail polish remover, lighter fluid, hair spray, insecticides, and cleaning solvents.

Sniffing highly concentrated amounts of the chemicals in solvents or aerosol sprays can directly induce heart failure and death. High concentrations of inhalants also cause death from suffocation by displacing oxygen in the lungs and then in the central nervous system so that breathing stops.

People who use inhalants get a quick, giddy head rush. They are cheap and or readily available, making them an easy choice for those who use them. Users feel slightly stimulated and uninhibited, but within a minute or two, a major headache comes on (the first indication that this is a bad idea). Hallucinations and numb hands and feet are often part of the package. Suffocation and sudden death can occur even on the first time.

GHB

Street Names

Grievous Bodily Harm

Scoop

Liquid Ecstasy

Description

Sometimes it's a colorless, odorless, and slightly salty tasting liquid. (People often mix it into juices.) Sometimes it's a powder or a capsule. GHB (gamma hydroxybutyrate), a central nervous system depressant, was banned by the FDA in 1990.

Use

Gamma hydroxybutyric acid (GHB) produces a wide range of effects, drowsiness, dizziness, nausea, amnesia, visual hallucinations, severe respiratory depression, and coma. GHB is often combined in a carbonated, alcohol, or health food drink, and is reportedly popular among adolescents and young adults attending raves and nightclubs.

Dangers and Effects

Overdose frequently requires emergency room care and many GHB-related fatalities have been reported. GHB has been used in the commission of sexual assaults because it renders the victim incapable of resisting, and may cause memory problems that could complicate case prosecution. Since GHB has no odor or color, and because its taste is so subtle, there have been many cases of people slipping it into other people's drinks so they can take advantage of them.

LSD

Street Names

Acid

Blotter

Windowpane

Description

Lysergic acid diethylamide (LSD) is the most potent hallucinogen known to science. LSD is usually sold in the form of impregnated paper (blotter acid), typically imprinted with colorful graphic designs. It has also been encountered in tablets (microdots), thin squares of gelatin (window panes), in sugar cubes and, rarely, in liquid form.

Use

LSD usually comes in the form of a small, saturated piece of paper (a blotter) that users place on the tongue, where it infuses into the blood stream.

Dangers and Effects

In the hallucinatory state, the user may suffer impaired depth and time perception, accompanied by distorted perception of the size and shape of objects, movements, color; sound, touch, and the users own body image. During this period, the users' ability to perceive objects through the senses is distorted: they may describe "hearing colors" and "seeing sounds." The ability to make sensible judgments and see common dangers is impaired, making the user susceptible to personal injury. After an LSD "trip," the user may suffer acute anxiety or depression for a variable period of time. Flashbacks have been reported days or even months after taking the last dose.

Cocaine

Street Names

Blow

Snow

Nose Candy

Derivation

Cocaine is a powerful stimulant drug that comes from the leaves of the South American coca plant.

Description

Cocaine is a white powder that people either snort or dissolve and inject with a needle.

Use

Cocaine, at first, makes people feel energetic and powerful. As these feelings wear off, however, they quickly become depressed and edgy—and they start craving more to get their high back.

Dangers and Effects

Cocaine is among the most addictive drugs out there. Not only can it harm your body, it can mess up your life to the point where all that matters is your next fix. Being high on cocaine often results in violence, car crashes, falls, burns, and drowning. Cocaine can also make you violent or even make you do bizarre repetitive motions. Some users sit and repetitively draw doodles or, in severe cases, pick at their skin over and over to try to get the bugs out they think are underneath. People addicted to cocaine often do risky things they later regret. They may spend all their cash on cocaine, and do any number of other things to support their habit. In their pursuit to feed the crack and cocaine addiction, users hurt the people around them and often end up alone.

Crack Cocaine

Street Names

Rock

The Chunk

Derivation

"Crack" is the street name given to cocaine that has been processed from cocaine hydrochloride to a free base for smoking. The term "crack" refers to the crackling sound heard when the mixture is smoked (heated).

Description

"Crack," or the "rock" form of cocaine, is a ready-to-use freebase. It is sold in small, inexpensive dosage units that are smoked. Once introduced in the mid-1980s, crack abuse spread rapidly throughout America. It is noteworthy that the

emergence of crack was accompanied by a dramatic increase in drug abuse problems and drug-related violence.

Use

There is great risk whether cocaine is ingested by inhalation (snorting), injection, or smoking. It appears that compulsive cocaine use may develop even more rapidly if the substance is smoked rather than snorted. Smoking allows extremely high doses of cocaine to reach the brain very quickly and brings an intense and immediate high. The injecting drug user is at risk for transmitting or acquiring HIV infection/AIDS if needles or other injection equipment are shared.

Dangers and Effects

Smoking crack cocaine can produce a particularly aggressive paranoid behavior in users. When addicted individuals stop using cocaine, they often become depressed. Prolonged cocaine snorting can result in ulceration of the mucous membrane of the nose and can damage the nasal septum enough to cause it to collapse. Cocaine-related deaths are often a result of cardiac arrest or seizures followed by respiratory arrest.

Dr. Ira Chasnoff on Prenatal Cocaine Exposure

The following interview originally appeared in the Reconsider Drug Policy Quarterly, Spring 2000.

His research was preliminary…but then the media ran with it… and created the crack baby myth.

Dr. Ira Chasnoff, President of Children's Research Triangle, an independent research foundation in Chicago, and professor of pediatrics at the University of Illinois College of Medicine, has been studying the effects of drugs on developing fetuses and the long term development of these children for more than 20 years. His initial study of crack's effects on children, "Cocaine Use In Pregnancy," published in The New England Journal of Medicine, in 1985, was immediately picked up by the media, which launched terrifying stories about long-term damage crack does to babies, and the epidemic of "crack babies." Punitive drug policy grew out of this media frenzy, but Chasnoff and his researchers publicly objected to them. In this interview with Alexandra Eyle, Dr. Chasnoff talks about how the crack baby myth was born and discusses his longitudinal findings, which resulted in his latest book, "Understanding The Drug Exposed Child: Approaches to Behavior and Learning."

Q. Describe your initial findings, which resulted in the media uproar that resulted in a slew of articles and programs about an epidemic of "crack babies."

A. First of all, we never used the term "crack baby." That term was one of the things that evolved out of the media frenzy. That was a quick handle, but a very negative way to describe the children.

We had been following children prenatally exposed to drugs for over 10 years. We began recognizing increasing number of babies who had been born to mothers who used cocaine during pregnancy. Cocaine hit Chicago in 1980-1982, so we put together a prospective study to look at the effect of cocaine on pregnancy, because at that point there was very little information at all. We signed the study, and published it. We compared cocaine-exposed children to children whose mothers had been using heroin and methadone, and to a control group of children whose mothers had not been using drugs but who were from the same socio-economic background. We found that the children had an increased rate of birth problems, such as reduced birth weight, small head size, increased rates of pre-maturity and increased rates of *abruptio placenta,* where the placenta separates from the wall of the uterus, plus some neuro-behavioral problems-the babies were more irritable than those in the control group, they had difficulty focusing, and some had feeding problems.

And that was it. It was a very limited study in that it was on a new, relatively small population of children. We put it out there to raise the question – and that's what scientific research is all about: here's a clinical observation, here's a preliminary study beginning to look at that, and the question is, "what impact does cocaine have on prenatal growth and development?" After it was published, we began seeing articles written in the public media that went way beyond anything we ever said in the article… Rolling Stone magazine did a 12-page article all about crack babies and the horrible things that happen…and the very last paragraph…was a quote from me saying that, actually, the kind of stuff they'd been saying for the last 10-12 pages was probably not true. But they buried it right at the end…

Q. You did a longitudinal follow-up of the children ---

A. In 1992, we published our first article on the longitudinal follow-up of the children ["Cocaine/poly drug use in pregnancy: two-year follow up," *Pediatrics*, 1992], and we showed that at two ears of age, cocaine-exposed children had normal cognitive development. That was all the article said…All of a sudden we started seeing articles in the newspapers saying, "There's nothing wrong with cocaine use during pregnancy, it was all a myth," and again quoting our work. In fact, some of the articles were saying that the researchers who published this two-year outcome article were refuting everything the original [1985 New England Journal of Medicine] article had said.

Most of the people writing these articles didn't realize that we were the same people who had published the first article. Our follow-up article made it very clear that although cognitive development is normal, you have to look at the children long-term in order to understand what's really going to happen because cognitive development, as measured at two years of age, is not the whole picture.

When the children were three years old, we published another article that still looked at cognitive development and showed that when you controlled for environment, IQs of the children were in the normal range compared to controls. But [we also said that] although cognitive development was normal, we were beginning to see some behavioral problems that were going to have to be followed up as the children get older.

Two years ago, and last year, we began to publish articles on the children at four, five, and six years of age, as they reached school age. Bottom line is, long-term growth is normal, long-term medical issues are normal, and cognitive development is normal. However, we began to see behavioral issues emerge, with increased impulsivity, distractibility, difficulty concentrating, increased rates of off-task behavior. We reported these behavioral issues, and we did some sophisticated statistical modeling that asked the question, "Looking at cognitive development and behavioral development, what are the factors that most closely predict long-term development?"

For cognitive development, what we found was that prenatal drug exposure did not influence long-term cognitive development, but family environment was the strongest factor. Within the environment the single factor most closely related to long-term cognitive development was whether the mother continued to use drugs or not. The most important factor predicting long-term cognitive development is the home environment. We looked at the psychological status of the mother, her continuing drug use patterns and the level of developmental support in the home, and the single most important factor predicting cognitive development was whether the mother was continuing to use drugs.

Q: In other words, while she's parenting, the mother is dealing with drug-use issues, and related behaviors. So with a drug-using mom, the child is likely to have more problems.

A: …Which makes sense if he's not getting stimulation because his mom's on drugs. So, from a policy perspective, this means that we have to provide drug treatment to parenting women. So, out of this, many Head Start programs now incorporate linkages to drug treatment programs to mothers. Because, no matter how much you do in Head Start, if you're not also addressing substance abuse and violence issues at the home, the child is not going to do as well in the long term.

Q: What about behavioral development?

A: With behavioral development, we found that, although home environment had some influence on behavior, the most important factor predicting behavior long term was actually prenatal exposure (to cocaine).

Q: That goes against all common sense. You would think it would be the reverse.

A: Absolutely. In fact, we were so surprised by it that we were reluctant to publish it because we thought it couldn't be right. However, at the same time some animal studies started coming out – and I would refer you to the Annals of the New York Academy of Science, because there is an entire issue devoted to cocaine's effect on the brain in the growing child – and the animal studies showed the exact same thing. In the animal studies, what you found was that little baby rats born to mothers who use cocaine prenatally have long-term disruptions or abnormalities in the dopamine receptor system. The dopamine receptor system is mainly in the prefrontal cortex of the brain. That is the area of the brain that controls impulsivity, controls and regulates behavior. If the same physiological changes that are found in the animal studies hold true for humans – and of course you can't do autopsies on human

children – that would explain the behavioral issues we're seeing in drug-exposed children. And so we have to think of it as a problem in behavioral regulation. The same physiologic changes have been found in children with ADHD, but there are differences so we do not label these children as ADHD. I don't use that term. We talk about regulatory difficulties.

We have been doing a long-term outcome study of adopted children exposed to alcohol and cocaine prenatally. And what we are finding is the same thing. That cognitive development is quite good. The kids are quite bright. The adoptive family is really influencing cognitive development. However, significant numbers of these children are having the same behavioral difficulties.

How do you put this all together? We have been looking at this issue for a long time and our main interest now is not only what happens to children, but what do you do about it?

So now out intervention strategies focus on helping children develop regulatory capabilities.

Q: Can you do this?

A: It can be done in the early ages. We're now doing studies in the children 8-12 years old.

Q: What is your perspective on America's War on Drugs?

A: When the War on Drugs was initiated, it focused on what people called the hard drugs, cocaine, heroin. Those were the bad drugs. The good drugs were alcohol and tobacco. The other factor was, the War on Drugs focused on minorities, especially blacks. That was what is was all about. Now, if anybody at a policy level would admit that alcohol and tobacco are drugs of abuse and that white people as well as black people use drugs, you never would hear the term, "war on drugs." Because you don't declare war against the white middle class, and you certainly don't declare war on the tobacco companies.

Q: As a result of the mass media frenzy regarding crack babies, some state policies have been pretty intense – arresting mothers and separating them from their babies. As a physician, do you find that to be acceptable?

A: We were the first group to publish a statement saying that that is not acceptable…what's interesting is that there was a famous case in South Carolina [Whitner v. State. The 1996 South Carolina Supreme Court decision allowed a women to be criminally prosecuted for drug use during her pregnancy.] The frightening aspect of that was that both sides were using our publication to support their argument. And then I was called in as a witness for the ones fighting against that policy, and I support very much the fight against that policy, because it was clear to me, from looking at their data, that all that they accomplished was to drive the pregnant women out of the prenatal health care system. But the other side used our data! So it was quite an interesting experience.

From a policy perspective, you have to look at it from a public health perspective: when you implement laws and policies that drive women out of the prenatal health

care system, you do nothing but make matters worse and you are only increasing the number of risk factors the child is going to face.

Dr. Bruce Perry on Attachment and Bonding in Childhood

The following article was *adapted in part from* "Maltreated Children: Experience, Brain Development and the Next Generation" *(W.W. Norton & Company, New York, in preparation). From www.scholastic.com.*

Introduction

The most important property of humankind is the capacity to form and maintain relationships. These relationships are absolutely necessary for any of us to survive, learn, work, love, and procreate. Human relationships take many forms but the most intense, most pleasurable and most painful are those relationships with family, friends and loved ones. Within this inner circle of intimate relationships, we are bonded to each other with "emotional glue" — bonded with love.

Each individual's ability to form and maintain relationships using this "emotional glue" is different. Some people seem "naturally" capable of loving. They form numerous intimate and caring relationships and, in doing so, get pleasure. Others are not so lucky. They feel no "pull" to form intimate relationships, find little pleasure in being with or close to others. They have few, if any, friends, and more distant, less emotional glue with family. In extreme cases an individual may have no intact emotional bond to any other person. They are self-absorbed, aloof, or may even present with classic neuropsychiatric signs of being schizoid or autistic.

The capacity and desire to form emotional relationships is related to the organization and functioning of specific parts of the human brain. Just as the brain allows us to see, smell, taste, think, talk, and move, it is the organ that allows us to love — or not. The systems in the human brain that allow us to form and maintain emotional relationships develop during infancy and the first years of life. Experiences during this early vulnerable period of life are critical to shaping the capacity to form intimate and emotionally healthy relationships. Empathy, caring, sharing, inhibition of aggression, capacity to love, and a host of other characteristics of a healthy, happy, and productive person are related to the core *attachment* capabilities which are formed in infancy and early childhood.

Frequently Asked Questions

What is attachment?

Well, it depends. The word "attachment" is used frequently by mental health, child development, and child protection workers but it has slightly different meanings in these different contexts. The first thing to know is that we humans create many kinds of "bonds." A bond is a connection between one person and another. In the field of infant development, attachment refers to a special bond characterized by the unique qualities of maternal-infant or primary caregiver-infant relationships. The attachment bond has several key elements:

(1) an attachment bond is an enduring emotional relationship with a specific person;

(2) the relationship brings safety, comfort, and pleasure; and

(3) loss or threat of loss of the person evokes intense distress.

This special form of relationship is best characterized by the maternal-child relationship. As we study the nature of these special relationships, we are finding out about how important they can be for the future development of the child. Indeed, many researchers and clinicians feel that the maternal-child attachment provides the working framework for all subsequent relationships that the child will develop. A solid and healthy attachment with a primary caregiver appears to be associated with a high probability of healthy relationships with others, while poor attachment with the mother or primary caregiver appears to be associated with a host of emotional and behavioral problems later in life.

In the mental health field, attachment has come to reflect the global capacity to form relationships. For the purposes of this paper, *attachment capabilities* refers to the capacity to form and maintain an emotional relationship while *attachment* refers to the nature and quality of the actual relationship. A child, for example, may have an "insecure" attachment or "secure" attachment.

What is bonding?

Simply stated, bonding is the process of forming an attachment. Just as bonding is the term used when gluing one object to another, bonding is using our "emotional glue" to become connected to another. Bonding, therefore, involves a set of behaviors that will help lead to an emotional connection (attachment).

Are bonding and attachment genetic?

The biological capacity to bond and form attachments is most certainly genetically determined. The drive to survive is basic in all species. Infants are defenseless and must depend upon a caregiving adult for survival. It is in the context of this primary dependence, and the maternal response to this dependence, that a relationship develops. This attachment is crucial for survival.

An emotionally and physically healthy mother will be drawn to her infant — she will feel a physical longing to smell, cuddle, rock, coo, and gaze at her infant. In turn the infant will respond with snuggling, babbling, smiling, sucking, and clinging. In most cases, the mother's behaviors bring pleasure and nourishment to the infant, and the infant's behaviors bring pleasure and satisfaction to the mother. This reciprocal positive feedback loop, this maternal-infant dance, is where attachment develops.

Therefore, despite the genetic potential for bonding and attachment, it is the nature, quantity, pattern, and intensity of early life experiences that express that genetic potential. Without predictable, responsive, nurturing, and sensory-enriched caregiving, the infant's potential for normal bonding and attachments will be unrealized. The brain systems responsible for healthy emotional relationships will not develop in an optimal way without the right kinds of experiences at the *right times* in life.

What are bonding experiences?

The acts of holding, rocking, singing, feeding, gazing, kissing, and other nurturing behaviors involved in caring for infants and young children are bonding experiences. Factors crucial to bonding include time together (in childhood, *quantity* does matter!), face-to-face interactions, eye contact, physical proximity, touch, and other primary sensory experiences such as smell, sound, and taste. Scientists believe the most important factor in creating attachment is positive physical contact (e.g., hugging, holding, and rocking). It should be no surprise that holding, gazing, smiling, kissing, singing, and laughing all cause specific neurochemical activities in the brain. These neurochemical activities lead to normal organization of brain systems that are responsible for attachment.

The most important relationship in a child's life is the attachment to his or her primary caregiver — optimally, the mother. This is due to the fact that this first relationship determines the biological and emotional 'template' for all future relationships. Healthy attachment to the mother built by repetitive bonding experiences during infancy provides the solid foundation for future healthy relationships. In contrast, problems with bonding and attachment can lead to a fragile biological and emotional foundation for future relationships.

When are these windows of opportunity?

Timing is everything. Bonding experiences lead to healthy attachments and healthy attachment capabilities when they are provided in the earliest years of life. During the first three years of life, the human brain develops to 90 percent of adult size and puts in place the majority of systems and structures that will be responsible for all future emotional, behavioral, social, and physiological functioning during the rest of life. There are critical periods during which bonding experiences *must be present* for the brain systems responsible for attachment to develop normally. These critical periods appear to be in the first year of life, and are related to the capacity of the infant and caregiver to develop a positive interactive relationship.

What happens if this window of opportunity is missed?

The impact of impaired bonding in early childhood varies. With severe emotional neglect in early childhood the impact can be devastating. Children without touch, stimulation, and nurturing can literally lose the capacity to form any meaningful relationships for the rest of their lives. Fortunately, most children do not suffer this degree of severe neglect. There are, however, many millions of children who have some degree of impaired bonding and attachment during early childhood. The problems that result from this can range from mild interpersonal discomfort to profound social and emotional problems. In general, the severity of problems is related to how early in life, how prolonged, and how severe the emotional neglect has been.

This does not mean that children with these experiences have no hope to develop normal relationships. Very little is known about the ability of replacement experiences later in life to "replace" or repair the undeveloped or poorly organized bonding and attachment capabilities. Clinical experiences and a number of studies

suggest that improvement can take place, but it is a long, difficult, and frustrating process for families and children. It may take many years of hard work to help repair the damage from only a few months of neglect in infancy.

Are there ways to classify attachment?

Like traits such as height or weight, individual attachment capabilities are continuous. In an attempt to study this range of attachments, however, researchers have clustered the continuum into four categories of attachment: secure, insecure-resistant, insecure-avoidant, and insecure-disorganized/disoriented. Securely attached children feel a consistent, responsive, and supportive relation to their mothers even during times of significant stress. Insecurely attached children feel inconsistent, punishing, unresponsive emotions from their caregivers, and feel threatened during times of stress.

Dr. Mary Ainsworth developed a simple process to examine the nature of a child's attachment. This is called the Strange Situation procedure. Simply stated, the mother and infant are observed in a sequence of "situations": parent-child alone in a playroom; stranger entering room; parent leaving while the stranger stays and tries to comfort the baby; parent returns and comforts infant; stranger leaves; mother leaves infant all alone; stranger enters to comfort infant; parent returns and tries to comfort and engage the infant. The behaviors during each of these situations is observed and "rated." The behaviors of children in this testing paradigm is observed and categorized based upon both the child's willingness to re-engage with the parent, and the child's emotional state during the reunion.

Classification of Attachment	Percentage at One Year	Response in Strange Situation
Securely Attached	60 – 70%	Explores with M in room; upset with separation; warm greeting upon return; seeks physical touch and comfort upon reunion.
Insecure: Avoidant	15 – 20%	Ignores M when present; little distress on separation; actively turns away from M upon reunion.
Insecure: Resistant	10 – 15%	Little exploration with M in room, stays close to M; very distressed upon separation; ambivalent or angry and resists physical contact upon reunion with M.
Insecure: disorganized/ disoriented	5 – 10%	Confusion about approaching or avoiding M; most distressed by separation; upon reunion acts confused and dazed — similar to approach-avoidance confusion in animal models.

What other factors influence bonding and attachment?

Any factors that interfere with bonding experiences can interfere with the development of attachment capabilities. When the interactive, reciprocal "dance"

between the caregiver and infant is disrupted or difficult, bonding experiences are difficult to maintain. Disruptions can occur because of primary problems with the infant, the caregiver, the environment, or the "fit" between the infant and caregiver.

Infant: The child's "personality" or temperament influences bonding. If an infant is difficult to comfort, irritable, or unresponsive compared to a calm, self-comforting child, he or she will have more difficulty developing a secure attachment. The infant's ability to participate in the maternal-infant interaction may be compromised due to a medical condition, such as prematurity, birth defect, or illness.

Caregiver: The caregiver's behaviors can also impair bonding. Critical, rejecting, and interfering parents tend to have children that avoid emotional intimacy. Abusive parents tend to have children who become uncomfortable with intimacy, and withdraw. The child's mother may be unresponsive to the child due to maternal depression, substance abuse, overwhelming personal problems, or other factors that interfere with her ability to be consistent and nurturing for the child.

Environment: A major impediment to healthy attachment is fear. If an infant is distressed due to pain, pervasive threat, or a chaotic environment, the infant will have a difficult time participating in even a supportive caregiving relationship. Infants or children in domestic violence, refugee situations, community violence, or war zone environments are vulnerable to developing attachment problems.

Fit: The "fit" between the temperament and capabilities of the infant and those of the mother is crucial. Some caregivers can be just fine with a calm infant, but are overwhelmed by an irritable infant. The process of reading each other's non-verbal cues and responding appropriately is essential to maintain the bonding experiences that build in healthy attachments. Sometimes a style of communication and response familiar to a mother from one of her other children may not fit her new infant. The mutual frustration of being "out of sync" can impair bonding.

How do abuse and neglect influence attachment?

There are three primary themes that have been observed in abusive and neglectful families. The most common effect is that maltreated children are, essentially, rejected. Children who are rejected by their parents will have a host of problems including difficulty developing emotional intimacy; some of these are listed below. In abusive families, it is common for this rejection and abuse to be transgenerational. The neglectful parent was neglected as a child; they in turn pass on the way they were parented. Another theme is "parentification" of the child. This takes many forms. One common form is when an immature young woman becomes a single parent. The infant is treated like a playmate and very early in life like a friend. It is common to hear these young mothers talk about their four-year-old as "my best friend" or "my little man." In other cases, the adults are so immature and uninformed about children that they treat their children like adults — or even like another parent. As a result, their children may participate in fewer activities with other children who are "immature." This false sense of maturity in children often interferes with the development of same-aged friendships. The third common theme is the transgenerational nature of attachment problems — they pass from generation to generation.

It is important to note that previously secure attachments can change suddenly following abuse and neglect. The child's perception of a consistent and nurturing world may no longer "fit" with their reality. For example, a child's positive views of adults may change following physical abuse by a baby-sitter.

Are attachment problems always from abuse?

No, in fact the majority of attachment problems are likely due to parental ignorance about development rather than abuse. Many parents have not been educated about the critical nature of the experiences of the first three years of life. With more public education and policy support for these areas, this will improve. Currently, this ignorance is so widespread that it is estimated that one in three people had an avoidant, ambivalent, or resistant attachment with their caregiver. Despite this insecure attachment, these individuals can form and maintain relationships — yet not with the ease that others can.

What specific problems can I expect to see in maltreated children with attachment problems?

The specific problems that you may see will vary depending upon the nature, intensity, duration, and timing of the neglect and abuse. Some children will have profound and obvious problems, while some will have very subtle problems that you may not realize are related to early life neglect. Sometimes these children do not appear to have been affected by their experiences. However, it is important to remember why you are working with the children and that they have been exposed to terrible things. There are some clues that experienced clinicians consider when working with such children; these are listed below.

Developmental delays: Children experiencing emotional neglect in early childhood often have developmental delay in other domains. The bond between the young child and her caregivers provides the major vehicle for developing physically, emotionally, and cognitively. It is in this primary context that children learn language, social behaviors, and a host of other key behaviors required for healthy development. Lack of consistent and enriched experiences in early childhood can result in delays in motor, language, social, and cognitive development.

Eating: Odd eating behaviors are common, especially in children with severe neglect and attachment problems. They will hoard food, hide food in their rooms, or eat as if there will be no more meals even if they have had years of consistent available foods. They may have failure to thrive, rumination (throwing up food), swallowing problems and, later in life, odd eating behaviors that are often misdiagnosed as anorexia nervosa.

Soothing behavior: These children will use very primitive, immature and bizarre soothing behaviors. They may bite themselves, head bang, rock, chant, scratch, or cut themselves. These symptoms will increase during times of distress or threat.

Emotional functioning: A range of emotional problems is common in maltreated children, including depressive and anxiety symptoms. One common behavior is "indiscriminant" attachment. All children seek safety. Keeping in mind that attachment is important for survival, children may seek attachments — any

attachments — for their safety. Non-clinicians may notice abused and neglected children are "loving" and hug virtual strangers. Children do not develop a deep emotional bond with relatively unknown people; rather, these "affectionate" behaviors are actually safety-seeking behaviors. Clinicians are concerned because these behaviors contribute to the abused child's confusion about intimacy, and are not consistent with normal social interactions.

Inappropriate modeling: Children model adult behavior — even if it is abusive. Maltreated children learn that abusive behavior is the "right" way to interact with others. As you can see, this potentially causes problems in their social interactions with adults and other children. For children who have been sexually abused, they may become more at-risk for future victimization. Boys who have been sexually abused may become sexual offenders.

Aggression: One of the major problems with these children is aggression and cruelty. This is related to two primary problems in neglected children: (1) lack of empathy and (2) poor impulse control. The ability to emotionally "understand" the impact of your behavior on others is impaired in these children. They really do not understand or feel what it is like for others when they do or say something hurtful. Indeed, these children often feel compelled to lash out and hurt others — most typically something less powerful than they are. They will hurt animals, smaller children, peers and siblings. One of the most disturbing elements of this aggression is that it is often accompanied by a detached, cold lack of empathy. They may show regret (an intellectual response) but not remorse (an emotional response) when confronted about their aggressive or cruel behaviors.

Responsive adults, such as parents, teachers, and other caregivers make all the difference in the lives of maltreated children. The next article in this series, "Bonding and Attachment in Maltreated Children: How You Can Help," suggests some strategies to use to make a difference in a child's life.

Dr. Bruce D. Perry, M.D., Ph.D., is an internationally recognized authority on brain development and children in crisis. Dr. Perry leads the ChildTrauma Academy, a pioneering center providing service, research and training in the area of child maltreatment (http://www.childtrauma.org/). In addition he is the Medical Director for Provincial Programs in Children's Mental Health for Alberta, Canada. Dr. Perry served as consultant on many high-profile incidents involving traumatized children, including the Columbine High School shootings in Littleton, Colorado; the Oklahoma City Bombing; and the Branch Davidian siege. His clinical research and practice focuses on traumatized children: examining the long-term effects of trauma in children, adolescents and adults. Dr. Perry's work has been instrumental in describing how traumatic events in childhood change the biology of the brain. He is the author of more than 200 journal articles, book chapters, and scientific proceedings, and is the recipient of a variety of professional awards.

Intervention and Treatment

Introduction

In this section, we will discuss assessment tools that may be useful in working with families affected by drug use. We will include overviews of common treatment options, and an article by Dr. Ira Chasnoff on drug treatment for pregnant women and women with children.

The Addiction Severity Index (ASI)

The following description of the ASI is from the National Institute on Alcohol Abuse and Alcoholism.

The ASI is a semi-structured interview designed to address seven potential problem areas in substance-abusing patients:

- Medical status
- Employment and support
- Drug use
- Alcohol use
- Legal status
- Family/social status
- Psychiatric status

In 1 hour, a skilled interviewer can gather information on recent (past 30 days) and lifetime problems in all of the problem areas. The ASI provides an overview of problems related to substance, rather than focusing on any single area.

Target Population

The ASI can be used effectively to explore problems within any adult group of individuals who report substance abuse as their major problem.

It has been used with psychiatrically ill, homeless, pregnant, and prisoner populations, but its major use has been with adults seeking treatment for substance abuse problems.

Administrative Issues

- Approximately 200 items, 7 subscales
- Pencil and paper self-administered or interview
- Time required: 50 minutes to 1 hour
- Administered by technician
- Training required for administration
- A self-training packet is available as well as onsite training by experienced trainers

Scoring

- Time required: 5 minutes for severity rating
- Scored by technician
- Computerized scoring or interpretation available

The ASI provides two scores:

- **Severity ratings** are subjective ratings of the client's need for treatment, derived by the interviewer
- **Composite scores** are measures of problem severity during the prior 30 days and are calculated by a computerized scoring program

The ASI is normed on the following treatment groups:

- Alcohol, opiate, cocaine
- Public, private
- Inpatient, outpatient

The ASI is normed on the following subject groups: males, females, psychiatrically ill substance users, pregnant substance users, gamblers, homeless, probationers, and employee assistance clients.

Psychometrics

Reliability studies done:

- Test-retest
- Split half
- Internal consistency

Measures of validity derived:

- Content
- Criterion (predictive, concurrent, "postdictive")
- Construct

Clinical Utility of Instrument

The ASI has been used extensively for treatment planning and outcome evaluation. Outcome evaluation packages for individual programs or for treatment systems are available.

Research Applicability

Researchers have used the ASI for a wide variety of clinical outcome studies.

Copyright, Cost, and Source Issues

- Public domain: supported by grants from the Veterans Administration and the National Institute on Drug Abuse.

- No cost; minimal charges for photocopying and mailing may apply.

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NOTE: The full text of the Addiction Severity Index Lite instrument is in the Appendix.

The Trauma Symptom Checklist for Children (TSCC)

The Trauma Symptom Checklist for Children (TSCC) is a 54-item, standardized, self-report instrument that evaluates trauma-related symptomatology in children ages eight to sixteen. It includes the effects of child abuse and neglect, other interpersonal violence, and witnessing trauma to others. The following five items are samples taken from this instrument.

0 Never   1 Sometimes   2 Lots of times   3 Almost all of the time

1. Pretending I am someone else . . .	0	1	2	3
2. Remembering things that happened that I didn't like…	0	1	2	3
3. Getting mad and can't calm down . . .	0	1	2	3
4. Feeling like I did something wrong . . .	0	1	2	3
5. Having sex feelings in my body . . .	0	1	2	3

Dr. Ira Chasnoff on Drug Treatment for Mothers

The following article is from the Professional Education Series of the Maternity Care Coalition.

In his discussion of the links between drugs, alcohol, pregnancy and parenting, Chasnoff emphasized that secrecy about addiction inhibits effective intervention. He shared his belief that health care and social service providers can only help substance-abusing women by learning to ask questions that break down the secrecy barrier.

Chasnoff then summarized a research project conducted by his organization in Chicago to explain the variety of factors involved in women's substance abuse and interventions designed to address these causes in a realistic manner. The study involved 75 drug-using and 60 non-drug-using pregnant women from the same low-

income neighborhood in Chicago. Almost all of the women were African-American and with incomes below the poverty level. They had an average of 11 years of education. Chasnoff noted that the drug-using women had more children than the non-users (2.4 compared to 1.3). Child care, he said, is thus critical to any effective intervention for substance-abusing women.

According to Chasnoff, the traditional twelve-step rehabilitation model is not a realistic intervention for substance-abusing women. Throughout his discussion, Chasnoff underscored the need for gender-specific interventions. In addition to child care considerations, he explained that the strong link between sexual abuse and early drug use in women needs to be addressed in intervention. Also, the two-week blackout period of the twelve-step program, which calls for complete detachment from all existing relationships, neglects the critical role of positive relationships in women's lives.

Chasnoff shared a story to further explain his belief that drug-addicted women can be rehabilitated if their needs as women and individuals are truly addressed. Eight years ago, the police dropped off an incarcerated woman at his residence program, referring to her as "useless." She had 8 children and was using cocaine. Chasnoff's staff determined that the woman had an IQ of 56. Previous treatments had ignored her cognitive delays. Chasnoff's staff transferred her to a residential treatment program for the mentally impaired. She has been drug-free for 8 years. In Chasnoff's opinion, this story illustrates how treatment works when it meets the specific needs of an individual.

Noting murder as the number one cause of death for women of childbearing age in the U.S., Chasnoff called for an integration of domestic violence and drug abuse treatment programs. In his study, approximately 85% of the drug-using women had a history of sexual abuse. Chasnoff also discussed the role of attachment in substance abuse. A much larger percentage of the drug-using women in his study had negative attachments compared to the non-users. Most of the drug-using women had been told they were worthless, felt unwanted by their parents, and said they did not have a close relationship with their mothers or other childhood caregivers. Chasnoff offered data linking the strength of adult relationships to positive childhood attachments.

According to Chasnoff, women's lives revolve primarily around relationships. If the link between women's drug addiction and problematic relationships is true, then effective interventions must concentrate on helping women develop positive relationships. Good treatment programs do this, Chasnoff said. He also noted that effective interventions take lack of literacy in low-income neighborhoods into account. They also address the high rate of depression and borderline personality in substance-abusing women. Ultimately, successful treatment programs are holistic and integrate the variety of services necessary to treat substance-abusing women's complex needs. Chasnoff strongly believes that drug-addicted women heal through positive supportive relationships that strengthen ties with their children and family.

Chasnoff then showed a series of drawings by drug-addicted pregnant women in his program who were asked to sketch a picture of themselves and their baby. While non-users tend to draw themselves holding their baby, the drug-using women

depicted themselves physically detached from their child. The pictures, many of which were accompanied by negative expressions of parenthood, further revealed the link between depression, substance abuse, and negative attachment in women. Chasnoff ended his discussion by calling for increased knowledge of women's drug addiction and a broad implementation of treatment programs designed with gender specificity and individual needs in mind.

Cognitive-Behavioral Therapy for Cocaine Addiction

Following are the first two chapters of Manual Two of the Therapy Manuals for Drug Abuse*, published by from the National Institute on Drug Abuse (NIDA), which is part of the National Institutes of Health (NIH), a component of the U.S. Department of Health and Human Services. The manual is available on their website (www.nida.nih.gov).*

A Cognitive-Behavioral Approach: Treating Cocaine Addiction
Chapter One: An Overview

Cognitive-behavioral coping skills treatment (CBT) is a short-term, focused approach to helping cocaine-dependent individuals become abstinent from cocaine and other substances (the term cocaine abuser or cocaine-dependent individual is used to refer to individuals who meet DSM-IV criteria for cocaine abuse or dependence). The underlying assumption is that learning processes play an important role in the development and continuation of cocaine abuse and dependence. These same learning processes can be used to help individuals reduce their drug use.

Very simply put, CBT attempts to help patients recognize, avoid, and cope. That is, RECOGNIZE the situations in which they are most likely to use cocaine, AVOID these situations when appropriate, and COPE more effectively with a range of problems and problematic behaviors associated with substance abuse.

Why CBT?

Several features of CBT make it particularly promising as a treatment for cocaine abuse and dependence:

- CBT is a short-term, comparatively brief approach well-suited to the resource capabilities of most clinical programs.

- CBT has been extensively evaluated in rigorous clinical trials and has solid empirical support as treatment for cocaine abuse. In particular, evidence points to the durability of CBT's effects as well as its effectiveness with subgroups of more severely dependent cocaine abusers.

- CBT is structured, goal-oriented, and focused on the immediate problems faced by cocaine abusers entering treatment who are struggling to control their cocaine use.

- CBT is a flexible, individualized approach that can be adapted to a wide range of patients as well as a variety of settings (inpatient, outpatient) and formats (group, individual).

- CBT is compatible with a range of other treatments the patient may receive, such as pharmacotherapy.

- CBT's broad approach encompasses several important common tasks of successful substance abuse treatment.

Components of CBT

CBT has two critical components:

- Functional analysis
- Skills training

Functional Analysis

For each instance of cocaine use during treatment, the therapist and patient do a functional analysis, that is, they identify the patient's thoughts, feelings, and circumstances before and after the cocaine use. Early in treatment, the functional analysis plays a critical role in helping the patient and therapist assess the determinants, or high-risk situations, that are likely to lead to cocaine use and provides insights into some of the reasons the individual may be using cocaine (e.g., to cope with interpersonal difficulties, to experience risk or euphoria not otherwise available in the patient's life). Later in treatment, functional analyses of episodes of cocaine use may identify those situations or states in which the individual still has difficulty coping.

Skills Training

CBT can be thought of as a highly individualized training program that helps cocaine abusers unlearn old habits associated with cocaine abuse and learn or relearn healthier skills and habits. By the time the level of substance use is severe enough to warrant treatment, patients are likely to be using cocaine as their single means of coping with a wide range of interpersonal and intrapersonal problems. This may occur for several reasons:

- The individual may have never learned effective strategies to cope with the challenges and problems of adult life, as when substance use begins during early adolescence.

- Although the individual may have acquired effective strategies at one time, these skills may have decayed through repeated reliance on substance use as a primary means of coping. These patients have essentially forgotten effective strategies because of chronic involvement in a drug-using lifestyle in

which the bulk of their time is spent in acquiring, using, and then recovering from the effects of drugs.

- The individual's ability to use effective coping strategies may be weakened by other problems, such as cocaine abuse with concurrent psychiatric disorders.

Because cocaine abusers are a heterogeneous group and typically come to treatment with a wide range of problems, skills training in CBT is made as broad as possible. The first few sessions focus on skills related to initial control of cocaine use (e.g., identification of high-risk situations, coping with thoughts about cocaine use). Once these basic skills are mastered, training is broadened to include a range of other problems with which the individual may have difficulty coping (e.g., social isolation, unemployment). In addition, to strengthen and broaden the individual's range of coping styles, skills training focuses on both intrapersonal (e.g., coping with craving) and interpersonal (e.g., refusing offers of cocaine) skills. Patients are taught these skills as both specific strategies (applicable in the here and now to control cocaine use) and general strategies that can be applied to a variety of other problems. Thus, CBT is not only geared to helping each patient reduce and eliminate substance use while in treatment, but also to imparting skills that can benefit the patient long after treatment.

Critical Tasks

CBT addresses several critical tasks that are essential to successful substance abuse treatment (Rounsaville and Carroll 1992).

Foster the motivation for abstinence. An important technique used to enhance the patient's motivation to stop cocaine use is to do a decisional analysis which clarifies what the individual stands to lose or gain by continued cocaine use.

Teach coping skills. This is the core of CBT - to help patients recognize the high-risk situations in which they are most likely to use substances and to develop other, more effective means of coping with them.

Change reinforcement contingencies. By the time treatment is sought, many patients spend most of their time acquiring, using, and recovering from cocaine use to the exclusion of other experiences and rewards. In CBT, the focus is on identifying and reducing habits associated with a drug-using lifestyle by substituting more enduring, positive activities and rewards.

Foster management of painful affects. Skills training also focuses on techniques to recognize and cope with urges to use cocaine; this is an excellent model for helping patients learn to tolerate other strong affects such as depression and anger.

Improve interpersonal functioning and enhance social supports. CBT includes training in a number of important interpersonal skills and strategies to help patients expand their social support networks and build enduring, drug-free relationships.

Parameters of CBT

Format

An individual format is preferred for CBT because it allows for better tailoring of treatment to meet the needs of specific patients. Patients receive more attention and are generally more involved in treatment when they have the opportunity to work with and build a relationship with a single therapist over time. Individual treatment affords greater flexibility in scheduling sessions and eliminates the problem of either having to deliver treatment in a "rolling admissions" format or asking patients to wait several weeks until sufficient numbers of patients are recruited to form a group. Also, the comparatively high rates of retention in programs and studies may reflect, in part, particular advantages of individual treatment.

However, a number of researchers and clinicians have emphasized the unique benefits of delivering treatment to substance users in the group format (e.g., universality, peer pressure). It is relatively straightforward to adapt the treatment described in this manual for groups. This generally requires lengthening the sessions to 90 minutes to allow all group members to have an opportunity to comment on their personal experiences in trying out skills, give examples, and participate in role-playing. Treatment will also be more structured in a group format because of the need to present the key ideas and skills in a more didactic, less individualized format.

Length

CBT has been offered in 12 to 16 sessions, usually over 12 weeks. This comparatively brief, short-term treatment is intended to produce initial abstinence and stabilization. In many cases, this is sufficient to bring about sustained improvement for as long as a year after treatment ends. Preliminary data suggest that patients who are able to attain 3 or more weeks of continuous abstinence from cocaine during the 12-week treatment period are generally able to maintain good outcome during the 12 months after treatment ends. For many patients, however, brief treatment is not sufficient to produce stabilization or lasting improvement. In these cases, CBT is seen as preparation for longer term treatment. Further treatment is recommended directly when the patient requests it or when the patient has not been able to achieve 3 or more weeks of continuous abstinence during the initial treatment. We are currently evaluating whether additional booster sessions of CBT during the 6 months following the initial treatment phase improves outcome. The maintenance version of CBT focuses on the following:

- Identifying situations, affects, and cognitions that remain problematic for patients in their efforts to maintain abstinence or which emerge after cessation or reduction of cocaine use.

- Maintaining gains through solidifying the more effective coping skills and strategies the subject has implemented.

- Encouraging patient involvement in activities and relationships that are incompatible with drug use. Rather than introducing new material or skills, the

maintenance version of CBT focuses on broadening and mastering the skills to which the patient was exposed during the initial phase of treatment.

Setting

Treatment is usually delivered on an outpatient basis for several reasons:

- CBT focuses on understanding the determinants of substance use, and this is best done in the context of the patient's day-to-day life. By understanding who the patients are, where they live, and how they spend their time, therapists can develop more elaborate functional analyses.

- Skills training is most effective when patients have an opportunity to practice new skills and approaches within the context of their daily routine, learn what does and does not work for them, and discuss new strategies with the therapist.

Patients

CBT has been evaluated with a broad range of cocaine abusers. The following are generally *not appropriate* for CBT delivered on an out-patient basis:

- Those who have psychotic or bipolar disorders and are not stabilized on medication

- Those who have no stable living arrangements

- Those who are not medically stable (as assessed by a pretreatment physical examination)

- Those who have other concurrent substance dependence disorders, with the exception of alcohol or marijuana dependence (although we assess the need for alcohol detoxification in the former)

No significant differences have been found in outcome or retention for patients who seek treatment because of court or probation pressure and those who have DSM-IV diagnoses of antisocial personality disorder or other Axis II disorders, nor has outcome varied by patient race/ethnicity or gender.

Compatibility With Adjunctive Treatments

CBT is highly compatible with a variety of other treatments designed to address a range of comorbid problems and severities of cocaine abuse:

- Pharmacotherapy for cocaine use and/or concurrent psychiatric disorders

- Self-help groups such as Cocaine Anonymous (CA) and Alcoholics Anonymous (AA)

- Family and couples therapy

- Vocational counseling, parenting skills, and so on When CBT is provided as part of a larger treatment package, it is essential for the CBT therapist to maintain close and regular contact with other treatment providers.

Active Ingredients of CBT

All behavioral or psychosocial treatments include both common and unique factors or "active ingredients." Common factors are those dimensions of treatment that are found in most psychotherapies: the provision of education, a convincing rationale for the treatment, enhancing expectations of improvement, provision of support and encouragement, and, in particular, the quality of the therapeutic relationship (Rozenzweig 1936; Castonguay 1993). Unique factors are those techniques and interventions that distinguish or characterize a particular psychotherapy.

CBT, like most therapies, consists of a complex combination of common and unique factors. For example, in CBT mere delivery of skills training without grounding in a positive therapeutic relationship leads to a dry, overly didactic approach that alienates or bores most patients and ultimately has the opposite effect of that intended. It is important to recognize that CBT is thought to exert its effects through this intricate interplay of common and unique factors.

A major task of the therapist is to achieve an appropriate balance between attending to the relationship and delivering skills training. For example, without a solid therapeutic alliance, it is unlikely that a patient will stay in treatment, be sufficiently engaged to learn new skills, or share successes and failures in trying new approaches to old problems. Conversely, empathic delivery of skills training as tools to help patients manage their lives more effectively may form the basis of a strong working alliance.

Essential and Unique Interventions

The key active ingredients that distinguish CBT from other therapies and that must be delivered for adequate exposure to CBT include the following:

- Functional analyses of substance abuse

- Individualized training in recognizing and coping with craving, managing thoughts about substance use, problemsolving, planning for emergencies, recognizing seemingly irrelevant decisions, and refusal skills

- Examination of the patient's cognitive processes related to substance use

- Identification and debriefing of past and future high-risk situations

- Encouragement and review of extra-session implementation of skills

- Practice of skills within sessions

Recommended But Not Unique Interventions

Interventions or strategies that should be delivered, as appropriate, during the course of each patient's treatment but that are not necessarily unique to CBT include those listed below.

- Discussing, reviewing, and reformulating the patient's goals for treatment

- Monitoring cocaine abuse and craving

- Monitoring other substance abuse

- Monitoring general functioning

- Exploring positive and negative consequences of cocaine abuse

- Exploring the relationship between affect and substance abuse

- Providing feedback on urinalysis results

- Setting the agenda for the session

- Making process comments as indicated

- Discussing advantages of an abstinence goal

- Exploring the patient's ambivalence about abstinence

- Meeting resistance with exploration and a problemsolving approach

- Supporting patient efforts

- Assessing level of family support

- Explaining the distinction between a slip and a relapse

- Including family members or significant others in up to two sessions

Acceptable Interventions

Four interventions are not required or strongly recommended as part of CBT but are not incompatible with this approach:

- Exploring self-help involvement as a coping skill

- Identifying means of self-reinforcement for abstinence

- Exploring discrepancies between a patient's stated goals and actions

- Eliciting concerns about substance abuse and consequences

Interventions Not Part of CBT

Interventions that are distinctive of dissimilar approaches to treatment and less consistent with a cognitive-behavioral approach include those listed below.

- Extensive self-disclosure by the therapist

- Use of a confrontational style or a confrontation-of-denial approach

- Requiring the patient to attend self-help groups

- Extended discussion of 12-step recovery, higher power, "Big Book" philosophy

- Use of disease model language or slogans

- Extensive exploration of interpersonal aspects of substance abuse

- Extensive discussion or interpretation of underlying conflicts or motives

- Provision of direct reinforcement for abstinence (e.g., vouchers, tokens)

- Interventions associated with Gestalt therapy, structural interventions, rational-emotive therapy, or other prescriptive treatment techniques

CBT Compared to Other Treatments

It is often easier to understand a treatment in terms of what it is not. This section discusses CBT for cocaine abuse in terms of its similarities to and differences from other psychosocial treatments for substance abuse.

Similar Approaches

CBT is most similar to other cognitive and behavioral therapies, all of which understand substance abuse in terms of its antecedents and consequences. These include Beck's Cognitive Therapy (Beck et al. 1991) and the Community Reinforcement Approach (CRA) (Azrin 1976; Meyers and Smith 1995), and particularly, Marlatt's Relapse Prevention (Marlatt and Gordon 1985), from which it was adapted.

Cognitive Therapy

Cognitive therapy "is a system of psychotherapy that attempts to reduce excessive emotional reactions and self-defeating behavior by modifying the faulty or erroneous thinking and maladaptive beliefs that underlie these reactions" (Beck et al. 1991, p. 10).

CBT is particularly similar to cognitive therapy in its emphasis on functional analysis of substance abuse and identifying cognitions associated with substance abuse. It differs from cognitive therapy primarily in terms of emphasis on identifying, understanding, and changing underlying beliefs about the self and the self in relationship to substance abuse as a primary focus of treatment. Rather, in the initial sessions of CBT, the focus is on learning and practicing a variety of coping skills, only some of which are cognitive.

In CBT, initial strategies stress behavioral aspects of coping (e.g., avoiding or leaving the situation, distraction, and so on) rather than "thinking" one's way out of a situation. In cognitive therapy, the therapist's approach to focusing on cognitions is Socratic and based on leading the patient through a series of questions; in CBT, the approach is somewhat more didactic. In cognitive therapy, the treatment is thought to reduce substance use by changing the way the patient thinks; in CBT, the treatment is thought to work by changing what the patient does and thinks.

Community Reinforcement Approach

The Community Reinforcement Approach (CRA) "is a broad-spectrum behavioral treatment approach for substance abuse problems...that utilizes social, recreational, familial, and vocational reinforcers to aid clients in the recovery process" (Meyers and Smith 1995, p. 1).

This approach uses a variety of reinforcers, often available in the community, to help substance users move into a drug-free lifestyle. Typical components of CRA treatment include:

   (1) Functional analysis of substance use

   (2) Social and recreational counseling

   (3) Employment counseling

(4) Drug refusal training

(5) Relaxation training

(6) Behavioral skills training

(7) reciprocal relationship counseling.

In the very successful approach developed by Higgins and colleagues for cocaine-dependent individuals (Higgins et al. 1991, 1994), a contingency management component is added that provides vouchers for staying in treatment. The vouchers are redeemable for items consistent with a drug-free lifestyle and are contingent upon the patient's provision of drug-free urine toxicology specimens.

Thus, CRA and CBT share a number of common features, most importantly, the functional analysis of substance abuse and behavioral skills training. CBT differs from CRA in not typically including the direct provision of either contingency management (vouchers) for abstinence or intervening with patients outside of treatment sessions or the treatment clinic, as do community-based interventions (job or social clubs).

Motivational Enhancement Therapy

CBT has some similarities to Motivational Enhancement Therapy (MET) (Miller and Rollnick 1992). MET "is based on principles of motivational psychology and is designed to produce rapid, internally motivated change. This treatment strategy does not attempt to guide and train the client, step by step, through recovery, but instead employs motivational strategies to mobilize the client's own change resources" (Miller et al. 1992, p. 1).

CBT and MET share an exploration, early in the treatment process, of what patients stand to gain or lose through continued substance use as a strategy to build patients' motivation to change their substance abuse.

CBT and MET differ primarily in emphasis on skill training. In MET, responsibility for how patients are to go about changing their behavior is left to the patients; it is assumed that patients can use available resources to change behavior and training is not required. CBT theory maintains that learning and practice of specific substance-related coping skills foster abstinence. Thus, because they focus on different aspects of the change process (MET on why patients may go about changing their substance use, CBT on how patients might do so), these two approaches may be seen as complementary. For example, for a patient with low motivation and few resources, an initial focus on motivational strategies before turning to specific coping skills (MET before CBT) may be the most productive approach.

Dissimilar Approaches

While it is important to recognize that all psychosocial treatments for drug abuse share a number of features and may overlap or closely resemble one another in several ways, some approaches differ significantly from CBT.

Twelve-Step Facilitation

CBT is dissimilar to 12-step, or disease-model approaches, in a number of ways. Twelve-Step Facilitation (TSF) (Nowinski et al. 1994) "is grounded in the concept of alcoholism as a spiritual and medical disease. The content of this intervention is consistent with the 12 Steps of Alcoholics Anonymous (AA), with primary emphasis given to Steps 1 through 5. In addition to abstinence from all psychoactive substances, a major goal of the treatment is to foster the participant's commitment to and participation in AA or Cocaine Anonymous (CA). Participants are actively encouraged to attend self-help meetings and to maintain journals of their AA/CA attendance and participation" (Project MATCH Research Group 1993).

While CBT and TSF share some concepts - for example, the similarity between the disease model's "people, places, and things" and CBT's "high-risk situations" - there are a number of important differences. The disease-model approaches are grounded in a concept of addiction as a disease that can be controlled but never cured. In CBT, substance abuse is a learned behavior that can be modified. The emphasis in disease model approaches is on patients' loss of control over substance abuse and other aspects of their lives; the emphasis in CBT is on self-control strategies, that is, what patients can do to recognize the processes and habits that underlie and maintain substance use and what can be done to change them.

Similarly, the major change agent in disease-model approaches is involvement with the fellowship of AA/CA and working the 12 Steps, that is, the way to cope with nearly all drug-related problems is by going to meetings or deepening involvement with fellowship activities. In CBT, coping strategies are much more individualized and based on the specific types of problems encountered by patients and their usual coping style.

While attending AA or CA meetings is not required or strongly encouraged in CBT, some patients find attending meetings very helpful in their efforts to become or remain abstinent. CBT therapists take a neutral stance to attending AA; they encourage patients to view going to meetings as *a* coping strategy, not *the* coping strategy. The CBT therapist may explore with the patient the ways in which going to a meeting when faced with strong urges to use may be a very useful and important strategy to cope with craving; however, therapists will also encourage patients to think about and have ready a range of other strategies as well.

Interpersonal Psychotherapy

CBT is also different from interpersonal and short-term dynamic approaches such as Interpersonal Psychotherapy (IPT) (Rounsaville and Carroll 1993) or Supportive-Expressive Therapy (SE) (Luborsky 1984). IPT "is based on the concept that many psychiatric disorders, including cocaine dependence, are intimately related to disorders in interpersonal functioning which may be associated with the genesis or perpetuation of the disorder. IPT, as adapted for cocaine dependence, has four definitive characteristics: (1) adherence to a medical model of psychiatric disorders, (2) focus on patients' difficulties in current interpersonal functioning, (3) brevity and consistency of focus, and (4) use of an exploratory stance by the therapist that is similar to that of supportive and expressive therapies."

IPT differs from CBT in several ways: CBT has a structured approach, whereas IPT is more exploratory. Extensive efforts are made in CBT to teach and encourage patients to use skills to control their substance abuse, while in the more exploratory IPT approaches, substance abuse is viewed as a symptom of other difficulties and conflicts and thus may deal less directly with the substance use.

Chapter Two: Basic Principles of CBT

CBT is collaborative. The patient and therapist consider and decide together on the appropriate treatment goals, the type and timing of skills training, whether a significant other is brought into some of the sessions, the nature of outside practice tasks, and so on. Not only does this foster the development of a good working relationship and avoid an overly passive stance by the therapist, but it also assures that treatment will be most useful and relevant to the patient.

Learned Behavior

CBT is based on social learning theory. It is assumed that an important factor in how individuals begin to use and abuse substances is that they learn to do so. The several ways individuals may learn to use drugs include modeling, operant conditioning, and classical conditioning.

Modeling

People learn new skills by watching others and then trying it themselves. For example, children learn language by listening to and copying their parents. The same may be true for many substance abusers. By seeing their parents use alcohol, individuals may learn to cope with problems by drinking. Teenagers often begin smoking after watching their friends use cigarettes. So, too, may some cocaine abusers begin to use after watching their friends or family members use cocaine or other drugs.

Operant Conditioning

Laboratory animals will work to obtain the same substances that many humans abuse (cocaine, opiates, and alcohol) because they find exposure to the substance pleasurable, that is, reinforcing. Drug use can also be seen as behavior that is reinforced by its consequences. Cocaine may be used because it changes the way a person feels (e.g., powerful, energetic, euphoric, stimulated, less depressed), thinks (I can do anything, I can only get through this if I am high), or behaves (less inhibited, more confident).

The perceived positive (and negative) consequences of cocaine use vary widely from individual to individual. People with family histories of substance abuse, a high need for sensation seeking, or those with a concurrent psychiatric disorder may find cocaine particularly reinforcing. It is important that clinicians understand that any given individual uses cocaine for *important* and *particular* reasons.

Classical Conditioning

Pavlov demonstrated that, over time, repeated pairings of one stimulus (e.g., a bell ringing) with another (e.g., the presentation of food) could elicit a reliable response (e.g., a dog salivating). Over time, cocaine abuse may become paired with money or cocaine paraphernalia, particular places (bars, places to buy drugs), particular people (drug-using associates, dealers), times of day or week (after work, weekends), feeling states (lonely, bored), and so on. Eventually, exposure to those cues alone is sufficient to elicit very intense cravings or urges that are often followed by cocaine abuse.

Functional Analysis

The first step in CBT is helping patients recognize why they are using cocaine and determining what they need to do to either avoid or cope with whatever triggers their use. This requires a careful analysis of the circumstances of each episode and the skills and resources available to patients. These issues can often be assessed in the first few sessions through an open-ended exploration of the patients' substance abuse history, their view of what brought them to treatment, and their goals for treatment. Therapists should try to learn the answers to the following questions.

Deficiencies and Obstacles

- Have the patients been able to recognize the need to reduce availability of cocaine?

- Have they been able to recognize important cocaine cues?

- Have they been able to achieve even brief periods of abstinence?

- Have they recognized events that have led to relapse?

- Have the patients been able to tolerate periods of cocaine craving or emotional distress without resorting to drug use?

- Do they recognize the relationship of their other substance abuse (especially alcohol) in maintaining cocaine dependence?

- Do the patients have concurrent psychiatric disorders or other problems that might confound efforts to change behavior?

Skills and Strengths

- What skills or strengths have they demonstrated during any previous periods of abstinence?

- Have they been able to maintain a job or positive relationships while abusing drugs?

- Are there people in the patients' social network who do not use or supply drugs?

- Are there social supports and resources to bolster the patients' efforts to become abstinent?

- How do the patients spend time when not using drugs or recovering from their effects?

- What was their highest level of functioning before using drugs?

- What brought them to treatment now?

- How motivated are the patients?

Determinants of Cocaine Use

- What is their individual pattern of use (weekends only, every day, binge use)?

- What triggers their cocaine use?

- Do they use cocaine alone or with other people?

- Where do they buy and use cocaine?

- Where and how do they acquire the money to buy drugs?

- What has happened to (or within) the patients before the most recent episodes of abuse?

- What circumstances were at play when cocaine abuse began or became problematic?

- How do they describe cocaine and its effects on them?

- What are the roles, both positive and negative, that cocaine plays in their lives?

Relevant Domains

In identifying patients' determinants of drug abuse, it may be helpful for clinicians to focus their inquiries to cover at least five general domains:

Social: With whom do they spend most of their time? With whom do they use drugs? Do they have relationships with those individuals that do not involve substance abuse? Do they live with someone who is a substance abuser? How has their social network changed since drug abuse began or escalated?

Environmental: What are the particular environmental cues for their drug abuse (e.g., money, alcohol use, particular times of the day, certain neighborhoods)? What is the level of their day-to-day exposure to these cues? Can some of these cues be easily avoided?

Emotional: Research has shown that feeling states commonly precede substance abuse or craving. These include both negative (depression, anxiety, boredom, anger) and positive (excitement, joy) affect states. Because many patients initially have difficulty linking particular emotional states to their substance abuse (or do so, but only at a surface level), affective antecedents of substance abuse typically are more difficult to identify in the initial stages of treatment.

Cognitive: Particular sets of thought or cognition frequently precede cocaine use (I need to escape, I can't deal with this unless I'm high, With what I am going through I

deserve to get high). These thoughts are often charged and have a sense of urgency.

Physical: Desire for relief from uncomfortable physical states such as withdrawal has been implicated as a frequent antecedent of drug abuse. While controversy surrounding the nature of physical withdrawal symptoms from cocaine dependence continues, anecdotally, cocaine abusers frequently report particular physical sensations as precursors to substance abuse (e.g., tingling in their stomachs, fatigue or difficulty concentrating, thinking they smell cocaine).

Assessment Tools

Standardized instruments may also be useful in rounding out the therapist's understanding of the patient and identifying treatment goals. The following assessment tools have been helpful.

Substance abuse and related problems:

- The *Addiction Severity Index* (McLellan et al. 1992) assesses the frequency and severity of substance abuse as well as the type and severity of psychosocial problems that typically accompany substance abuse (e.g., medical, legal, family/ social, employment, psychiatric).

- The *Change Assessment Scale* (DiClemente and Hughes 1990) assesses the patient's current position on readiness for change (e.g., precontemplation, contemplation, commitment), which may be an important predictor of response to substance abuse treatment (Prochaska et al. 1992).

- A record of daily substance use can be used to collect inform-ation on cocaine and other substance use day by day over a significant period.

- The *Treatment Attitudes and Expectation* form, a self-report instrument, has been adapted from the National Institute of Mental Health Treatment of Depression Collaborative Research Program (Elkin et al. 1985) and modified for use with cocaine abusers. Greater congruence between patients' expectations of treatment and beliefs about the causes of substance use and those of the treatment they receive may result in improved outcome, as compared to persons whose treatment expectations contrast with the treatment received (Hall et al. 1991).

Psychiatric diagnosis and symptoms:

- The *Structured Clinical Interview for DSM-IV (SCID)* and *SCID-P* (First et al. 1995) provides DSM-IV diagnoses (for Axis I and II psychiatric diagnoses). It can also be used to assess severity of cocaine dependence by the total number of dependence syndrome elements endorsed (from the DSM-III-R substance abuse criteria).

- The *California Psychological Inventory Socialization Scale (CPI-So)* has been found to be a valid continuous measure of sociopathy in alcoholics (Cooney et al. 1990) and an important variable for patient-treatment matching in alcoholics (Kadden et al. 1989).

- The self-report *Beck Depression Inventory (BDI)* (Beck et al. 1961) and a clinician-rated instrument, the *Hamilton Depression Rating Scale* (Hamilton 1960), assess depression. The *Symptom Checklist (SCL-90)* (Derogatis et al. 1973) assesses a broader range of symptoms.

Baseline level of coping skills and self-efficacy:

- The *Cocaine Use Situations Inventory* monitors changes in patients' self-efficacy and expectations of abstinence. This self-report form lists approximately 30 different types of high-risk situations and helps clinicians pinpoint specific situations that the patient does not cope with effectively. This instrument was derived from the self-efficacy instrument developed by Condiotte and Lichtenstein (1981) for use with alcoholics.

Skills Training

Learning serves as an important metaphor for the treatment process throughout CBT. Therapists tell patients that a goal of the treatment is to help them "unlearn" old, ineffective behaviors and "learn" new ones. Patients, particularly those who are demoralized by their failure to cease their cocaine abuse, or for whom the consequences of cocaine abuse have been highly negative, are frequently surprised to consider cocaine abuse as a type of skill, as something they have learned to do over time. After all, they are surprised when they think of themselves as having *learned* a complex set of skills that enabled them to acquire the money needed to buy cocaine (which often led to another set of licit or illicit skills), acquire cocaine without being arrested, use cocaine and avoid detection, and so on. Patients who can reframe their self-appraisals in terms of being skilled in this way often see that they also have the capacity to learn a new set of skills that will help them remain abstinent.

Learning Strategies Aimed at Cessation of Cocaine Use

In CBT, it is assumed that individuals essentially learn to become cocaine abusers through complex interplays of modeling, classical conditioning, or operant conditioning. Each of these principles is used to help the patient stop abusing cocaine.

Modeling is used to help the patient learn new behaviors by having the patient participate in role-plays with the therapist during treatment. The patient learns to respond in new, unfamiliar ways by first watching the therapist model those new strategies and then practicing those strategies within the supportive context of the therapy hour. New behaviors may include how to refuse an offer of drugs or how to break off or limit a relationship with a drug-using associate.

Operant conditioning concepts are used several ways in CBT:

- Through a detailed examination of the antecedents and consequences of substance abuse, therapists attempt to understand why patients may be more likely to use in a given situation and to understand the role that cocaine plays in their lives. This functional analysis of substance abuse is used to identify the high-risk situations in which they are likely to abuse drugs and, thus, to

provide the basis for learning more effective coping behaviors in those situations.

- Therapists attempt to help patients develop meaningful alternative reinforcers to drug abuse, that is, other activities and involvements (relationships, work, hobbies) that serve as viable alternatives to cocaine abuse and help them remain abstinent.

- A detailed examination of the consequences, both long- and short-term, of cocaine and other substance abuse is employed as a strategy to build or reinforce the patient's resolve to reduce or cease substance abuse.

Classical conditioning concepts also play an important role in CBT, particularly in interventions directed at reducing some forms of craving for cocaine. Just as Pavlov demonstrated that repeated pairings of a conditioned stimulus with an unconditioned stimulus could elicit a conditioned response, he also demonstrated that repeated exposure to the conditioned stimulus *without* the unconditioned stimulus would, over time, extinguish the conditioned response. Thus, the therapist attempts to help patients understand and recognize conditioned craving, identify their own idiosyncratic array of conditioned cues for craving, avoid exposure to those cues, and cope effectively with craving when it does occur so that conditioned craving is reduced.

Generalizable Skills

Since CBT treatment is brief, only a few specific skills can be introduced to most patients. Typically, these are skills designed to help the patient gain initial control over cocaine and other substance abuse, such as coping with craving and managing thoughts about drug abuse. However, the therapist should make it clear to the patient that any of these skills can be applied to a variety of problems, not just cocaine abuse.

The therapist should explain that CBT is an approach that seeks to teach skills and strategies that the patient can use long after treatment. For example, the skills involved in coping with craving (recognizing and avoiding cues, modifying behavior through urge-control techniques, and so on) can be used to deal with a variety of strong emotional states that may also be related to cocaine abuse. Similarly, the session on problemsolving skills can be applied to nearly any problem the patient faces, whether drug abuse-related or not.

Basic Skills First

This manual describes a sequence of sessions to be delivered to patients; each focuses on a single or related set of skills (e.g., craving, coping with emergencies). The order of presentation of these skills has evolved with experience with the types of problems most often presented by cocaine-abusing patients coming into treatment.

Early sessions focus on the fundamental skills of addressing ambivalence and fostering motivation to stop cocaine abuse, helping the patient deal with issues of drug availability and craving, and other skills intended to help the patient achieve initial abstinence or control over use. Later sessions build on these basic skills to

help the patient achieve stronger control over cocaine abuse by working on more complex topics and skills (problemsolving, addressing subtle emotional or cognitive states). For example, the skills patients learn in achieving control over craving (urge control) serve as a model for helping them manage and tolerate other emotional states that may lead to cocaine abuse.

Match Material to Patient Needs

CBT is highly individualized. Rather than viewing treatment as cookbook psychoeducation, the therapist should carefully match the *content, timing*, and *nature of presentation* of the material to the patient. The therapist attempts to provide skills training at the moment the patient is most in need of the skill. The therapist does not belabor topics, such as breaking ties with cocaine suppliers, with a patient who is highly motivated and has been abstinent for several weeks. Similarly, the therapist does not rush through material in an attempt to cover all of it in a few weeks; for some patients, it may take several weeks to truly master a basic skill. It is more effective to slow down and work at a pace that is comfortable and productive for a particular individual than to risk the therapeutic alliance by using a pace that is too aggressive.

Similarly, therapists should be careful to use language that is compatible with the patient's level of understanding and sophistication. For example, while some patients can readily understand concepts of conditioned craving in terms of Pavlov's experiments on classical conditioning, others require simpler, more concrete examples, using familiar language and terms.

Therapists should frequently check with patients to be sure they understand a concept and that the material feels relevant to them. The therapist should also be alert to signals from patients who think the material is not well suited to them. These signals include loss of eye contact and other forms of drifting away, overly brief responses, failure to come up with examples, failure to do homework, and so on.

An important strategy in matching material to patient needs (and providing treatment that is patient driven rather than manual driven) is to use, whenever possible, *specific examples* provided by the patients, either through their history or relating events of the week. For example, rather than focusing on an abstract recitation of "Seemingly Irrelevant Decisions," the therapist should emphasize a recent, specific example of a decision made by the patient that ended in an episode of cocaine use or craving. Similarly, to make sure the patient understands a concept, the therapist should ask the patient to think of a specific experience or example that occurred in the past week that illustrates the concept or idea.

"It sounds like you had a lot of difficulty this week and wound up in some risky situations without quite knowing how you got there. That's exactly what I'd like to talk about this week, how by not paying attention to the little decisions we make all the time, we can land in some rough spots. Now, you started out talking about how you had nothing to do on Saturday and decided to hang out in the park, and 2 hours later you were driving into the city to score with Teddy. If we look carefully at what happened Saturday, I bet we can come up with a whole chain of decisions you made

that seemed pretty innocent at the time, but eventually led to you being in the city. For example, how did it happen that you felt you had nothing to do on Saturday?"

Use Repetition

Learning new skills and effective skill-building requires time and repetition. By the time they seek treatment, cocaine users' habits related to their drug abuse tend to be deeply ingrained. Any given patient's routine around acquiring, using, and recovering from cocaine use is well established and tends to feel comfortable to the patient, despite the negative consequences of cocaine abuse. It is important that therapists recognize how difficult, uncomfortable, and even threatening it is to change these established habits and try new behaviors. For most patients, mastering a new approach to old situations takes several attempts.

Moreover, many patients come to treatment only after long periods of chronic use, which may affect their attention, concentration, and memory and thus their ability to comprehend new material. Others seek treatment at a point of extreme crisis (e.g., learning they are HIV positive, after losing a job); these patients may be so preoccupied with their current problems that they find it difficult to focus on the therapist's thoughts and suggestions. Thus, in the early weeks of treatment, repetition is often necessary if a patient is to be able to understand or retain a concept or idea.

In fact, the basic concepts of this treatment are repeated throughout the CBT process. For example, the idea of a functional analysis of cocaine abuse occurs formally in the first session as part of the rationale for treatment, when the therapist describes understanding cocaine abuse in terms of antecedents and consequences. Next, patients are asked to practice conducting a functional analysis as part of the homework assignment for the first session. The concept of a functional analysis then recurs in each session; the therapist starts out by asking about any episodes of cocaine use or craving, what preceded the episodes, and how the patient coped.

The idea of cocaine use in the context of its antecedents and consequences is inherent in most treatment sessions. For example, craving and thoughts about cocaine are common antecedents of cocaine abuse and are the focus of two early sessions. These sessions encourage patients to identify their own obvious and more subtle determinants of cocaine abuse, with a slightly different focus each time. Similarly, each session ends with a review of the possible pitfalls and high-risk situations that may occur before the next session, to again stimulate patients to become aware of and change their habits related to cocaine abuse.

While key concepts are repeated throughout the manual, therapists should recognize that repetition of whole sessions, or parts of sessions, may be necessary for patients who do not readily grasp these concepts because of cognitive impairment or other problems. Therapists should feel free to repeat session material as many times and in as many different ways as needed with particular patients.

Practice Mastering Skills

We do not master complex new skills by merely reading about them or watching others do them. We learn by trying out new skills ourselves, making mistakes, identifying those mistakes, and trying again.

In CBT, practice of new skills is a central, essential component of treatment. The degree to which the treatment is skills *training* over merely skills *exposure* has to do with the amount of practice. It is critical that patients have the opportunity to try out new skills within the supportive context of treatment. Through firsthand experience, patients can learn what new approaches work or do not work for them, where they have difficulty or problems, and so on.

CBT offers many opportunities for practice, both within sessions and outside of them. Each session includes opportunities for patients to rehearse and review ideas, raise concerns, and get feedback from the therapist. Practice exercises are suggested for each session; these are basically homework assignments that provide a structured way of helping patients test unfamiliar behaviors or try familiar behaviors in new situations.

However, practice is only useful if the patient sees its value and actually tries the exercise. Compliance with extra-session assignments is a problem for many patients. Several strategies are helpful in encouraging patients to do homework.

Give a Clear Rationale

Therapists should not expect a patient to practice a skill or do a homework assignment without understanding why it might be helpful. Thus, as part of the first session, therapists should stress the importance of extra-session practice.

"It will be important for us to talk about and work on new coping skills in our sessions, but it is even more important to put these skills into use in your daily life. You are really the expert on what works and doesn't work for you, and the best way to find out what works for you is to try it out. It's very important that you give yourself a chance to try out new skills outside our sessions so we can identify and discuss any problems you might have putting them into practice. We've found, too, that people who try to practice these things tend to do better in treatment. The practice exercises I'll be giving you at the end of each session will help you try out these skills. We'll go over how well they worked for you, what you thought of the exercises, and what you learned about yourself and your coping style at the beginning of each session."

Get a Commitment

We are all much more likely to do things we have told other people we would do. Rather than assume that patients will follow through on a task, CBT therapists should be direct and ask patients whether they are willing to practice skills outside of sessions and whether they think it will be helpful to do so. A clear "yes" conveys the message that the patient understands the importance of the task and its usefulness. Moreover, it sets up a discussion of discrepancy if the patient fails to follow through.

On the other hand, hesitation or refusal may be a critical signal of clinical issues that are important to explore with the patient. Patients may refuse to do homework because they do not see the value of the task, because they are ambivalent about treatment or renouncing cocaine abuse, because they do not understand the task, or for various other reasons.

Anticipate Obstacles

It is essential to leave enough time at the end of each session to develop or go over the upcoming week's practice exercise in detail. Patients should be given ample opportunity to ask questions and raise concerns about the task. Therapists should ask patients to anticipate any difficulties they might have in carrying out the assignment and apply a prob-lemsolving strategy to help work through these obstacles. Patients should be active participants in this process and have the opportunity to change or develop the task with the therapist, to plan how the skill will be put into practice, and so on.

Working through obstacles may include a different approach to the task (e.g., using a tape recorder for self-monitoring instead of writing), thinking through when the task will be done, whether someone else will be asked to help, and so on. The goal of this discussion should be the patient's expressed commitment to do the exercise.

Monitor Closely

Following up on assignments is critical to improving compliance and enhancing the effectiveness of these tasks. Checking on task completion underscores the importance of practicing coping skills outside of sessions. It also provides an opportunity to discuss the patient's experience with the tasks so that any problems can be addressed in treatment.

In general, patients who do homework tend to have therapists who value homework, spend a lot of time talking about homework, and expect their patients to actually do the homework. The early part of each session must include at least *5 minutes* for reviewing the practice exercise in detail; it should not be limited to asking patients whether they did it. If patients expect the therapist to ask about the practice exercise, they are more likely to attempt it than are patients whose therapist does not follow through.

Similarly, if any other task is discussed during a session (e.g., implementation of a specific plan to avoid a potential high-risk situation), be sure to bring it up in the following session. For example, "Were you able to talk to your brother about not coming over after he gets high?"

Use the Data

The work patients do in implementing a practice exercise and their thoughts about the task convey a wealth of important information about the patients, their coping style and resources, and their strengths and weaknesses. It should be valued by the therapist and put to use during the sessions.

A simple self-monitoring assignment, for example, can quickly reveal patients' understanding of the task or basic concepts of CBT, level of cognitive flexibility,

insight into their own behavior, level of motivation, coping style, level of impulsivity, verbal skills, usual emotional state, and much more. Rather than simply checking homework, the CBT therapist should explore with the patients what they learned about themselves in carrying out the task. This, along with the therapist's own observations, will help guide the topic selection and pacing of future sessions.

Explore Resistance

Some patients literally do the practice exercise in the waiting room before a session, while others do not even think about their practice exercises. Failure to implement coping skills outside of sessions may have a variety of meanings: patients feel hopeless and do not think it is worth trying to change behavior; they expect change to occur through willpower alone, without making specific changes in particular problem areas; the patients' life is chaotic and crisis ridden, and they are too disorganized to carry out the tasks; and so on. By exploring the specific nature of patients' difficulty, therapists can help them work through it.

Praise Approximations

Just as most patients do not immediately become fully abstinent on treatment entry, many are not fully compliant with practice exercises. Therapists should try to shape the patients' behavior by praising even small attempts at working on assignments, highlighting anything they reveal was helpful or interesting in carrying out the assignment, reiterating the importance of practice, and developing a plan for completion of the next session's homework assignment.

Community Resources

Introduction

A constant in the life of any social worker is the scarcity of the resources you need to serve your clients. A rural social worker may find this situation exacerbated by the need to distribute resources across large, sparsely populated areas. This section will focus on resources available to you, such as state and federal programs.

Child Abuse Treatment (CHAT)

Program Description

This program provides comprehensive therapeutic treatment to all child victims of all types of child abuse and neglect as well as other crimes affecting children.

The project must provide treatment services to American Indian children under 18 years of age who are victims of: physical abuse, sexual abuse, emotional abuse, or sexual exploitation; neglect; domestic or family violence; child endangerment; child abduction; school and community violence; hate crimes; and acts of terrorism

Special outreach services are to be provided to adolescent victims of abuse. Additionally, outreach services and accommodations are to be provided to children with disabilities who are victims of abuse.

Who is eligible to apply?

All governmental and community-based organizations are eligible.

Number of Funded Projects

47

Dollar Amount and Source of Funds

$10,001,972 is allocated through the Victims of Crime Act.

Grant Period

The start date was October 1, 2002 and will end on September 30, 2003.

Next Application Date

Spring of 2004

Next Competitive Cycle

Spring of 2005

Where can I get more information?

This program is administered by the Children's Branch at (916) 323-7449.

Additional Program Information

Recipient agencies must have licensed clinicians to provide therapeutic services, advocacy and support to child victims participating in the criminal justice system.

California Victim Compensation Program

The State of California has funds available to assist victims of crimes. The following Frequently Asked Questions about the Victim Compensation Program are from the website of the California Victim Compensation and Government Claims Board website, (www.boc.ca.gov/Victims.htm).

What is the Victim Compensation Program (VCP)?

The Victim Compensation Program (VCP) can help victims of violent crime and their families deal with the emotional, physical, and financial aftermath of crime. Victims can apply for compensation by filing an application with the California Victim Compensation and Government Claims Board (Board), which administers the VCP.

Who is eligible for compensation?

To be eligible for compensation, a person must be a victim of a qualifying crime involving physical injury, threat of physical injury or death. For certain crimes, emotional injury alone is all that needs to be shown. Certain family members or other loved ones who suffer an economic loss resulting from an injury to, or death of, a victim of a crime may also be eligible for compensation.

Applicants must meet the following eligibility requirements. The victim must:

- Have been a California resident when the crime occurred, or the crime must have occurred in California.
- Cooperate reasonably with police and court officials to arrest and prosecute the offender.
- Cooperate with VCP staff to verify the application.
- Not have been involved in events leading to the crime or have participated in the crime.
- File the application within one year of the crime, one year after the direct victim turns 18 years of age, or one year from when the crime could have been discovered, whichever is later. Applications may also be accepted after these filing periods under certain circumstances.

People in the following categories are generally eligible for compensation. If you are not sure whether or not you might qualify, please call us at 1-800-777-9229. Applications may be filed by:

- A person who is physically injured or threatened with physical injury as a result of a crime or act of terrorism that occurred in the State of California.
- A California resident or member of the military stationed in California who is a victim of a qualifying crime, wherever it occurs.

- An eligible family member or other specified persons who were legally dependent on the victim.

- A parent, sibling, spouse, or child of the victim.

- The fiancé(e) of the victim at the time of the crime or another family member of the victim who witnessed the crime.

- A grandparent or grandchild of the victim at the time of the crime, or a person living with the victim at the time of the crime, or who had previously lived with the victim for at least two years in a relationship similar to a parent, grandparent, spouse, sibling, child, or grandchild of the victim.

- A minor who witnesses a crime of domestic violence or who resides in a home where domestic violence occurs.

- Anyone who pays or assumes legal liability for a deceased victim's medical, funeral, or burial expenses, or anyone who pays for the costs of crime scene clean-up for a homicide that occurred in a residence.

- A person who is the primary caretaker of a minor victim when treatment is rendered.

Who is not eligible?

- Persons who commit the crime.

- Persons who knowingly and willingly participated in or were involved in the events leading to the crime; some exceptions may be raised.

- Persons who do not cooperate reasonably with a law enforcement agency in the apprehension and conviction of a criminal committing the crime; some exceptions may be considered.

- A person who is convicted of a felony may not be granted compensation until that person has been discharged from probation or has been released from a correctional institution and has been discharged from probation or parole, if any. The time for filing an application is still one year from the date the crime occurred.

What are examples of crimes that are typically covered?

- Assault with a deadly weapon

- Battery (when there is injury or threat of injury)

- Child abuse

- Child sexual assault

- Child endangerment and abandonment

- Domestic violence

- Driving under the influence

- Hit and run

- Vehicular manslaughter

- Murder

- Robbery

- Sexual assault

- Stalking

- Sexual battery

- Unlawful sexual intercourse (where there is injury or threat of injury)

- Terrorism

- Other crimes that result in physical injury or a threat of physical injury to the victim

What types of expenses may be eligible for reimbursement?

The VCP may reimburse the following expenses if they are necessary due to a crime and if there are no other sources of reimbursement available such as health insurance, worker's compensation or other benefits. Caps or limits may apply.

- Medical and medical-related expenses for the victim, including dental expenses.

- Outpatient mental health treatment or counseling.

- Funeral and burial expenses.

- Wage or income loss up to five years following the date of the crime. If the victim is permanently disabled, wage or income loss may be extended.

- Support loss for legal dependents of a deceased or injured victim.

- Up to 30 days wage loss for the parent or legal guardian of a minor victim who is hospitalized or dies as a direct result of a crime. Job retraining.

- Medically necessary renovation or retrofitting of a home or vehicle for a person permanently disabled as a result of the crime.

- Home security installation or improvements up to $1,000 if the crime occurred in the victim's home.

- In-patient psychiatric hospitalization costs under dire or exceptional circumstances.

- Relocation expenses up to $2,000 per household.

- Crime scene cleanup up to $1,000 if a victim dies as a result of a crime in a residence.

What expenses are not eligible for reimbursement?

The VCP cannot reimburse applicants for the following expenses:

- Personal property losses, except medically necessary replacement of items such as eyeglasses and assistive devices.

- Expenses related to the prosecution of an alleged perpetrator.

- Compensation for "pain and suffering."

- Expenses submitted more than three years after they are incurred may not be eligible for reimbursement unless the victim is liable for the debt at the time the expense is submitted to the VCP or has already paid the expense.

- Expenses of a victim or other applicant convicted of a felony may not be paid during the time of his/her parole, probation, or incarceration.

- Expenses incurred by the victim or other applicant convicted of a felony while he/she was incarcerated, on felony probation, or on parole.

What are the limits on assistance?

Assistance is limited to the amount of out-of-pocket expenses or bills incurred by or on behalf of the victim or applicant that have not been reimbursed by other sources such as insurance, and the amount of lost wages or loss of support (based on the victim's income) if that benefit is applicable.

The limits of various types of benefits are described below. For crimes that occurred prior to January 1, 2001, the total of all benefits paid to one person could not exceed $46,000. For crimes that occurred on or after January 1, 2001, the maximum amount that can be reimbursed is $70,000.

California law authorizes the Board to establish maximum rates and service limitations for reimbursement of medical and medical-related services and for mental health and counseling services. Currently, the VCP has established the following rate limits for medical, medical-related and mental health services:

Medical and Dental Services:

- Eligible medical expenses are reimbursed at the Medicare rate minus 20 percent.

- Currently, all eligible dental expenses will be reimbursed at the DentiCal rate.

Mental Health Services:

- Reimbursement is set at $90 per hour for services provided by a licensed psychiatrist or licensed clinical psychologist.

- Reimbursement is set at $70 per hour for services provided by a licensed clinical social worker, marriage and family therapist (MFT), MFT or psychology intern, mental health nurse, or clinical nurse specialist with a specialty in psychiatric mental health nursing.

- Group therapy is reimbursed at 40 percent of the maximum individual session rates above.

- Family therapy is reimbursed at individual session rates above.

    Mental health session limits became effective February 3, 2003, and apply to all applications submitted on or after February 3, 2003, as well as some submitted prior to that date. Find our more about the session limits by calling the VCP at 1-800-777-9229.

- Initially, an eligible victim will receive up to 5 mental health counseling sessions.

- No additional sessions will be approved without the submission of a Treatment Plan (TP) by the therapist.

- If the TP is approved, eligible victims may receive up to 10 more sessions, for a total of 15.

- No sessions beyond the first 15 will be reimbursed without submission of a Treatment Progress Report (TPR) by the therapist.

- When a TPR is approved:

    ◦ An eligible victim who was a minor at the time of the crime may receive up to 25 more sessions, for a total of 40;

    ◦ An eligible victim who was an adult at the time of the crime may receive up to 15 more sessions, for a total of 30; and

    ◦ An eligible applicant who is a close family member or fiancé(e) of a homicide victim may receive up to 15 more sessions, for a total of 30.

    ◦ Up to two eligible applicants who are the primary caretakers of a minor victim may share a combined total of 30 sessions.

- If the therapist determines additional treatment is necessary once a victim reaches the session limits of 15, 30, or 40 sessions, an Additional Treatment Plan (ATP) must be submitted for review. If approved, a limited number of additional sessions may be authorized.

What if I have reimbursements from other sources?

The VCP can only reimburse qualified expenses that have not or will not be paid by any other source such as health insurance, workers compensation, MediCal, or other benefits. By law, the VCP is the "payer of last resort." If any other sources of reimbursement are available for the applicant's crime-related losses, they must be used before VCP payment can be made. Other reimbursement sources that may be available include, but are not limited to:

- Medical/health, dental, or vision insurance

- Public program benefits (MediCal, unemployment insurance, or Department of Rehabilitation or other disability benefits, etc.)

- Auto insurance

- Workers' compensation benefits

- Court-ordered restitution

- Civil lawsuit recoveries

Applicants are responsible for informing the VCP of all available reimbursement sources for their losses. Applicants must repay the VCP for any payments for which it was later determined they were not eligible.

Does the Victim Compensation Program have the right to be reimbursed if another source pays later on?

The state is entitled to recover the amount of assistance granted to a victim out of any recovery by or on behalf of the victim from any third party liable for the victim's losses. This right is secured by a statutory lien against the recovery (Government Code Section 13963). The state is also entitled to recover the amount of assistance granted out of any form of workers' compensation (Labor Code Section 4903(h)). The VCP application includes a notice of the state's lien and recovery rights.

How do I apply for compensation?

There are several ways to apply for compensation:

- Contact your local Victim/Witness Assistance Center for help.

- Apply on-line

- Download an application, print it, and mail it in.

- Call 1-800-777-9229 to receive an application by mail or to get help with applying.

An applicant may request an emergency award for reimbursement of any eligible expense if the Board determines that such an award is necessary to avoid or mitigate substantial hardship that may result from delaying compensation until complete and final consideration on an application. If granted, an Emergency Award represents an advance pending the final award of compensation. The amount of the Emergency Award shall be dependent upon the immediate needs of the victim or derivative victim subject to the rates and benefit limitations established by the Board. The applicant must repay any amount awarded on the Emergency Award if the regular application is later found to be ineligible for the VCP.

What are the time limitations for filing an application?

An application for VCP compensation should be filed within one year of the date of the crime, one year after the victim turns 18 years of age, or one year from the date the victim or derivative victim knew or in the exercise of ordinary diligence could have discovered that an injury or death had been sustained as a direct result of a

crime, whichever is later.

Under certain circumstances, the Board may grant an extension of this time period for good cause. Some of the reasons an extension may be granted include:

- A recommendation from the prosecuting attorney regarding the victim's or derivative victim's cooperation with law enforcement and the prosecuting attorney in the apprehension and prosecution of the person charged with the crime.

- Whether particular events occurring during the prosecution or in the punishment of the person convicted of the crime have resulted in the victim or derivative victim incurring additional pecuniary loss.

- Whether the nature of the crime is such that a delayed reporting of the crime is reasonably excusable.

For crimes on or after January 1, 2002, a family member or other applicant may file an application at any time after the Board has accepted the application filed by or on behalf of a victim of the same qualifying crime.

A parent with legal custody, guardian, conservator, or relative caregiver may sign an application filed on behalf of a minor or victim. However, an eligible minor victim or derivative victim may sign the VCP application on his or her own behalf in certain circumstances.

How is the application reviewed?

After receiving an application and related documentation, including a complete crime report, VCP staff reviews the information to determine if the victim and/or the applicant are eligible for assistance. Law enforcement officials in the investigation and prosecution of the crime, physicians, counselors, hospitals, employers, and witnesses to the crime may be contacted for verification of the injuries, losses, and expenses incurred as a result of the crime.

Upon completion of the application review process, staff makes a written recommendation to the Board to approve or deny the claim. Recommendations are generally made within 90 days of receiving the application.

Do applicants have the right to appeal?

An applicant has a right to file an appeal if a claim is recommended for denial, or if any part of the claim is recommended for denial. An appeal must be filed within 45 days of the date the Board mailed the notice to deny the claim and/or expense. In some cases, if new information is provided, the denial may be reconsidered immediately. Otherwise, most appeals are scheduled for a hearing before a Hearing Officer. This hearing will give the applicant the opportunity to present information supporting the claim. Hearings are not held to contest the denial of an emergency award.

If the applicant does not agree with the outcome of the Board's final decision, a Petition for a Writ of Mandate may be filed in the Superior Court.

What California laws govern the compensation program?

Government Code sections 13950 - 13969.7 govern the California law that allows victims of crime to receive payments from the Restitution Fund for unreimbursed losses that are necessary due to a crime. The Restitution Fund is the VCP's primary funding source and it receives monies collected through fines and penalties imposed by judges upon persons convicted of crimes and traffic offenses in California.

How can I get more information?

For more information regarding the Victim Compensation Program, contact us toll-free at 1-800-777-9229 or call your local Victim/Witness Assistance Center. You can also contact us by e-mail.

You can write to us at:

California Victim Compensation and Government Claims Board

Victim Compensation Program

P.O. Box 3036

Sacramento, CA 95812-3036

Useful Websites

www.nida.hih.gov (National Institute on Drug Abuse)

www.brainmapping.org (UCLA)

www.uclaisap.org (UCLA)

nidanotes@masimax.com (NIDA newsletter)

www.zerotothree.com (Zero to Three)

www.childtrauma.org (Child Trauma Academy)

www.apsac.org (American Professional Society on the Abuse of Children)

www.safefromthestart.org (Safe From the Start)

www.child-abuse.com (Child Abuse Prevention Network)

APPENDIX

METHAMPHETAMINE
Abuse and Addiction

What is methamphetamine?

Methamphetamine is a powerfully addictive stimulant that dramati-cally affects the central nervous system. The drug is made easily in clandestine laboratories with relatively inexpensive over-the-counter ingredients. These factors combine to make meth-amphetamine a drug with high potential for widespread abuse.

Trends in number of emergency department mentions of methamphetamine, 1997-2001

Source: Drug Abuse Warning Network, SAMHSA, 2000.

The Drug Abuse Warning Network tracks the number of times a drug is mentioned in connection with emergency room visits in 21 metropolitan areas.

Methamphetamine is commonly known as "speed," "meth," and "chalk." In its smoked form, it is often referred to as "ice," "crystal," "crank," and "glass." It is a white, odorless, bitter-tasting crystalline powder that easily dissolves in water or alcohol. The drug was developed early in this century from its parent drug, amphetamine, and was used originally in nasal decongestants and bronchial inhalers. Methamphetamine's chemical structure is similar to that of amphetamine, but it has more pronounced effects on the central nervous system. Like amphetamine, it causes increased activity, decreased appetite, and a general sense of well-being. The effects of methamphetamine can last 6 to 8 hours. After the initial "rush," there is typically a state of high agitation that in some individuals can lead to violent behavior.

Methamphetamine is a Schedule II stimulant, which means it has a high potential for abuse and is available only through a prescription that cannot be refilled. There are a few accepted medical reasons for its use, such as the treatment of narcolepsy, attention deficit disorder, and––for short-term use––obesity; but these medical uses are limited.

What is the scope of methamphetamine abuse in the United States?

Methamphetamine abuse, long reported as the dominant drug problem in the San Diego, CA, area, has become a substantial drug problem in other sections of the West and Southwest, as well. There are indications that it is spreading to other areas of the country, including both rural and urban sections of the South and Midwest. Methamphetamine, traditionally associated with white, male, blue-collar workers, is being used by more diverse population groups that change over time and differ by geographic area.
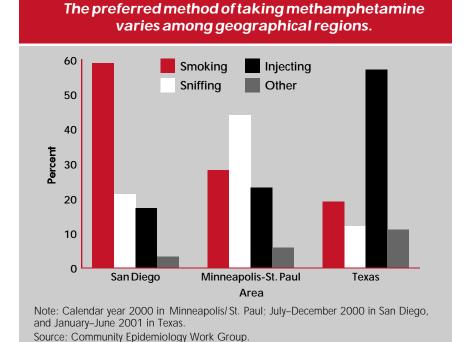
According to the 2000 National Household Survey on Drug Abuse, an estimated 8.8 million people (4.0 percent of the population) have tried methamphetamine at some time in their lives.

Data from the 2000 Drug Abuse Warning Network (DAWN), which collects information on drug-related episodes from hospital emergency departments in 21 metropolitan areas, reported that methamphetamine-related episodes increased from approximately 10,400 in 1999 to 13,500 in 2000, a 30 percent increase. However, there was a significant decrease in methamphetamine-related episodes reported between 1997 (17,200) and 1998 (11,500).

NIDA's Community Epidemiology Work Group (CEWG), an early warning network of researchers that provides information about the nature and patterns of drug use in major cities, reported in its June 2001 publication that methamphetamine continues to be a problem in Hawaii and in major Western cities, such as San Francisco,

The preferred method of taking methamphetamine varies among geographical regions.

Note: Calendar year 2000 in Minneapolis/St. Paul; July–December 2000 in San Diego, and January–June 2001 in Texas.
Source: Community Epidemiology Work Group.

Denver, and Los Angeles. Methamphetamine availability and production are being reported in more diverse areas of the country, particularly rural areas, prompting concern about more widespread use.

Drug abuse treatment admissions reported by the CEWG in June 2001 showed that methamphetamine remained the leading drug of abuse among treatment clients in the San Diego area and Hawaii. Stimulants, including methamphetamine, accounted for smaller percentages of treatment admissions in other states and metropolitan areas of the West (e.g., 9 percent in Los Angeles and Seattle and 8 percent in Texas). By comparison, stimulants were the primary drugs of abuse in a smaller percent of treatment admissions in most Eastern and Midwestern metropolitan areas, such as Minneapolis-St. Paul and St. Louis, where they accounted for approximately 3 percent of total admissions, or Baltimore, where no stimulant-related treatment admissions were reported in the first half of 2000.

How is methamphetamine used?

Methamphetamine comes in many forms and can be smoked, snorted, orally ingested, or injected. The drug alters moods in different ways, depending on how it is taken.

Immediately after smoking the drug or injecting it intra-venously, the user experiences an intense rush or "flash" that lasts only a few minutes and is described as extremely pleasurable. Snorting or oral ingestion produces euphoria––a high but not an intense rush. Snorting produces effects within 3 to 5 minutes, and oral ingestion produces effects within 15 to 20 minutes.

As with similar stimulants, methamphetamine most often is used in a "binge and crash" pattern. Because tolerance for methamphetamine occurs within minutes––meaning that the pleasurable effects disappear even before the drug concentration in the blood falls significantly–– users try to maintain the high by binging on the drug.

In the brain, dopamine plays an important role in the regulation of pleasure. In addition to other regions, dopamine is manufactured in nerve cells within the ventral tegmental area and is released in the nucleus accumbens and the frontal cortex.

Methamphetamine

Dopamine

Methamphetamine stimulates the release of excess dopamine.

In the 1980's, "ice," a smokable form of methamphetamine, came into use. Ice is a large, usually clear crystal of high purity that is smoked in a glass pipe like crack cocaine. The smoke is odorless, leaves a residue that can be resmoked, and produces effects that may continue for 12 hours or more.

What are the immediate (short-term) effects of methamphetamine abuse?

As a powerful stimulant, methamphetamine, even in small doses, can increase wakefulness and physical activity and decrease appetite. A brief, intense sensation, or rush, is reported by those who smoke or inject methamphetamine. Oral ingestion or snorting produces a long-lasting high instead of a rush, which reportedly can continue for as long as half a day. Both the rush and the high are believed to result from the release of very high levels of the neurotransmitter dopamine into areas of the brain that regulate feelings of pleasure.

Methamphetamine has toxic effects. In animals, a single high dose of the drug has been shown to damage nerve terminals in the dopamine-containing regions of the brain. The large release of dopamine produced by methamphetamine is thought to contribute to the drug's toxic effects on nerve terminals in the brain. High doses can elevate body temperature to dangerous, sometimes lethal, levels, as well as cause convulsions.

Short-term effects may include:
Increased attention and decreased fatigue
Increased activity
Decreased appetite
Euphoria and rush
Increased respiration
Hyperthermia

What are the long-term effects of methamphetamine abuse?

Long-term methamphetamine abuse results in many damaging effects, including addiction. Addiction is a chronic, relapsing disease, characterized by compulsive drug-seeking and drug use which is accompanied by functional and molecular changes in the brain. In addition to being addicted to methamphetamine, chronic methamphetamine abusers exhibit symptoms that can include violent behavior, anxiety, confusion, and insomnia. They also can display a number of psychotic features, including paranoia, auditory hallucinations, mood disturbances, and delusions (for example, the sensation of insects creeping on the skin, which is called "formication"). The paranoia can result in homicidal as well as suicidal thoughts.

With chronic use, tolerance for methamphetamine can develop. In an effort to intensify the desired effects, users may take higher doses of the drug, take it more frequently, or change their method of drug intake. In some

Long-term effects may include:
Dependence and addiction psychosis
– paranoia
– hallucinations
– mood disturbances
– repetitive motor activity
Stroke
Weight loss

cases, abusers forego food and sleep while indulging in a form of binging known as a "run," injecting as much as a gram of the drug every 2 to 3 hours over several days until the user runs out of the drug or is too disorganized to continue. Chronic abuse can lead to psychotic behavior, characterized by intense paranoia, visual and auditory hallucinations, and out-of-control rages that can be coupled with extremely violent behavior.

Although there are no physical manifestations of a withdrawal syndrome when methamphetamine use is stopped, there are several symptoms that occur when a chronic user stops taking the drug. These include depression, anxiety, fatigue, paranoia, aggression, and an intense craving for the drug.

In scientific studies examining the consequences of long-term methamphetamine exposure in animals, concern has arisen over its toxic effects on the brain. Researchers have reported that as much as 50 percent of the dopamine-producing cells in the brain can be damaged after prolonged exposure to relatively low levels of methamphetamine. Researchers also have found that serotonin-containing nerve cells may be damaged even more extensively. Whether this toxicity is related to the psychosis seen in some long-term methamphetamine abusers is still an open question.

How is methamphetamine different from other stimulants, such as cocaine?

Methamphetamine is classified as a psychostimulant, as are other drugs of abuse such as amphetamine and cocaine. We know that methamphetamine is structurally similar to amphetamine and the neurotransmitter dopamine, but it is quite different from cocaine. Although these stimulants have similar behavioral and physiological effects, there are some major differences in the basic mechanisms of how they work at the level of the nerve cell. However, the bottom line is that methamphetamine, like cocaine, results in an accumulation of the neurotransmitter dopamine, and this excessive dopamine concentration appears to produce the stimulation and feelings of euphoria experienced by the user. In contrast to cocaine, which is quickly removed and almost completely metabolized in the body, methamphetamine has a much longer duration of action and a larger percentage of the drug remains unchanged in the body. This results in methamphetamine being present in the brain longer, which ultimately leads to prolonged stimulant effects.

What are the medical complications of methamphetamine abuse?

Methamphetamine can cause a variety of cardiovascular problems. These include rapid heart rate, irregular heartbeat, increased blood pressure, and irreversible, stroke-producing damage to small blood vessels in the brain. Hyperthermia (elevated body temperature) and convulsions occur with methamphetamine overdoses, and if not treated immediately, can result in death.

Chronic methamphetamine abuse can result in inflammation of the heart lining, and among users who inject the drug, damaged blood vessels and skin abscesses. Methamphetamine abusers also can have episodes of violent behavior, paranoia, anxiety, confusion, and insomnia. Heavy users also show progressive social and occupational deterioration. Psychotic symptoms

Although both methamphetamine and cocaine are psychostimulants, there are differences between them.		
Methamphetamine	*vs.*	*Cocaine*
Man-made		*Plant-derived*
Smoking produces a high that lasts 8-24 hours		*Smoking produces a high that lasts 20-30 minutes*
50% of the drug is removed from the body in 12 hours		*50% of the drug is removed from the body in 1 hour*
Limited medical use		*Used as a local anesthetic in some surgical procedures*

can sometimes persist for months or years after use has ceased.

Acute lead poisoning is another potential risk for methamphetamine abusers. A common method of illegal methamphetamine production uses lead acetate as a reagent. Production errors therefore may result in methamphetamine contaminated with lead. There have been documented cases of acute lead poisoning in intravenous methamphetamine abusers.

Fetal exposure to methamphetamine also is a significant problem in the United States. At present, research indicates that methamphetamine abuse during pregnancy may result in prenatal complications, increased rates of premature delivery, and altered neonatal behavioral patterns, such as abnormal reflexes and extreme irritability. Methamphetamine abuse during pregnancy may be linked also to congenital deformities.

Are methamphetamine abusers at risk for contracting HIV/AIDS and hepatitis B and C?

Increased HIV and hepatitis B and C transmission are likely consequences of increased methamphetamine abuse, particularly in individuals who inject the drug and share injection equipment. Infection with HIV and other infectious diseases is spread among injection drug users primarily through the re-use of contaminated syringes, needles, or other paraphernalia by more than one person. In nearly one-third of Americans infected with HIV, injection drug use is a risk factor, making drug abuse the fastest growing vector for the spread of HIV in the nation.

Research also indicates that methamphetamine and related psychomotor stimulants can increase the libido in users, in contrast to opiates which actually decrease the libido. However, long-term methamphetamine use may be associated with decreased sexual functioning, at least in men. Additionally, methamphetamine seems to be associated with rougher sex, which may lead to bleeding and abrasions. The combination of injection and sexual risks may result in HIV becoming a greater problem among methamphetamine abusers than among opiate and other drug abusers, something that already seems to be occurring in California.

NIDA-funded research has found that, through drug abuse treatment, prevention, and community-based outreach programs, drug abusers can change their HIV risk behaviors. Drug use can be eliminated and drug-related risk behaviors, such as needle-sharing and unsafe sexual practices, can be reduced significantly thus decreasing the risk of exposure. Therefore, drug abuse treatment is also highly effective in preventing the spread of HIV, hepatitis B, and hepatitis C.

What treatments are effective for methamphetamine abusers?

At this time the most effective treatments for methamphetamine addiction are cognitive behavioral interventions. These approaches are designed to help modify the patient's thinking, expectancies, and behaviors and to increase skills in coping with various life stressors. Methamphetamine recovery support groups also appear to be effective adjuncts to behavioral interventions that can lead to long-term drug-free recovery.

There are currently no particular pharmacological treatments for dependence on amphetamine or amphetamine-like drugs such as methamphetamine. The current pharmacological approach is borrowed from experience with treatment of cocaine dependence. Unfortunately, this approach has not met with much success since no single agent has proven efficacious in controlled clinical studies. Antidepressant medications are helpful in combating the depressive symptoms frequently seen in methamphetamine users who recently have become abstinent.

There are some established protocols that emergency room physicians use to treat individuals who have had a methamphetamine overdose. Because hyperthermia and convulsions are common and often fatal complications of such

overdoses, emergency room treatment focuses on the immediate physical symptoms. Overdose patients are cooled off in ice baths, and anticonvulsant drugs may be administered also.

Acute methamphetamine intoxication can often be handled by observation in a safe, quiet environment. In cases of extreme excitement or panic, treatment with antianxiety agents such as benzodiazepines has been helpful, and in cases of methamphetamine-induced psychoses, short-term use of neuroleptics has proven successful.

Where can I get further scientific information about methamphetamine abuse?

To learn more about methamphetamine and other drugs of abuse, contact the National Clearinghouse for Alcohol and Drug Information (NCADI) at 1-800-729-6686. Information specialists are available to assist you in locating needed information and resources. Information can be accessed through the NIDA Web site (www.drugabuse.gov) or the NCADI Web site (www.health.org).

Fact sheets on health effects of drug abuse and other topics can be ordered free of charge, in English and Spanish, by calling NIDA INFOFAX at 1-800-NIH-NIDA (1-800-644-6432) or 1-888-TTY-NIDA (1-888-889-6432) for the hearing impaired.

A list of fact sheet topics follows:

Health Effects of Specific Drugs
- Cigarettes and other tobacco products
- Crack and cocaine
- Ecstasy
- Heroin
- Inhalants
- LSD
- Marijuana
- Methamphetamine
- Pain medications
- PCP
- Ritalin
- Rohypnol and GHB
- Steroids (anabolic)

Drug Abuse and AIDS, Lessons from Prevention Research, and Treatment Research
- Treatment methods
- Treatment medications
- Treatment methods for women
- Behavior change through treatment

Trends and Surveys
- Costs to society from drug abuse
- High school and youth trends
- Hospital visits and deaths
- Nationwide trends
- Pregnancy and drug abuse trends
- Treatment trends
- Workplace trends

News Releases on Research Findings and Information about NIDA
- Web page
- Mission and structure
- Opportunities for special populations
- Funding opportunities
- Upcoming events and conferences

Access information on the Internet

- What's new on the NIDA Web site
- Information on drugs of abuse
- Publications and communications (including *NIDA NOTES*)
- Calendar of events
- Links to NIDA organizational units
- Funding information (including program announcements and deadlines)
- International activities
- Links to related Web sites (access to Web sites of many other organizations in the field)

NIDA Web Sites
www.drugabuse.gov
www.steroidabuse.org
www.clubdrugs.org

National Clearinghouse for Alcohol and Drug Information (NCADI)
Web Site: www.health.org
Phone No.: 1-800-729-6686

Glossary

Addiction: a chronic, relapsing disease, characterized by compulsive drug-seeking and drug use and by neurochemical and molecular changes in the brain.

Analog: a chemical compound that is similar to another drug in its effects but differs slightly in its chemical structure.

Benzodiazepines: drugs that relieve anxiety or are prescribed as sedatives; among the most widely prescribed medications, including valium and librium.

Central nervous system (CNS): the brain and spinal cord.

Craving: a powerful, often uncontrollable desire for drugs.

Designer drug: an analog of a restricted drug that has psychoactive properties.

Detoxification: a process of allowing the body to rid itself of a drug while managing the symptoms of withdrawal; often the first step in a drug treatment program.

Dopamine: a neurotransmitter present in regions of the brain that regulate movement, emotion, motivation, and feelings of pleasure.

Narcolepsy: a disorder characterized by uncontrollable attacks of deep sleep.

Physical dependence: an adaptive physiological state that occurs with regular drug use and results in a withdrawal syndrome when drug use stops.

Psychosis: a mental disorder characterized by symptoms such as delusions or hallucinations that indicate an impaired conception of reality.

Rush: a surge of euphoric pleasure that rapidly follows administration of a drug.

Serotonin: a neurotransmitter that has been implicated in states of consciousness, mood, depression, and anxiety.

Tolerance: a condition in which higher doses of a drug are required to produce the same effect as experienced initially; often leads to physical dependence.

Toxic: temporary or permanent drug effects that are detrimental to the functioning of an organ or group of organs.

Withdrawal: a variety of symptoms that occur after use of an addictive drug is reduced or stopped.

Resources

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NIDA
NATIONAL INSTITUTE ON DRUG ABUSE

Addiction Severity Index *Lite* - CF

Clinical/Training Version

Thomas McLellan, Ph.D.
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Deni Carise, Ph.D.
Thomas H. Coyne, MSW
Remember: This is an interview, not a test

»Item numbers circled are to be asked at follow-up. »
»Items with an asterisk* are cumulative and should be rephrased at follow-up. »
»Items in a double border gray box are questions for the interviewer. Do not ask these questions of the client. »

INTRODUCING THE ASI: Seven potential problem areas: Medical, Employment/Support Status, Alcohol, Drug, Legal, Family/Social, and Psychological. All clients receive this same standard interview. All information gathered is confidential.
There are two time periods we will discuss:
    1. The past 30 days
    2. Lifetime Data

Patient Rating Scale: Patient input is important. For each area, I will ask you to use this scale to let me know how bothered you have been by any problems in each section. I will also ask you how important treatment is for you for the area being discussed.
The scale is: 0 - Not at all
               1 - Slightly
               2 - Moderately
               3 - Considerably
               4 - Extremely
If you are uncomfortable giving an answer, then don't answer.
Please do not give inaccurate information!

INTERVIEWER INSTRUCTIONS:
1. Leave no blanks.
2. Make plenty of Comments (if another person reads this ASI, they should have a relatively complete picture of the client's perceptions of his/her problems).
3. X = Question not answered.
   N = Question not applicable.
4. Terminate interview if client misrepresents two or more sections.
5. When noting comments, please write the question number.
6. Tutorial/clarification notes are preceded with "●".

HALF TIME RULE: If a question asks the number of months, round up periods of 14 days or more to 1 month. Round up 6 months or more to 1 year.

CONFIDENCE RATINGS:⇒ Last two items in each section.
        Ᵽ Do not over interpret.
        Ᵽ Denial does not warrant misrepresentation.
        Ᵽ Misrepresentation = overt contradiction in information.
Probe and make plenty of comments!

HOLLINGSHEAD CATEGORIES:
1. Higher execs, major professionals, owners of large businesses.
2. Business managers if medium sized businesses, lesser professions, i.e., nurses, opticians, pharmacists, social workers, teachers.
3. Administrative personnel, managers, minor professionals, owners/proprietors of small businesses, i.e., bakery, car dealership, engraving business, plumbing business, florist, decorator, actor, reporter, travel agent.
4. Clerical and sales, technicians, small businesses (bank teller, bookkeeper, clerk, draftsman, timekeeper, secretary).
5. Skilled manual - usually having had training (baker, barber, brakeman, chef, electrician, fireman, lineman, machinist, mechanic, paperhanger, painter, repairman, tailor, welder, policeman, plumber).
6. Semi-skilled (hospital aide, painter, bartender, bus driver, cutter, cook, drill press, garage guard, checker, waiter, spot welder, machine operator).
7. Unskilled (attendant, janitor, construction helper, unspecified labor, porter, including unemployed).
8. Homemaker.
9. Student, disabled, no occupation.

LIST OF COMMONLY USED DRUGS:

Alcohol:	Beer, wine, liquor
Methadone:	Dolophine, LAAM
Opiates:	Pain killers = Morphine, Diluaudid, Demerol, Percocet, Darvon, Talwin, Codeine, Tylenol 2,3,4, Syrups = Robitussin, Fentanyl
Barbiturates:	Nembutal, Seconal, Tuinol, Amytal, Pentobarbital, Secobarbital, Phenobarbital, Fiorinol
Sed/Hyp/Tranq:	Benzodiazepines = Valium, Librium, Ativan, Serax Tranxene, Dalmane, Halcion, Xanax, Miltown, Other = ChloralHydrate (Noctex), Quaaludes
Cocaine:	Cocaine Crystal, Free-Base Cocaine or "Crack, and "Rock Cocaine"
Amphetamines:	Monster, Crank, Benzedrine, Dexedrine, Ritalin, Preludin, Methamphetamine, Speed, Ice, Crystal
Cannabis:	Marijuana, Hashish
Hallucinogens:	LSD (Acid), Mescaline, Mushrooms (Psilocybin), Peyote,
Green,	PCP (Phencyclidine), Angel Dust, Ecstacy
Inhalants:	Nitrous Oxide, Amyl Nitrate (Whippits, Poppers), Glue, Solvents, Gasoline, Toluene, Etc.

Just note if these are used: Antidepressants,
                                Ulcer Meds = Zantac, Tagamet
                                Asthma Meds = Ventoline Inhaler, Theodur
                                  Other Meds = Antipsychotics, Lithium

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ALCOHOL/DRUG USE INSTRUCTIONS:
The following questions look at two time periods: the past 30 days and lifetime. Lifetime refers to the time prior to the last 30 days. However if the client has been incarcerated for more than 1 year, you would only gather lifetime information, unless the client admits to significant alcohol /drug use during incarceration. This guideline only applies to the Alcohol/Drug Section.
        Ᵽ 30 day questions only require the number of days used.
        Ᵽ Lifetime use is asked to determine extended periods of use.
        Ᵽ Regular use = 3+ times per week, binges, or problematic irregular use in which normal activities are compromised.
        Ᵽ Alcohol to intoxication does not necessarily mean "drunk", use the words felt the effects", "got a buzz", "high", etc. instead of intoxication. As a rule of thumb, 5+ drinks in one setting, or within a brief period of time defines "intoxication".
        Ᵽ "How to ask these questions:
        ® "How many days in the past 30 have you used....?
        ® "How many years in your life have you regularly used....?"

Addiction Severity Index *Lite* - Training Version
GENERAL INFORMATION

G1.ID No.:

G2. SS No. :

G3. Program No:

G4. Date of Admission:

G5. Date of Interview:

G8. Class: 1. Intake   2. Follow-up

G9. Contact Code: 1. In person
                      2. Telephone (Intake ASI must be in person)
                      3. Mail

G10. Gender: 1. Male   2. Female

G11. Interviewer Code No.:

G12. Special: 1. Patient terminated
                  2. Patient refused
                  3. Patient unable to respond

_____
Name

_____
Address 1

_____
Address 2

_____(____)_____
City   State   Zip Code   Tel. No.

G14.   How long have you lived at this
       address?   Years   Months

G16. Date of birth:
      (Month/Day/Year)

G17. Of what race do you consider yourself?
     1. White (not Hisp)   5. Asian/Pacific   9. Other Hispanic
     2. Black (not Hisp)   6. Hispanic-Mexican
     3. American Indian   7. Hispanic-Puerto Rican
     4. Alaskan Native   8. Hispanic-Cuban

G18. Do you have a religious preference?
     1. Protestant   3. Jewish   5. Other
     2. Catholic   4. Islamic   6. None

G19.   Have you been in a controlled environment in
       the past 30 days?
       1. No   4. Medical Treatment
       2. Jail   5. Psychiatric Treatment
       3. Alcohol/Drug Treat.   6. Other: _____
          • A place, theoretically, without access to drugs/alcohol.

G20. How many days?
       • "NN" if Question G19 is No. Refers to total
       number of days detained in the past 30 days.

(Clinical/Training Version)

MEDICAL STATUS

M1.* How many times in your life have you been hospitalized for medical problems? ☐☐
• Include O.D.'s and D.T.'s. Exclude detox, alcohol/drug, psychiatric treatment and childbirth (if no complications). Enter the number of *overnight* hospitalizations for medical problems.

M3. Do you have any chronic medical problems which continue to interfere with your life?   0 -No 1 - Yes ☐
• *If "Yes", specify in comments.*
• A chronic medical condition is a serious physical condition that requires regular care, (i.e., medication, diet ary restriction) preventing full advantage of their abilities.

M4. Are you taking any prescribed medication on a regular basis   0 - No 1 - Yes ☐ for a physical problem?
• *If Yes, specify in comments.*
• Medication prescribed by a MD for medical conditions; *not psychiatric medicines*. Include medicines prescribed whether or not the patient is currently taking them. The intent is to verify chronic medical problems.

M5. Do you receive a pension for a physical disability?   0 - No 1 - Yes ☐
• *If Yes, specify in comments.*
• Include Workers' compensation, exclude psychiatric disability.

M6. How many days have you experienced medical problems in the past 30 days? ☐☐
• Do not include ailments directly caused by drugs/alcohol.
• Include flu, colds, etc. Include serious ailments related to drugs/alcohol, which would continue even if the patient were abstinent (e.g., cirrhosis of liver, abscesses from needles, etc.).

For Questions M7 & M8, ask the patient to use the Patient Rating scale.

M7. How troubled or bothered have you been by these medical problems in the past 30 days?
• Restrict response to problem days of Question M6. ☐

M8. How important to you *now* is treatment for these medical problems? ☐
• Refers to the need for *new* or *additional* medical treatment by the patient.

CONFIDENCE RATINGS
Is the above information significantly distorted by: ☐

M10. Patient's misrepresentation?   0 - No 1 - Yes

M11. Patient's inability to understand?   0 - No 1 - Yes ☐

MEDICAL COMMENTS
(Include question number with your notes)

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EMPLOYMENT/SUPPORT STATUS

E1. Education completed:
- GED = 12 years, note in comments.
- Include formal education only.

☐☐ Years ☐☐ Months

E2. Training or Technical education completed:
- Formal/organized training only. For military training, only include training that can be used in civilian life, i.e., electronics or computers.

☐☐ Months

E4. Do you have a valid driver's license?
- Valid license; not suspended/revoked. 0 - No 1 - Yes ☐

E5. Do you have an automobile available?
- If answer to **E4** is "**No**", then **E5** must be "**No**". 0 - No 1 - Yes ☐
Does not require ownership, only requires availability on a regular basis.

E6. How long was your longest full time job?
- Full time = 35+ hours weekly; does not necessarily mean most recent job.

☐☐ **/** ☐☐ Yrs / Mos

E7. Usual (or last) occupation?
(specify) _____ ☐
(use Hollingshead Categories Reference Sheet)

E9 Does someone contribute the majority of your support? 0 - No 1 - Yes ☐

E10. Usual employment pattern, past three years? ☐
1. Full time (35+ hours)   5. Service
2. Part time (regular hours) 6. Retired/Disability
3. Part time (irregular hours) 7. Unemployed
4. Student   8. In controlled environment
- Answer should represent the *majority* of the last 3 years, not just the most recent selection. If there are equal times for more than one category, select that which best represents more current situation.

E11 How many days were you paid for working in the past 30 days? ☐☐
- Include "under the table" work, paid sick days and vacation.

EMPLOYMENT/SUPPORT COMMENTS
(Include question number with your notes)

EMPLOYMENT/SUPPORT (cont.)

For questions E12-17: How much money did you receive from the following sources in the past 30 days?

(E12) Employment?
- <u>Net</u> or "take home" pay, include any "under the table" money.

(E13) Unemployment Compensation?

(E14) Welfare?
- Include food stamps, transportation money provided by an agency to go to and from treatment.

(E15) Pensions, benefits or Social Security?
- Include disability, pensions, retirement, veteran's benefits, SSI & workers' compensation.

(E16) Mate, family, or friends?
- Money for personal expenses, (i.e. clothing), include unreliable sources of income (e.g. gambling). Record *cash* payments only, include windfalls (unexpected), money from loans, gambling, inheritance, tax returns, etc.).

(E17) Illegal?
- *Cash* obtained from drug dealing, stealing, fencing stolen goods, gambling, prostitution, etc. *Do not* attempt to convert drugs exchanged to a dollar value.

(E18) How many people depend on you for the majority of their food, shelter, etc.?
- Must be regularly depending on patient, do include alimony/child support, do not include the patient or self-supporting spouse, etc.

(E19) How many days have you experienced employment problems in the past 30 ?
- Include inability to find work, if they are actively looking for work, or problems with present job in which that job is jeopardized.

For Question E20, ask the patient to use the Patient Rating scale.

(E20) How troubled or bothered have you been by these employment problems in the past 30 days?
- If the patient has been incarcerated or detained during the past 30 days, they cannot have employment problems.

(E21). How important to you *now* is counseling for these employment problems?
- The patient's ratings in Questions E20-21 refer to Question E19.
- Stress help in finding or preparing for a job, not giving them a job.

CONFIDENCE RATINGS
Is the above information <u>significantly</u> distorted by:

(E23) Patient's misrepresentation   0-No 1-Yes

(E24) Patient's inability to understand?   0-No 1-Yes

EMPLOYMENT/SUPPORT COMMENTS
(Include question number with your notes)

ALCOHOL/DRUGS

Route of Administration Types:
1. Oral 2. Nasal 3. Smoking 4. Non-IV injection 5. IV

• Note the usual or most recent route. For more than one route, choose the most severe. The routes are listed from least severe to most severe.

		Past 30 Days	Lifetime (years)	Route of Admin
D1	Alcohol (any use at all)	☐☐	☐☐	■
D2	Alcohol (to intoxication)	☐☐	☐☐	■
D3	Heroin	☐☐	☐☐	☐
D4	Methadone	☐☐	☐☐	☐
D5	Other Opiates/Analgesics	☐☐	☐☐	☐
D6	Barbiturates	☐☐	☐☐	☐
D7	Sedatives/Hypnotics/ Tranquilizers	☐☐	☐☐	☐
D8	Cocaine	☐☐	☐☐	☐
D9	Amphetamines	☐☐	☐☐	☐
D10	Cannabis	☐☐	☐☐	☐
D11	Hallucinogens	☐☐	☐☐	☐
D12	Inhalants	☐☐	☐☐	☐
D13	More than 1 substance per day (including alcohol)	☐☐	☐☐	■

D17. How many times have you had Alcohol DT's? ☐☐

• Delirium Tremens (DT's): Occur 24-48 hours after last drink, or significant decrease in alcohol intake, shaking, severe disorientation, fever, , hallucinations, they usually require medical attention.

ALCOHOL/DRUGS COMMENTS
(Include question number with your notes)

Page 5

ALCOHOL/DRUGS (cont.)

How many times in your life have you been treated for :

(D19*). Alcohol abuse? ☐☐

(D20*). Drug abuse? ☐☐

• Include detoxification, halfway houses, in/outpatient counseling, and AA or NA (if 3+ meetings within one month period).

How many of these were detox only:

(D21). Alcohol? ☐☐

(D22). Drugs? ☐☐

• If D19 = "00", then question D21 is "NN"
   If D20 = '00', then question D22 is "NN"

How much money would you say you spent during the past 30 days on:

(D23). Alcohol? ☐☐☐☐☐

(D24). Drugs? ☐☐☐☐☐

• Only count actual *money* spent. What is the financial burden caused by drugs/alcohol?

(D25). How many days have you been treated as an outpatient for alcohol or drugs in the past 30 days? • Include AA/NA ☐☐

For Questions D28-D31, ask the patient to use the Patient Rating scale. The patient is rating the need for additional substance abuse treatment.

How many days in the past 30 have you experienced:

(D26). Alcohol problems? ☐☐

How troubled or bothered have you been in the past 30 days by these

(D28). Alcohol problems? ☐

How important to you *now* is treatment for these:

(D30). Alcohol problems? ☐

How many days in the past 30 have you experienced:

(D27). Drug problems? ☐☐

• Include only: Craving, withdrawal symptoms, disturbing effects of use, or wanting to stop and being unable to.

How troubled or bothered have you been in the past 30 days by these

(D29). Drug problems? ☐

How important to you *now* is treatment for these:

(D31). Drug problems? ☐

CONFIDENCE RATINGS

Is the above information significantly distorted by:

(D34). Patient's misrepresentation?   0-No 1-Yes ☐

(D35). Patient's inability to understand?   0-No 1-Yes ☐

ALCOHOL/DRUGS COMMENTS
(Include question number with your notes)

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LEGAL STATUS

L1. Was this admission prompted or suggested by the criminal justice system?　　0 - No　1 - Yes ☐
- Judge, probation/parole officer, etc.

L2. Are you on parole or probation?
- Note duration and level in comments.　　0 - No　1 - Yes ☐

How many times in your life have you been arrested and charged with the following:

L3 * Shoplift/Vandal	☐☐	L10* Assault	☐☐
L4 * Parole/Probation	☐☐	L11* Arson	☐☐
L5 * Drug Charges	☐☐	L12* Rape	☐☐
L6 * Forgery	☐☐	L13* Homicide/Mansl.	☐☐
L7* Weapons Offense	☐☐	L14* Prostitution	☐☐
L8* Burglary/Larceny/B&E	☐☐	L15* Contempt of Court	☐☐
L9 * Robbery	☐☐	L16* Other: _____	☐☐

- Include total number of counts, not just convictions. Do not include juvenile (pre-age 18) crimes, unless they were charged as an adult.
- Include formal charges only.

L17* How many of these charges resulted in convictions? ☐☐
- If L03-16 = 00, then question L17 = "NN".
- Do not include misdemeanor offenses from questio ns L18-20 below.
- Convictions include fines, probation, incarcerations, suspended sentences, and guilty pleas.

How many times in your life have you been charged with the following:

L18* Disorderly conduct, vagrancy, public intoxication? ☐☐

L19* Driving while intoxicated? ☐☐

L20* Major driving violations? ☐☐
- Moving violations: speeding, reckless driving, no license, etc.

L21* How many months were you incarcerated in your life? ☐☐
- If incarcerated *2 weeks or more*, round this up to 1 month. List total number of months incarcerated.

L24 Are you presently awaiting charges, trial, or sentence?　　0 - No　1 - Yes ☐

L25 What for? ☐☐
- Use the number of the type of crime committed: 03-16 and 18-20
- Refers to Q. L24. If more than one, choose most severe.
- Don't include civil cases, unless a criminal offense is involved.

L26 How many days in the past 30, were you detained or incarcerated? ☐☐
- Include being arrested and released on the same day.

LEGAL STATUS (cont.)

L27 How many days in the past 30 have you engaged in illegal activities for profit? ☐☐

    • Exclude simple drug possession. Include drug dealing, prostitution, selling stolen goods, etc. May be cross checked with Question E17 under Employment/Family Support Section.

For Questions L28-29, ask the patient to use the Patient Rating scale.

L28 How serious do you feel your present legal problems are? ☐

    • Exclude civil problems

L29 How important to you *now* is counseling or referral for these legal problems? ☐

    • Patient is rating a need for *additional* referral to legal counsel for defense against criminal charges.

CONFIDENCE RATINGS

Is the above information <u>significantly</u> distorted by:

L31 Patient's misrepresentation?   0 - No 1- Yes ☐

L32 Patient's inability to understand?   0 - No 1 - Yes ☐

LEGAL COMMENTS
(Include question number with your notes)

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FAMILY/SOCIAL RELATIONSHIPS

F1. Marital Status:
1-Married   3-Widowed   5-Divorced
2-Remarried 4-Separated 6-Never Married
  • Common-law marriage = 1. Specify in comments. ☐

F3. Are you satisfied with this situation?
0-No 1-Indifferent 2-Yes ☐
• Satisfied = generally liking the situation. - Refers to Question F1

F4.* Usual living arrangements (past 3 years): ☐
1-With sexual partner & children   6-With friends
2-With sexual partner alone   7-Alone
3-With children alone   8-Controlled Environment
4-With parents   9-No stable arrangement
5-With family
• Choose arrangements most representative of the past 3 years. If there is an even split in time between these arrangements, choose the most recent arrangement.

F6. Are you satisfied with these arrangements? ☐
0-No 1-Indifferent 2-Yes

Do you live with anyone who:

F7. Has a current alcohol problem?   0-No 1-Yes ☐

F8 Uses non-prescribed drugs?   0-No 1-Yes ☐

F9. With whom do you
spend most of your free time? 1-Family 2-Friends 3-Alone ☐
  • If a girlfriend/boyfriend is considered as family by patient, then they
    must refer to them as family throughout this section, not a friend.

F10. Are you satisfied with spending your free time
this way?   0-No 1-Indifferent 2-Yes ☐
  • A satisfied response must indicate that the person generally
    likes the situation. Referring to Question F9.

Have you had significant periods in which you have experienced serious problems getting along with:

| | 0 - No 1 - Yes | |
	Past 30 days	In Your Life
F18 Mother	☐	☐
F19 Father	☐	☐
F20 Brother/Sister	☐	☐
F21 Sexual Partner/Spouse	☐	☐
F22 Children	☐	☐
F23 Other Significant Family (specify)_____	☐	☐
F24 Close Friends	☐	☐
F25 Neighbors	☐	☐
F26 Co-workers	☐	☐

• "Serious problems" mean those that endangered the relationship.
• A "problem" requires contact of some sort, either by telephone or in person.

Did anyone abuse you?   0- No 1-Yes

	Past 30 days	In Your Life
F28. Physically?	☐	☐
• Caused you physical harm.		
F29. Sexually?	☐	☐
• Forced sexual advances/acts.		

FAMILY/SOCIAL COMMENTS
(Include question number with your notes)

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FAMILY/SOCIAL (cont.)

How many days in the past 30 have you had serious conflicts:

(F30) With your family? ☐☐

For Questions F32-34, ask the patient to use the Patient Rating scale.

How troubled or bothered have you been in the past 30 days by:

(F32) Family problems ? ☐

FHow important to you now is treatment or counseling for these:

(F34) Family problems ☐
   • Patient is rating *his/her* need for counseling for family problems, not whether the family would be willing to attend.

How many days in the past 30 have you had serious conflicts:

(F31). With other people (excluding family)? ☐☐

For Questions F33-35, ask the patient to use the Patient Rating scale.

How troubled or bothered have you been in the past 30 days by:

(F33) Social problems? ☐

How important to you now is treatment or counseling for these:

(F35) Social problems ☐
   • Include patient's need to seek treatment for such social problems as loneliness, inability to socialize, and dissatisfaction with friends. Patient ratin g should refer to dissatisfaction, conflicts, or other serious problems.

CONFIDENCE RATING
Is the above information significantly distorted by:

(F37) Patient's misrepresentation?   0-No 1-Yes ☐

(F38) Patient's inability to understand?   0-No 1-Yes ☐

PSYCHIATRIC STATUS

How many times have you been treated for any psychological or emotional problems:

(P1.)*   In a hospital or inpatient setting? ☐☐

(P2.)*   Outpatient/private patient? ☐☐

• Do not include substance abuse, employment, or family counseling.
Treatment episode = a series of more or less continuous visits or treatment days, not the number of visits or treatment days.

• Enter diagnosis in comments if known.

(P3.) Do you receive a pension for a psychiatric disability? ☐

0-No 1-Yes

Have you had a significant period of time (that was not a direct result of alcohol/drug use) in which you have:

0-No 1-Yes

Past 30 Days   Lifetime

(P4.) Experienced serious depression-sadness, hopelessness, loss of interest, difficulty with daily function? ☐ ☐

(P5.) Experienced serious anxiety/ tension, uptight, unreasonably worried, inability to feel relaxed? ☐ ☐

(P6.) Experienced hallucinations-saw things or heard voices that were not there? ☐ ☐

(P7.) Experienced trouble understanding, concentrating, or remembering? ☐ ☐

For Items P8-10, Patient can have been under the influence of alcohol/drugs.

(P8.) Experienced trouble controlling violent behavior including episodes of rage, or violence? ☐ ☐

(P9.) Experienced serious thoughts of suicide? ☐ ☐

• Patient seriously considered a plan for taking his/her life.

(P10) Attempted suicide? ☐ ☐

• Include actual suicidal gestures or attempts.

(P11) Been prescribed medication for any psychological or emotional problems? ☐ ☐

• Prescribed for the patient by MD. Record "Yes" if a medication was prescribed *even if* the patient is not taking it.

(P12) How many days in the past 30 have you experienced these psychological or emotional problems? ☐☐

• This refers to problems noted in Questions P4-P10.

For Questions P13-P14, ask the patient to use the Patient Rating scale

(P13) How much have you been troubled or bothered by these psychological or emotional problems in the past 30 days? ☐

• Patient should be rating the problem days from Question P12.

(P14) How important to you *now* is treatment for these psychological or emotional problems? ☐

CONFIDENCE RATING
Is the above information significantly distorted by:

(P22) Patient's misrepresentation?   0-No 1-Yes ☐

(P23) Patient's inability to understand?   0-No 1-Yes ☐

PSYCHIATRIC STATUS COMMENTS
(Include question number with your comments)

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Page 11

Bonding and Attachment in Maltreated Children: How you can Help *

By Bruce D. Perry, M.D., Ph.D.

The most important property of humankind is the capacity to form and maintain relationships. These relationships are absolutely necessary for any of us to survive, learn, work, love, and procreate. Human relationships take many forms but the most intense, most pleasurable and most painful are those relationships with family, friends and loved ones. Within this inner circle of intimate relationships, we are bonded to each other with "emotional glue" — bonded with love.

Each individual's ability to form and maintain relationships using this "emotional glue" is different. Some people seem "naturally" capable of loving. They form numerous intimate and caring relationships and, in doing so, get pleasure. Others are not so lucky. They feel no "pull" to form intimate relationships, find little pleasure in being with or close to others. They have few, if any, friends, and more distant, less emotional glue with family. In extreme cases an individual may have no intact emotional bond to any other person. They are self-absorbed, aloof, or may even present with classic neuropsychiatric signs of being schizoid or autistic.

The capacity and desire to form emotional relationships is related to the organization and functioning of specific parts of the human brain. Just as the brain allows us to see, smell, taste, think, talk, and move, it is the organ that allows us to love — or not. The systems in the human brain that allow us to form and maintain emotional relationships develop during infancy and the first years of life. Experiences during this early vulnerable period of life are critical to shaping the capacity to form intimate and emotionally healthy relationships. Empathy, caring, sharing, inhibition of aggression, capacity to love, and a host of other characteristics of a healthy, happy, and productive person are related to the core *attachment* capabilities which are formed in infancy and early childhood.

What Can I Do To Help Maltreated Children?

Responsive adults, such as parents, teachers, and other caregivers make all the difference in the lives of maltreated children. This section suggests a few different ways to help.

Nurture these children. They need to be held, rocked, and cuddled. Be physical, caring, and loving to children with attachment problems. Be aware that for many of these children, touch in the past has been associated with pain, torture, or sexual abuse. In these cases, make sure you carefully monitor how they respond — be "attuned" to their responses to your nurturing and act accordingly. In many ways, you are providing replacement experiences that should have taken place during their infancy — but you are doing this when their brains are harder to modify and change. Therefore, they will need even more bonding experiences to help them to develop attachments.

Try to understand the behaviors before punishment or consequences. The more you can learn about attachment problems, bonding, normal development, and abnormal development, the more you will be able to develop useful behavioral and social interventions. Information about these problems can prevent you from misunderstanding the child's behaviors. When these children hoard food, for example, it should not be viewed as "stealing" but as a common and predictable result of being deprived of food during early childhood. A punitive approach to this problem (and many others) will not help the child mature. Instead, punishment may actually increase the child's sense of insecurity, distress, and need to hoard food. So many of these children's behaviors are confusing and disturbing to adults. You can get help from professionals if you find yourself struggling to create or implement a practical and useful approach to these problems.

Interact with these children based on emotional age. Abused and neglected children will often be emotionally and socially delayed. And whenever they are frustrated or fearful, they will regress. This means that, at any given moment, a ten-year old child may emotionally be a two-year old. Despite our wishes that they would "act their age" and our insistence to do so, they are not capable of that. These are the times that we must interact with them at their emotional level. If they are tearful, frustrated, or overwhelmed (emotionally age two), treat them as if they were that age. Use soothing non-verbal interactions. Hold them. Rock them. Sing quietly. This is not the time to use complex verbal arguments about the consequences of inappropriate behavior.

Be consistent, predictable and repetitive. Maltreated children with attachment problems are very sensitive to changes in schedule, transitions, surprises, chaotic social situations, and, in general, any new situation. Busy and unique social situations will overwhelm them, even if they are pleasant! Birthday parties, sleepovers, holidays, family trips, the start of the school year, and the end of the school year — all can be disorganizing for these children. Because of this, any efforts that can be made to be consistent, predictable, and repetitive will be very important in making maltreated children feel safe and secure. When they feel safe, they can benefit from the nurturing and enriching emotional and social experiences you provide them. If they are anxious and fearful, they cannot benefit from your nurturing in the same ways.

Model and teach appropriate social behaviors. Many abused and neglected children do not know how to interact with other people. One of the best ways to teach them is to model this in your own behaviors, and then narrate for the child what you are doing and why. Become a play-by-play announcer: "I am going to the sink to wash my hands before dinner because…" or "I take the soap and put it on my hands like this…." Children see, hear, and imitate.

In addition to modeling, you can "coach" maltreated children as they play with other children. Use a similar play-by-play approach: "Well, when you take that from someone, they probably feel pretty upset; so if you want them to have fun when you play this game, then you should try…" By more effectively playing with other children, they will develop some improved self-esteem and confidence. Over

time, success with other children will make the child less socially awkward and aggressive. Maltreated children are often "a mess" because of their delayed socialization. If the child is teased because of their clothes or grooming, it would be helpful to have "cool" clothes and improved hygiene.

Maltreated children have problems with modulating appropriate physical contact. They don't know when to hug, how close to stand, when to establish or break eye contact, what are appropriate contexts to wipe their nose, touch their genitals, or do other grooming behaviors.

Ironically, children with attachment problems will often initiate physical contact (hugs, holding hands, crawling into laps) with strangers. Adults misinterpret this as affectionate behavior. It is not. It is best understood as "supplication" behavior, and it is socially inappropriate. How adults handle this inappropriate physical contact is very important. We should not refuse to hug the child and lecture them about "appropriate behavior." We can gently guide the child on how to interact differently with grownups and other children ("Why don't you sit over here?"). It is important to make these lessons clear using as few words as possible. They do not have to be directive — rely on nonverbal cues. It is equally important to explain in a way that does not make the child feel bad or guilty.

Listen to and talk with these children. One of the most helpful things to do is just stop, sit, listen, and play with these children. When you are quiet and interactive with them, you will often find that they will begin to show you and tell you about what is really inside them. Yet as simple as this sounds, one of the most difficult things for adults to do is to stop, quit worrying about the time or your next task, and really relax into the moment with a child. Practice this. You will be amazed at the results. These children will sense that you are there just for them, and they will feel how you care for them.

It is during these moments that you can best reach and teach these children. This is a great time to begin teaching children about their different "feelings." Regardless of the activity, the following principles are important to include: (1) All feelings are okay to feel — sad, glad, or mad (more emotions for older children); (2) Teach the child healthy ways to act when sad, glad, or mad; (3) Begin to explore how other people may feel and how they show their feelings — "How do you think Bobby feels when you push him?" (4) When you sense that the child is clearly happy, sad, or mad, ask them how they are feeling. Help them begin to put words and labels to these feelings.

Have realistic expectations of these children. Abused and neglected children have so much to overcome. And, for some, they will not overcome all of their problems. For a Romanian orphan adopted at age five after spending her early years without any emotional nurturing, the expectations should be limited. She was robbed of some, but not all, of her potential. We do not know how to predict potential in a vacuum, but we do know how to measure the emotional, behavioral, social, and physical strengths and weaknesses of a child. A comprehensive evaluation by skilled clinicians can be very helpful in beginning to define the skill areas of a child, as well as the areas where progress will be slower.

Be patient with the child's progress and with yourself. Progress will be slow. The slow progress can be frustrating, and many adults, espsecially adoptive parents, will feel inadequate because all of the love, time, and effort they spend with their child may not seem to be having any effect. But it does. Don't be hard on yourself. Many loving, skilled, and competent parents and teachers have been swamped by the needs of a neglected and abused child.

Take care of yourself. For parents and other adults, caring for maltreated children can be exhausting and demoralizing. Adults cannot provide the consistent, predictable, enriching, and nurturing care these children need if they are depleted; it is important to get rest and support. Respite care can be crucial for parents, who should also rely on friends, family, and community resources.

 Take advantage of other resources. Many communities have support groups for adoptive or foster families; as an education professional, you might help by suggesting some, or asking a school psychologist or other counselor to do so. Professionals with experience in attachment problems or maltreated children can also be very helpful. You too will need help; don't be afraid to ask for it. Remember, the earlier and more aggressive the interventions, the better. Children are most malleable early in life, and as they get older, change is more difficult. Take advantage of this time to make a difference in a child's life.

*Adapted in part from: "*Maltreated Children: Experience, Brain Development and the Next Generation*" (W.W. Norton & Company, New York, in preparation)

Trauma Symptom Checklist for Children (TSCC)

The TSCC is a 54-item, standardized, self-report instrument that evaluates trauma-related symptomatology in children ages eight to sixteen, including the effects of child abuse and neglect, other interpersonal violence, and witnessing trauma to others. The following five items are samples taken from this instrument.

		Never	Sometimes	Lots of Times	Almost all of the time
5.	Pretending I am someone else . . .	0	1	2	3
10.	Remembering things that happened that I didn't like . . .	0	1	2	3
16.	Getting Mad and can't calm down . . .	0	1	2	3
28.	Feeling like I did something wrong . . .	0	1	2	3
44.	Having Sex feelings in my body . . .	0	1	2	3

Healthy Minds:
Nurturing Your Child's Development from **0 to 2 Months**

What do we really know about how a young child develops? What can parents do to best support their child's healthy development and growing brain? Some of the answers are in this series of *Healthy Minds* handouts. Each handout is based on findings from a report* from the National Academy of Sciences that examined the research on child and brain development to establish what is known about the early years. The information we offer is age-specific, summarizes key findings from the report and suggests how you might be able to use these key findings to nurture your own child's healthy development.

These handouts are brought to you by ZERO TO THREE, the nation's leading resource on the first 3 years of life, and the American Academy of Pediatrics, dedicated to the health of all children.

▶ Key findings
from the report include:

● Your relationship with your child is the foundation of his or her healthy development.
● Your child's development depends on both the traits he or she was born with (nature), and what he or she experiences (nurture).
● All areas of development (social/emotional/intellectual/language/motor) are linked. Each depends on, and influences, the others.
● What children experience, including how their parents respond to them, shapes their development as they adapt to the world.

How it looks in everyday family life:

When 2-month-old Benjamin cries and cries each evening and kicks his arms and legs wildly, his parents try everything they can think of to comfort him. They rock, walk and swaddle him, massage his tummy in case he has gas and sing lullabies, all to calm him down. Sometimes it takes 20 minutes; sometimes it takes 2 hours.

Benjamin's crying, and his parents' response to it, shows how all areas of his development are linked, and how his parents help to encourage his development. Benjamin cries because he has come to expect that his parents will respond. When mom and dad don't give up trying to comfort Benjamin no matter how frustrating it can be, they are nurturing his **social and emotional development** because it makes him feel important and he learns to trust that his parents will care for him. This gives him the confidence to trust others, which will help him form healthy relationships as he grows. In addition, being soothed by his parents in these early months will help him learn to soothe himself as he gets older, a very important skill throughout life. Using his voice and body to communicate is part of Benjamin's early **language** and **motor development**. When his parents answer his cries, he learns that his efforts at communicating are successful, which encourages him to communicate more, first through gestures and sounds, and later through words.

Relationships are the foundation of a child's healthy development.

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Charting Your Child's
Healthy Development: **0 to 2 months**

The following chart describes many of the things your baby is learning between 0 and 2 months and what you can do to support your child in all areas of his development. As you read, remember that children develop at their own pace and in their own way. Understanding who your child is, what his strengths are and where he needs more support, is essential for promoting his healthy development. If you have questions regarding your child's development, ask your pediatrician

What's going on:	What you can do:	Questions to ask yourself:
One of the most important tasks of the first 2 months is to help newborns feel comfortable in their new world. They are learning to regulate their eating and sleeping patterns and their emotions, which help them feel content, safe and secure.	● Observe carefully. This will help you figure out what your baby's cries are telling you. ● Soothe your baby. When you respond to your baby's cries and meet his needs, you let him know he is loved. You can't spoil a baby. In fact, by responding lovingly to his needs, you are helping him learn skills now that allow him eventually to soothe himself. You are also promoting a strong bond and healthy brain development.	● What soothes your baby? How do you know? ● What most distresses him?
Newborns use their gestures (body movements), sounds and facial expressions to communicate their feelings and needs from day 1. They use different cries to let you know they are hungry, tired or bored. They ask for a break by looking away, arching their backs, frowning or crying. They socialize with you by watching your face and exchanging looks.	● Figure out what your baby is trying to tell you. Responding makes him feel important and tells him he is a good communicator. This builds a positive sense of self and a desire to communicate more. ● Talk and sing to your baby. Tell him about everything that's going on around him. Pay attention to the sights and sounds he likes. Find toys and everyday objects with different colors and textures and see which he likes best.	● How does your baby communicate with you? ● What kinds of interactions does he like best? How do you know? ● How does he let you know when he has had enough?
Even as newborns, babies can play in many ways. They can connect sounds with their sources, and love when you talk and sing to them. Play helps babies learn about the world around them. It is also an important way they connect with you, helping them to develop a strong attachment and promoting healthy social development.	● Offer your baby lots of different objects for him to look at, touch and even grip in his palms. He can focus best on things that are 8 to 12 inches away. ● Play "tracking" games by moving yourself and interesting objects back and forth. First he will use his eyes to follow. Eventually he will move his head from side to side. This helps strengthen his neck muscles as well as exercise his visual abilities.	● What experiences does your baby seem to like best? (For example, talking with him; looking at toys or other objects; hearing the cat "meow.") ● What kind of toys grab your baby's attention? How does he let you know what he's interested in? ● What kind of play do you enjoy most with your baby?

*The report, From Neurons to Neighborhoods: The Science of Early Childhood Development, was a 2$\frac{1}{2}$-year effort by a group of 17 leading professionals with backgrounds in neuroscience, psychology, child development, economics, education, pediatrics, psychiatry and public policy. They reviewed what was known about the nature of early child development and the influence of early experiences on children's health and well-being. The study was sponsored by a number of federal agencies and private foundations.

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Healthy Minds:
Nurturing Your Child's Development from **2 to 6 Months**

What do we really know about how a young child develops? What can parents do to best support their child's healthy development and growing brain? Some of the answers are in this series of *Healthy Minds* handouts. Each handout is based on findings from a report* from the National Academy of Sciences that examined the research on child and brain development to establish what is known about the early years. The information we offer is age-specific, summarizes key findings from the report and suggests how you might be able to use these key findings to nurture your own child's healthy development.

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▶ Key findings
from the report include:

● Your relationship with your child is the foundation of his or her healthy development.
● Your child's development depends on both the traits he or she was born with (nature), and what he or she experiences (nurture).
● All areas of development (social/emotional/intellectual/language/motor) are linked. Each depends on, and influences, the others.
● What children experience, including how their parents respond to them, shapes their development as they adapt to the world.

How it looks in everyday family life:

Five-month-old Tara loves playing peek-a-boo with her mom and dad. When they stop, she squeals and reaches out her arms to let them know she wants more. So they continue. Soon her parents add another twist to the game as they start to hide behind the pillow for a few seconds before they "reappear" to give her time to anticipate what will happen next.

This simple game is more than just fun. It shows how all areas of Tara's development are linked and how her parents help to encourage her healthy development. Tara's interest in playing with her parents is a sign of her **social and emotional development** because she has fun with her parents and can see how much they enjoy being with her. This makes her feel loved and secure, and will help her develop other positive relationships as she grows. Her desire to play this game with mom and dad leads to the development of new **intellectual abilities** as she learns to anticipate what comes next, an important skill for helping her feel more in control of her world. Knowing what to expect will also help her to more easily deal with being separated from you as she learns that people exist even when she can't see them.

Tara's early **language and motor abilities** emerge as she squeals, makes sounds and moves her arms to let her parents know that she does not want them to stop. When they continue, her parents let her know that she is a good communicator, and each time they reappear, she learns that she can trust them to always come back

Relationships are the foundation of a child's healthy development.

Charting Your Child's
Healthy Development: **2 to 6 months**

The following chart describes many of the things your baby is learning between 2 and 6 months and what you can do to support your child in all areas of her development. As you read, remember that children develop at their own pace and in their own way. Understanding who your child is, what her strengths are and where she needs more support, is essential for promoting her healthy development. If you have questions regarding your child's development, ask your pediatrician.

What's going on:	What you can do:	Questions to ask yourself:
Babies are very interactive at this age. They use their new language and communication skills as they smile and coo back and forth, and enjoy babbling, starting with "ohs" and "ahs" and progressing to P's, M's, B's and D's. Your baby may babble and then pause, waiting for you to respond. They also love to imitate, which helps them learn new skills. For example, mom sticks out her tongue, baby imitates and mom does it again. This also teaches them about the back and forth of conversation.	● When your baby babbles, both talk and babble back, as if you both understand every word. These early conversations will teach her hundreds of words before she can actually speak any of them. ● Engage in back-and-forth interactions with gestures. For example, hold out an interesting object, encourage your baby to reach for it and then signal her to give it back. Keep this going as long as your baby seems to enjoy it.	● How does your baby let you know what she wants and how she's feeling? ● How do you and your baby enjoy communicating with each other? What do you say or do that gets the biggest reaction from her?
Babies this age love to explore. They learn from looking at, holding and putting their mouths on different objects. At about 3 months, babies begin to reach for things and try to hold them. Make sure all objects are safe. A toy or anything else you give her shouldn't fit entirely in her mouth.	● Introduce one toy at a time so your baby can focus on, and explore, each one. Good choices include a small rattle with a handle, a rubber ring, a soft doll and a board book with pictures. ● Lay your baby on her back and hold brightly colored toys over her chest within her reach. She'll love reaching up and pulling them close. You will start to see what most interests her.	● What kind of toys or objects does your baby seem most interested in? How do you know? ● How do you and your baby most enjoy playing together? Why?
Babies have greater control over their bodies. By 4 to 6 months, they may be able to roll both ways, become better at reaching and grasping and will begin to sit with assistance. They also begin wanting to explore their food and help feed themselves. Touching and tasting different foods is good for learning and for building self-confidence.	● Place your baby in different positions—on her back, stomach, and sitting with support. Each gives her a different view and a chance to move and explore in different ways. ● Let your baby play with your fingers and explore the bottle or breast during feedings. As she grows, let her handle finger foods and help hold the spoon.	● How does your baby use her body to explore? Which positions does she like the best and least? ● How would you describe your baby's activity level? Does she like/need to move around a lot or is she more laid-back?

The report, From Neurons to Neighborhoods: The Science of Early Childhood Development, was a 2$\frac{1}{2}$-year effort by a group of 17 leading professionals with backgrounds in neuroscience, psychology, child development, economics, education, pediatrics, psychiatry and public policy. They reviewed what was known about the nature of early child development and the influence of early experiences on children's health and well-being. The study was sponsored by a number of federal agencies and private foundations.

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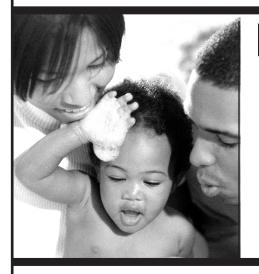**www.zerotothree.org**
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Healthy Minds:
Nurturing Your Child's Development from **6 to 9 Months**

What do we really know about how a young child develops? What can parents do to best support their child's healthy development and growing brain? Some of the answers are in this series of *Healthy Minds* handouts. Each handout is based on findings from a report* from the National Academy of Sciences that examined the research on child and brain development to establish what is known about the early years. The information we offer is age-specific, summarizes key findings from the report and suggests how you might be able to use these key findings to nurture your own child's healthy development.

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▶ Key findings
from the report include:

● Your relationship with your child is the foundation of his or her healthy development.
● Your child's development depends on both the traits he or she was born with (nature), and what he or she experiences (nurture).
● All areas of development (social/emotional/intellectual/language/motor) are linked. Each depends on, and influences, the others.
● What children experience, including how their parents respond to them, shapes their development as they adapt to the world.

How it looks in everyday family life:

Anne is the mother of 8-month-old Jenna. Anne's best friend, Claudia, is coming into town to meet Jenna for the first time. When Claudia arrives, Jenna will have nothing to do with her. Every time Claudia tries to talk to or play with Jenna she whimpers, turns away and clings to Anne. Anne feels frustrated and embarrassed. While tempted to just hand Jenna to Claudia, she stops, and instead holds Jenna on her lap and asks Claudia to sit next to them and read Jenna's favorite book. Slowly Jenna starts to look at Claudia and shows increasing interest. Soon Jenna starts to crawl off Anne's lap to get closer to Claudia.

This shows how all areas of Jenna's development are connected, and how her mother's response supports her healthy development. Jenna's strong bond with her mother, the trust she shows as she clings to her for safety and her fear of strangers are all signs of her **social and emotional development**. Her **intellectual development** enables her to tell the difference between who she knows and who she doesn't, and helps her take steps to get the comfort and protection she wants. She uses her sounds (**language development**), facial expressions and gestures (**motor development**) first to communicate to Anne that she is uncomfortable and wants support. Later she uses them to communicate that she is ready to interact. Anne's sensitivity to Jenna's need to warm up slowly to new situations and people helps Jenna feel loved and secure, which will help her feel more comfortable meeting new people as she grows.

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Charting Your Child's
Healthy Development: **6 to 9 months**

The following chart describes many of the things your baby is learning between 6 and 9 months and what you can do to support your child in all areas of her development. As you read, remember that children develop at their own pace and in their own way. Understanding who your child is, what her strengths are and where she needs more support, is essential for promoting her healthy development. If you have questions regarding your child's development, ask your pediatrician.

What's going on:	What you can do:	Questions to ask yourself:
Babies this age are big communicators. They use many sounds, gestures and facial expressions to communicate what they want. Their actions are their communications. They may be starting to put consonants and vowels together to form words like "dada" and "mama."	● Talk a lot with your baby. For example, label and narrate. "You're eating a big banana!" Give her time to respond. ● Respond to her communications. See how long you can keep a back-and-forth conversation going. For example, she makes a sound, you imitate it, she makes another sound and so on.	● How does your baby let you know what she wants; what she's feeling and thinking? ● What, if anything, do you find frustrating about understanding your baby's communications? Why?
As her brain grows, your baby will start to imitate others, especially you. This leads to the development of lots of new skills. Babies this age can also use toys in more complex ways. For example, instead of just holding a plastic cup, a baby this age may use it to pour water in the bathtub.	● Give your baby time to take in what you did and then copy you. Push a button on the jack-in-the-box, then wait for your baby to do it before you do it again. This teaches your baby cause and effect. Seeing that she can make things happen builds her self-confidence and makes her want to take on new challenges. ● Provide a variety of safe toys for the bath—containers, rubber toys, plastic bath books, plastic ladles. These will encourage your baby to explore and experiment with the different ways to use objects. Of course, never leave your baby alone in the bath.	● How have you seen your baby imitate? ● What kind of play does your baby most enjoy? What does this tell you about her?
Babies' motor skills are advancing by leaps and bounds at this stage. But all babies grow at their own rate. Many babies at this age can roll over both ways, scoot, crawl and even stand. Their motor skills allow them to make the ideas in their head happen, for example, getting the ball that rolled away.	● Encourage your baby to use her body to get what she wants. If she's showing you with her sounds and gestures that she wants the toy that is out of reach, don't just get it for her. Help her get it for herself by bringing it close enough for her to grab. This builds her confidence. ● Create an environment that is safe for exploration. Make sure only safe objects are within your baby's grasp, and that anything she might use to pull herself up to her feet is sturdy and fastened down to the floor or wall. This kind of baby-proofing of your house also will reduce conflicts between you and your baby.	● How does your baby use her body—to explore, to express her feelings? ● What do you need to do to make your home safer for your "little explorer?"

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Healthy Minds:
Nurturing Your Child's Development from **9 to 12 Months**

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● What children experience, including how their parents respond to them, shapes their development as they adapt to the world.

How it looks in everyday family life:

Eleven-month-old Tyra is with her dad, Kevin, at the park. Tyra is playing alone in the sandbox when a group of toddlers joins her. At first, Tyra smiles and eagerly watches their play. But as the toddlers become more active and noisy, Tyra's smiles turn quickly to tears. She starts to crawl out of the sandbox and reaches for Kevin who picks her up and comforts her. But then Kevin goes a step further. After Tyra calms down, Kevin gently encourages her to play near them. He sits at her side, talking and playing with her. Soon Tyra is slowly creeping closer to the other children, curiously watching their moves.

This shows how all areas of Tyra's development are linked, and how her father's response encourages her healthy development. Tyra's looking to her dad for comfort shows that she has developed a close and trusting relationship with him. This is an important sign of her **social and emotional development**. She uses her **intel-**lectual skills to make a plan ("I want to be comforted by Dad, how do I do that?"), and her **language** (crying) and **motor skills** (crawling away, reaching up to Dad) to carry out the plan and successfully get the comfort she is seeking.

Kevin's sensitive response has a powerful influence on what Tyra learns from this experience. He lets Tyra know that her needs and feelings are important. This will help Tyra develop future relationships based on love and trust. He is also letting her know that she is a good communicator, which will encourage Tyra to communicate more and more and help her develop good language and literacy skills. His response also makes Tyra a good problem-solver. She wanted comfort and she found a way to get it. By sitting with her near the other children, he lets Tyra know that she has the support she needs to successfully meet new challenges. This will help her feel confident to handle other challenges as she grows.

Relationships are the foundation of a child's healthy development.

Charting Your Child's
Healthy Development: 9 to 12 months

The following chart describes many of the things your baby is learning between 9 and 12 months and what you can do to support your child in all areas of her development. As you read, remember that children develop at their own pace and in their own way. Understanding who your child is, what her strengths are and where she needs more support, is essential for promoting her healthy development. If you have questions regarding your child's development, ask your pediatrician.

What's going on:	What you can do:	Questions to ask yourself:
Babies this age are very good at expressing their feelings with their gestures, sounds and facial expressions. They can engage in "conversation," for example, handing things back and forth to you, imitating each other's sounds and actions. They also understand "cause and effect"– that they can make something happen: "If I cry, Mom will come."	● Help your baby handle her feelings. Comfort her when she cries, acknowledge when she's frustrated and help her calm down and try again. This helps your child manage her very strong feelings and develop self-control. ● Engage in "circles" of communication with your baby. Keep it going as long as she's engaged. If she reaches for a book, ask, "Do you want that book?" Wait until she responds, and then hand it to her. See what she does with it and join her without taking over. These "conversations" help boost her overall development—social, emotional, language, intellectual and even motor.	● How would you describe your baby's personality? In what ways are you and your baby alike and different? ● How does your baby let you know what she wants; what she's thinking and feeling?
Thanks to their new memory skills, babies this age know that when you leave, you still exist. This is a very important skill, but also can lead to difficulty when leaving. This is why babies often protest at bedtime and cry out for you in the middle of the night. They try to get you to come back by gesturing, crying and calling out.	● Play hide-and-seek games like peek-a-boo. Disappearing and reappearing games like this help your baby learn to cope with separation and feel secure that you always come back. ● Be positive when leaving her. Go to her at night to reassure her you are still there but don't pick her up and rock her back to sleep. Falling asleep in your arms makes it more difficult for her to soothe herself back to sleep if she wakes up again at night. When saying "goodbye," tell her you will miss her, but that you will return. Make sure she has something that gives her comfort, like her "blankie" or favorite stuffed toy.	● How does your baby handle it when you leave? What helps make it easier? ● What's hardest for you about being away from your child? Being aware of your own feelings is very important.
Babies this age do things over and over again because that's the way they figure out how things work, and doing things repeatedly builds their self-confidence. It also strengthens the connections in their brains. Their ability to move in new ways (crawl, stand, even walk) makes it easier to explore and helps them make new discoveries, such as finding their favorite book under the chair.	● Be your child's learning partner and coach. Observe her closely to see what she can do. Then help her take the next step. For example, encourage her to put one more block on her tower or to try and fit the cube into a different hole. ● Follow your child's lead. The more she directs the play, the more invested she is and the more she will learn.	● What are your baby's favorite activities? What does this tell you about her? ● What does your baby do well? What does she find challenging? How can you be a partner in helping her face these challenges?
	The report, From Neurons to Neighborhoods: The Science of Early Childhood Development, was a 2¹/₂-year effort by a group of 17 leading professionals with backgrounds in neuroscience, psychology, child development, economics, education, pediatrics, psychiatry and public policy. They reviewed what was known about the nature of early child development and the influence of early experiences on children's health and well-being. The study was sponsored by a number of federal agencies and private foundations.	

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Healthy Minds:
Nurturing Your Child's Development from **12 to 18 Months**

What do we really know about how a young child develops? What can parents do to best support their child's healthy development and growing brain? Some of the answers are in this series of *Healthy Minds* handouts. Each handout is based on findings from a report* from the National Academy of Sciences that examined the research on child and brain development to establish what is known about the early years. The information we offer is age-specific, summarizes key findings from the report and suggests how you might be able to use these key findings to nurture your own child's healthy development.

These handouts are brought to you by ZERO TO THREE, the nation's leading resource on the first 3 years of life, and the American Academy of Pediatrics, dedicated to the health of all children.

▶ Key findings
from the report include:

● Your relationship with your child is the foundation of his or her healthy development.
● Your child's development depends on both the traits he or she was born with (nature), and what he or she experiences (nurture).
● All areas of development (social/emotional/intellectual/language/motor) are linked. Each depends on, and influences, the others.
● What children experience, including how their parents respond to them, shapes their development as they adapt to the world.

How it looks in everyday family life:

Sixteen-month-old Carlos wants juice and his mom doesn't know it. He is sitting in his high chair banging his cup and pushing the cartons of milk away when his mom, Marta, tries to pour some for him. They both are very frustrated. Marta takes Carlos out of the high chair and announces lunch is over. Carlos marches to the refrigerator and starts banging on the door. Marta is about to tell him to stop banging, but instead asks, "Do you want to open the refrigerator?" Carlos smiles and shakes his head "Yes!" Marta opens the door and Carlos points to the drinks on the shelf. Marta then points to each carton and asks, "Is this what you want?" Carlos shakes his head no until he gets to the juice. Then he jumps around and says, "juju!!" Marta pours him juice as he happily plops himself on her lap.

This shows how all areas of Carlos's development are linked, and how his mother's response encourages his healthy development. Carlos has learned to count on his mom as someone who helps him as he struggles to communicate what he wants. This signals strong **social and emotional development**. He uses his **intellectual** ability to make a plan to get what he wants, and uses his **motor and language skills** to carry out the plan as he walks to the refrigerator and bangs, points and uses sounds to get his message across.

Despite her frustration, Marta takes the time to watch and listen to Carlos. This encourages Carlos to feel like a good communicator and reinforces his sense of self-esteem by letting him know that he is worth listening and paying attention to.

Relationships are the foundation of a child's healthy development.

Charting Your Child's
Healthy Development: 12 to 18 months

The following chart describes many of the things your toddler is learning between 12 and 18 months and what you can do to support your child in all areas of his development. As you read, remember that children develop at their own pace and in their own way. Understanding who your child is, what his strengths are and where he needs more support, is essential for promoting his healthy development. If you have questions regarding your child's development, ask your pediatrician.

What's going on:	What you can do:	Questions to ask yourself:
Toddlers are great communicators. They are learning new words every day, and use them, along with their gestures, to let you know what they are thinking and feeling. For example, they take your hand, walk you to the shelf and point to what they want and say, "Book." Toddlers understand a lot more than they can say. By 12 months they will probably follow a 1-step instruction such as "Go get your shoes." By 18 months they will likely follow 2- and even 3-step directions.	● Encourage your child to use his words, sounds and gestures to communicate, even if you think you know what he wants. ● Play games that include instructions and see how many he can follow. ● Read with your toddler. It helps him learn new words and concepts. It also helps him develop a love of books and reading.	● How does your child communicate what he wants; what he's thinking and feeling? ● How does your child like to read with you? What are his favorite books?
Toddlers are beginning to do pretend play, a major developmental milestone. They continue to imitate what they see around them, for example, using a child-size broom to sweep the floor. But now, they are beginning to understand symbols and ideas—not just concrete things they can see and feel. For example, they begin to use objects in new and creative ways. A spoon can become an airplane or a toothbrush. Pretend play helps develop important intellectual skills and creativity.	● Offer toys that represent objects in your toddler's world, such as a play kitchen with plastic food, a mini-grocery cart or a toy telephone. Join in his play; help him develop his own stories by letting him be the director. ● Give your child different objects and watch the many ways he uses them.	● What kind of play does your child enjoy most? How do you see him pretending? ● What kind of play do you most/least enjoy with your toddler? Why?
During this stage of development, toddlers motor skills are taking off. They begin to walk and run, which opens up a whole new world of exploration for them, and a whole new world of watchfulness for you. As you try to keep your toddler safe, remember that while they understand "Stop!" or "Don't Touch," they don't have the impulse control yet to stop themselves the next time the temptation appears. Since they are better at doing things rather than stopping what they are doing, "Walk slowly" works better than "Don't run."	● Create lots of low, safe places in your home where your child can crawl under furniture, cruise around a coffee table or stand on his own. Help a child who's walked up the stairs to get down safely. ● Think of ways to divert your child away from a forbidden object so you don't have to say "no" all day long. If he's fixated on the TV remote, maybe a toy with buttons and twisty knobs could be a substitute.	● How does your child use his motor skills? Is he a very active child who uses his whole body, or does he prefer to explore with his fingers and hands? ● How is your child's need for physical activity the same or different from yours? How does this affect you and your relationship with your child?

The report, From Neurons to Neighborhoods: The Science of Early Childhood Development, was a 2$\frac{1}{2}$-year effort by a group of 17 leading professionals with backgrounds in neuroscience, psychology, child development, economics, education, pediatrics, psychiatry and public policy. They reviewed what was known about the nature of early child development and the influence of early experiences on children's health and well-being. The study was sponsored by a number of federal agencies and private foundations.
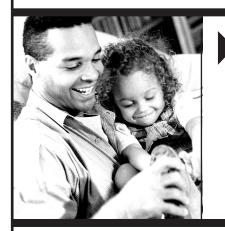
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Healthy Minds:
Nurturing Your Child's Development from **18 to 24 Months**

What do we really know about how a young child develops? What can parents do to best support their child's healthy development and growing brain? Some of the answers are in this series of *Healthy Minds* handouts. Each handout is based on findings from a report* from the National Academy of Sciences that examined the research on child and brain development to establish what is known about the early years. The information we offer is age-specific, summarizes key findings from the report and suggests how you might be able to use these key findings to nurture your own child's healthy development.

These handouts are brought to you by ZERO TO THREE, the nation's leading resource on the first 3 years of life, and the American Academy of Pediatrics, dedicated to the health of all children.

▶ ## Key findings
from the report include:

- Your relationship with your child is the foundation of his or her healthy development.
- Your child's development depends on both the traits he or she was born with (nature), and what he or she experiences (nurture).
- All areas of development (social/emotional/intellectual/language/ motor) are linked. Each depends on, and influences, the others.
- What children experience, including how their parents respond to them, shapes their development as they adapt to the world.

How it looks in everyday family life:

Darryl is excited about taking his 21-month-old daughter, Alicia, to story hour at the local library. He is planning to meet a friend there, who is taking his own daughter. As they enter the room, Alicia spots the noisy crowd, buries her head in her dad's legs, and pulls him toward the door, whining, "Go home!" Darryl is disappointed and tries to get her to take a seat in the circle of children that's forming. But the more he pushes, the more distressed she becomes. Dad is ready to give up and go home. As they are leaving, he sees Alicia look at a book. He stops and asks if she'd like to read it and she nods yes. They sit in the back of the room and read quietly together. The group begins, and Alicia starts to look up more and more frequently to watch and listen to the storyteller. The next week, when Darryl asks if she'd like to go to story time, Alicia smiles and says, "Yes!"

This shows how all areas of Alicia's development are linked and how her father's response encourages her healthy development. Because of Alicia's **social and emotional connection** to her father, he is the one she goes to for safety and comfort when she is feeling anxious. She knows that she can count on her father for support. Her **intellectual ability** enables her to communicate her feelings by using her **language skills** – gestures, facial expressions and words. She uses her **motor ability** to pull on Dad to get him to take her home. Darryl's response helps Alicia master a challenging situation. He is able to put aside his own interest in staying at the group and "listens" to what Alicia is trying to tell him. This allows him to help her feel more comfortable entering a new situation, now and in the future.

Relationships are the foundation of healthy development.

ZERO TO THREE®

American Academy of Pediatrics
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DEDICATED TO THE HEALTH OF ALL CHILDREN™

Charting Your Child's
Healthy Development: **18 to 24 months**

The following chart describes many of the things your toddler is learning between 18 and 24 months and what you can do to support your child in all areas of her development. As you read, remember that children develop at their own pace and in their own way. Understanding who your child is, what her strengths are and where she needs more support, is essential for promoting her healthy development. If you have questions regarding your child's development, ask your pediatrician.

What's going on:	What you can do:	Questions to ask yourself:
Toddlers' vocabularies are growing by leaps and bounds. They are learning and saying many new words, and stringing words together, such as "Dolly fall." Toddlers are very independent and eager to be in control. Among their favorite words are "Me" and "Mine!"	● Expand on what your child says. When she says, "Dolly fall!" you can say, "Yes, Dolly tumbled down to the floor!" This helps you expand your child's language skills. ● Give your toddler ways to feel in control by giving choices among options that are all acceptable. Let her choose between the red or blue cup and the pink or green shirt. Avoid asking her opinions when only one option is okay; for example, do not ask, "Are you ready to go?" unless she can stay longer. Use language to help her predict what will happen. "In five minutes it will be time to go."	● What are your child's strengths in communicating? Where does she need help? ● How does your child express her thoughts and feelings? Is she more likely to use her words or actions? How do you respond?
Toddlers are developing self-control, but they still cannot stop themselves from doing something unacceptable, even after many reminders. They also don't yet understand the consequences of their actions.	● Help prevent tantrums or loss of control by heading them off at the pass. If you see your child getting frustrated, try to calm her down and suggest another activity before she starts hurling puzzle pieces. Help your obviously angry toddler avoid a fight with her friend by inviting them to pause for a snack. ● Use consequences that are directly connected to the behavior of your child. If she is pouring water on her high chair after being told not to, take her out of her high chair. Then offer other acceptable options such as water play in the bathtub or outside.	● What behaviors do you find most difficult to handle? Why? ● How were you disciplined as a child? How do you think that influences how you discipline your child?
Toddlers are able to play and explore in more complex ways. They like toys that they can play with in many different ways such as blocks, cars and stuffed animals that lend themselves to imaginative play. Toddlers love to move. In just a matter of months, children go from crawling to walking to practically running! Practicing their new moves strengthens the brain connections that help with coordination. Children learn a lot from active play. For example, they learn about gravity and up and down when they swing and go down the slide.	● Provide your child with objects and toys that lend themselves to imaginative play and join in with them. You will learn a lot about her thoughts and feelings and can help her expand her thinking. Sand, water, play dough and drawing materials are all good choices for children this age. They help develop your child's creativity and strengthen muscles that your toddler will use later in handwriting. ● Turn a walk into a learning opportunity. Point out big and small dogs in the park. Talk about the colors of the cars on the street. This kind of learning makes new ideas and concepts stick.	● What are some of the ways your child uses pretend play? What does this tell you about her? ● What do you most/least enjoy about playing with your toddler?

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Healthy Minds:
Nurturing Your Child's Development from **24 to 36 Months**

What do we really know about how a young child develops? What can parents do to best support their child's healthy development and growing brain? Some of the answers are in this series of *Healthy Minds* handouts. Each handout is based on findings from a report* from the National Academy of Sciences that examined the research on child and brain development to establish what is known about the early years. The information we offer is age-specific, summarizes key findings from the report and suggests how you might be able to use these key findings to nurture your own child's healthy development.

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▶ Key findings
from the report include:

- Your relationship with your child is the foundation of his or her healthy development.
- Your child's development depends on both the traits he or she was born with (nature), and what he or she experiences (nurture).
- All areas of development (social/emotional/intellectual/language/motor) are linked. Each depends on, and influences, the others.
- What children experience, including how their parents respond to them, shapes their development as they adapt to the world.

How it looks in everyday family life:

Thirty-month-old Anthony wants to build a castle with his mom, Lena. They are almost done when Anthony begins to take it apart, block by block, and arrange the blocks in a straight line. Annoyed, Lena starts to pick up the blocks and put them back on the castle. Anthony starts to cry and tell his mom that she is not doing it right. Lena stops and asks Anthony what he is doing. Surprised that his mom isn't "getting it," he explains that he is building the path so the dragons can find their way to the castle. Lena smiles and watches as he completes his "dragon path."

This shows how all areas of Anthony's development are linked and how his mother's response encourages his healthy development. Anthony's ability to play cooperatively with his mom, not just side by side, demonstrates his social and emotional development. His **intellectual ability** now enables him to pretend as he uses his imagination to play "castle." Using blocks in new ways, such as building a path for his dragons, shows creativity and good problem-solving skills. He uses his **language skills** to clearly let Mom know what he's thinking and planning. He uses his **fine motor skills** (his fingers and hands) to build the structure that he's picturing in his mind. When Lena happily joins in Anthony's pretend play, she makes him feel important and loved. She is flexible as she is able to put aside her annoyance and try to understand what Anthony wants to do. This lets Anthony know that he is appreciated and respected. It also leads to Lena letting Anthony direct the play, which encourages his creativity and imagination, 2 very important aspects of overall healthy development.

Relationships are the foundation of a child's healthy development.

Charting Your Child's
Healthy Development: 24 to 36 months

The following chart describes many of the things your baby is learning between 24 and 36 months and what you can do to support your child in all areas of his development. As you read, remember that children develop at their own pace and in their own way. Understanding who your child is, what his strengths are and where he needs more support, is essential for promoting his healthy development. If you have questions regarding your child's development, ask your pediatrician.

What's going on:	What you can do:	Questions to ask yourself:
Two-year-olds typically can speak between 200 and 250 words. By the age of 3 years, their vocabulary is much larger still and they are able to put together 3- and 4-word sentences. Despite all this word power, 2-year-olds often lack the verbal skill to describe their emotions. This can leave them feeling powerless and frustrated.	● Have lots of conversations with your child. This will boost his language skills, introduce him to the pleasure of conversation and make him feel important. Also, read with your child as often as you can. ● Let your 2-year-old know that you understand what he's experiencing by saying, for example, "I know you are upset that you can't find your magic cape." Acknowledging his feelings will help calm him and make it easier for him to tackle the challenge.	● What does your child like to talk about? How do you and your toddler enjoy conversations together? ● How does your child manage difficult feelings and situations? What helps him cope?
Play is essential for the 2-year-old. It builds all areas of his development. Through play, he interacts more with friends, uses pretend play to understand things in more complex ways and learns important concepts such as big and small and up and down.	● Encourage pretend play and get involved. This will build a strong connection between you and your child, and can help encourage creativity. You can do this in many ways. For example, ask what will happen next in the story he is acting out. If he is "cooking," you might say, "What are you cooking? It smells good. Can I have some?" ● Make plans for your child to spend time with other children. He will learn about the pleasure of making friends. And the more opportunity he has to interact with peers, the more he will learn about how to get along well with others.	● What kind of play does your child most enjoy? How do you know? What does this tell you about him? ● How does your child use his imagination? What do you think he is learning through his pretend play?
Two-year olds are very active. Their motor development allows them the freedom to explore in new ways as they run, jump and climb.	● Spend time outside, where there is plenty of room to safely run, jump and climb. Visit a neighborhood park where there are other children to play with. Include your child in family sports, like swimming together or kickball. ● Create a safe place in your home where your child can actively explore. Take walks with your child and use them as opportunities to teach him important concepts such as big and small as you compare the houses on your block or the leaves on the ground.	● How active is your child? Does he seem to be in constant motion or is he happy to sit and play quietly for long periods, or somewhere in between? ● What do you think your child is learning when he is playing actively? How do you know?

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Additional Community Resources

CALWORKS
Public Health Clinic
Community Health Clinics
Family Service Centers
Women's Shelters
Private Industry Council (PIC)
Regional Centers
Prenatal Substance Abuse Programs (Public Health)
Drug Endangered Children (DEC) Teams
Early Start
Head Start
Indian Health Centers
County Office of Education (schools)
Drug Court
Family Drug Court
Food Banks/Pantry
PG&E (ICARE)
Faith Based Programs
Salvation Army
Catholic Social Services
Catholic Charities
Child Abuse Training &Technical Assistance (CATTA)
Veteran's Administration (VA)
Homeless Assistance/Shelters
Adolescent Addiction Severity Index (ASI)
Court Appointed Special Advocates (CASA)