Assessment/Intervention Strategies for Infants and Toddlers Affected by Maternal Substance Abuse

Any discussion of the developmental outcomes and intervention needs of children whose parents abuse alcohol, tobacco, and/or other drugs (ATOD) must consider the development of the whole child in the context of prenatal and postnatal environments which are often filled with developmental risks. The discussions to date concerning the effects which maternal abuse of ATOD may have on the development of infants and children have focused too narrowly on the effects of prenatal exposure, almost completely ignoring the postnatal environment. Further, these discussions have largely ignored the social and emotional development of children exposed pre- and postnatally to ATOD while focusing on the cognitive development of these infants/toddlers. This article presents an overview of risks to which children of ATOD abusing caretakers are often exposed, potential problems which might arise as a result of these risks, and recommended assessment/intervention strategies for high risk children.

Biological Risk Factors

The risk factors to which the infants/toddlers of caretakers who abuse ATOD are exposed can be broken down into two major categories: those which directly affect the biological development of the fetus, infant, and child, and those which may impair the emotional functioning of the child. The biological risks may occur during the prenatal period or the postnatal period. Common prenatal risks include whether or not the mother got prenatal care and the quality of same, maternal nutrition, sexually transmitted diseases, overall maternal health, and maternal use/abuse of ATOD. These prenatal risks may result in direct damage to the developing fetus or may indirectly put the fetus at risk for long-term health and/or learning problems through their effects on birth weight and/or the length of pregnancy.

Postnatal biological risks include poor infant/toddler nutrition; exposure to environmental toxins (especially lead); abuse and neglect; and postnatal exposure to ATOD. The developmental psychology literature indicates that children exposed to any of these risk factors are more likely to suffer health problems, learning impairments, and/or problems with behavior (McCormick, et al, 1990; Newman & Buka, 1991). Further, these risks tend to be additive in that the greater the number of risks to which an individual child is exposed, the greater the likelihood that the child will develop problems. The early intervention literature, however, indicates that the long-term outcomes for biologically at risk children can be substantially improved through early screening, diagnosis, and intervention programs (Chamberlin, 1987; Sameroff, 1992; Brooks-Gunn, 1993).

Assessment/Intervention for Children at Biological Risk

I recommend that children who are at risk due to exposure to one or more biological risk factors receive periodic developmental screenings in addition to their routine medical evaluations by a pediatrician. These screenings should be conducted at birth, three more times during the first year, twice during the second year, and yearly thereafter at least until the child has entered school. They should assess the developmental milestones of infants and toddlers in both the motor and cognitive areas and the quality of same; infant/toddler temperament; and the abilities of...
biologically at risk children to regulate their own behavior.

There are a number of methods which can be used to assess the developmental progress of infants and toddlers, including standardized assessment instruments and observations of the child in free and/or structured play situations. Two of the most widely used standardized assessment instruments are the Denver Developmental Screening Inventory and the Bayley Scales of Infant Development. Of the two, the Bayley requires a good deal more training and experience but offers a much more sensitive diagnosis of problems. Truthfully, however, the instrument is only as good as the person using it. A trained clinician can often get as much or more information from watching a child in a free play situation as from a standardized test. The developmental progress of biologically at risk children should, therefore, be monitored by a professional in child development who has the clinical skill and experience necessary to assess the quality of the children's behavior, provide developmental intervention services, and make referrals for specialized interventions.

Because of the number of variables (e.g., stranger anxiety, fatigue, illness) which can temporarily affect children's performance during developmental assessments, and because of natural variations in patterns and rates of development from child to child, evaluations need to be repeated across time paying special attention to problems or delays which persist from one assessment period to the next. Information concerning the consistency of children's behavior across time and situations should also be collected from primary caregivers at each assessment. Those individuals who live with their children day in and day out can provide much more information about their children's typical performance than a professional can possibly obtain during a brief assessment.

The most frequently occurring problems for biologically at risk children include muscle tone which is consistently too high or low, language delays, and problems with behavior. Motor problems should be referred to pediatric occupational or physical therapists for evaluation and treatment. Feeding and/or language problems should be evaluated by a speech pathologist for evaluation and treatment. Behavioral problems should be referred to a pediatric psychologist or other behaviorally trained professional who can help the parents to develop interventions which will enable the child to improve self-regulatory skills. Finally, children with persistent and/or generalized developmental delays should be referred to appropriate early intervention programs (e.g., zero to three programs, Head Start, transitional programs for pre-school aged children).

Environmental Risks for Healthy Emotional Development

In order to develop a well balanced sense of self and the ability to express emotions in healthy adaptive ways, children need environments which make them feel safe, and caregivers who give them consistent responses to their behavior and provide them with the consistent warmth and nurturing that make them feel valued. These factors are important building blocks in the development of trust in others and trust in self for all children.

Unfortunately, however, children pre- and postnatally exposed to ATOD are all too often exposed to risk factors which undermine healthy emotional development. Many children of caretakers who abuse ATOD live in physical environments where safety is a perpetual concern. Children's feelings of safety are undermined by conditions of neglect where basic physical needs are not met. Feelings of safety are further compromised in children who are either the witnesses or victims of violence. Finally, children's feelings of safety may be reduced by protective parents' often unrealistic fears concerning dangerous conditions in their environments.

The consistency and/or predictability of environments in which children pre- and postnatally exposed to ATOD live are often reduced by a number of factors. For children being raised by parents who continue to abuse drugs, the variations in parental behavior during different stages of addiction/recovery may create a source of confusion. Parents who were themselves raised in dysfunctional families may have never experienced the types of structure and consistency of care giving that they are now expected to give to their own children.

The life histories of many women receiving substance abuse treatment reveal a number of factors which place them at risk for parenting dysfunction, e.g., sexual and/or physical abuse as children, high rates of substance abuse in their families of origin, low levels of self esteem, poorly developed coping skills, and multiple mental disorders. Consequently, children's need for consistent warmth and nurturing may not be met in families where one or both parents are emotionally unavailable as a result of their addiction, their own dysfunctional childhoods, or both.

Nor will children's needs for consistent warmth and nurturing be met if they are forced to endure repeated episodes of attachment, loss, and grief as they are moved from one placement to another. If children being raised in foster homes have multiple placements, the inconsistencies in structure, expectations, and care giving which occur may create considerable confusion and emotional/behavioral fallout. Under such circumstances, children may be even less likely to develop emotional attachments which will allow them to trust, appreciate, and respond in appropriate ways to the positive attentions of others.

While these environmental risk factors are likely to interfere with the healthy emotional development of any child, they become even more potent as they interact with the biological risk factors discussed earlier. Biological risk factors may interfere with children's abilities to tolerate stimulation, to process information from their environments, and to establish relationships between their own actions and environmental outcomes (Cohen et al., 1989; Griffith, 1995). Infants and children who have been exposed to any of these risk factors have a greater likelihood of being "difficult children" who are disorganized and very difficult to take care of. These characteristics of the infants and children often elicit parenting patterns which are inappropriate, exacerbating the problems within the children and dooming the caretaker to feelings of failure and inadequacy.
Infants withdrawing from drugs require developmentally supportive care to help overcome the damage associated with drug exposure in utero (Zuckerman, 1994). The dramatic increase in infants prenatally drug exposed (PDE), combined with their special needs, has encumbered the foster care system, forcing professionals to objectively assess the value that group care can offer infants PDE. According to Benoit (1994), any substitute caregiving arrangement that provides responsive care to improve the medical conditions and ongoing emotional and developmental needs of these infants should be embraced. Benoit (1994) and Foley (1994) emphasize quality over category of care, and Foley insists that the success of the placement should be measured by the physical and emotional development of a child, rather than the type of placement. Furthermore, if the goal of placement is to promote family reunification and preservation, it should include the biological parents as an integral part of the process (Jones, 1994).

However, most programs for substance abusing women and their children have traditionally focused on either the mother’s recovery or the infant’s child’s development. Further, although infants PDE comprise a diverse, high risk population with a continuum of developmental needs, they often fall into a developmental gap between the intensive care nursery and Head Start (Barth, 1994). The implementation of Federal legislation (PL 99-457) has extended early intervention services to children birth to age three, but these services are not uniformly in place, and they are often unavailable to families with infants PDE unless there is a serious developmental delay.

As the field of child welfare confronts more complex and harder to resolve cases involving parental substance abuse, alternative caregiving settings for infants, which also provide comprehensive family-centered services, are essential. An effective model must incorporate various disciplines and provide a family-centered, interdisciplinary approach that treats the disease of drug addiction; promotes child development; offers education and family planning; provides medical care; and helps parents acquire adequate housing and ongoing social support (Jones, 1994; Schottenfeld, et al., 1994; Zuckerman, 1994). Additionally, Zuckerman (1994) found that treating drug addiction in a child-oriented context which includes parenting classes provides a single opportunity to promote children’s development while at the same time helping mothers to overcome their addiction.

This article describes efforts of the Epiphany Center Program to provide comprehensive family-centered services that integrate developmentally supportive interventions for PDE infants and toddlers with therapeutic treatment to help birth parents overcome their addictions, reunify with their children, and maintain healthy, stable families.

Mt. St. Joseph-St. Elizabeth Community Based Organization

Mt. St. Joseph-St. Elizabeth is a community-based child and family service agency administered by the Daughters of Charity, a catholic religious community. The agency has a mission to strengthen family life, and began serving homeless children in San Francisco during the Cholera Epidemic in 1852. Among its services are a group home for adolescent girls with behavioral and emotional disorders, and a residential home for pregnant and parenting adolescents living with their babies.

In 1986, the San Francisco Department of Social Services approached Mt. St. Joseph-St. Elizabeth to develop a residential infant program to care for babies PDE in protective custody. The majority of these infants were boarder babies, residing in hospitals because their parents were unable to care for them at the time they were medically ready for discharge. In 1991, the infant program expanded to provide services as the Epiphany Center for Families in Recovery, a comprehensive service demonstration project funded under the AIA legislation to provide intensive services to birth parents of infants PDE. Thus far, 60% of the babies in the infant program have reunified with their birth parents or other family members.

Epiphany Infant Program

Caregiving at the Epiphany Infant Program is based on a child-centered...
understanding of how babies prenatally exposed to drugs adjust postnatally. Each infant in the program receives individually planned developmental and behavioral interventions that promote physiological stability, behavioral adaptation, attachment, intellectual development and spiritual growth. Additionally, the staffing pattern reflects the need for consistency in primary caregivers. Because residential care can pose barriers to the western version of human attachment between a single caregiver and its offspring, every attempt is made to provide each infant with the opportunity to form a satisfying relationship with a primary caregiver.

A total of four primary caregivers and two assistant caregivers serve 16 infants in four separate but closely associated family groupings of four. With this model, four infants are cared for by one primary caregiver who is completely available to them during an eight hour shift. In addition, nurses monitor the health, nutritional and physiological needs of the babies; a physical therapist and psychologist assess and monitor each infant’s development; and an instructor teaches infant massage to the primary caregivers. The entire staff meets regularly to devise individualized developmental and behavioral treatment plans, which are child-centered and reunification-focused, and all of the caregivers strive for consistency in providing developmentally supportive care from the perspective of the baby. By attempting to respond to them in a similar manner, infants learn to predict responses to their behaviors and, as a result, their cognition and competency develop and they become more effective communicators and more self-assured.

The staff’s own development is enhanced through monthly in-service trainings on the theoretical and practical significance of early intervention and developmentally supportive care. They are taught how to care for babies in an environment that promotes organized behavior and normal development. For instance, given that all newborns, especially those prenatally exposed to drugs, show great sensitivity to sound, staff are encouraged to speak softly and to reduce environmental noise and stimuli. This helps soothe and calm the infants, alleviate tremors and irritability, and improve their sleeping patterns. Staff are also taught to swaddle or contain the babies when they are stressed or disorganized to help them conserve energy, maintain both sleep and alert states, and inhibit diffuse motor activity. Moreover, they are taught to ensure that the infants’ hands are available to suck on during swaddling because hand-to-mouth behavior is essential for self-regulation and organization. Further, caregivers learn to therapeutically massage infants, and to consistently respond early to the infants’ stress signals to reduce crying and foster the growth of attachment.

Thus far, all the infants in the program have made consistent developmental gains which the staff attributes to the developmentally supportive environment and family-centered care provided by the Infant Program in collaboration with Epiphany Center’s Recovery Program.

**Epiphany Center Recovery Program**

The Epiphany Center’s substance abuse day treatment program serves families who have an infant placed at the Infant Residential Program or in a foster home, as well as women who have a substance abuse problem and are pregnant or have a child under two years of age in their custody. The program provides culturally appropriate and woman-focused services which include an extended orientation and diagnostic period, substance abuse process and education groups, individual and group counseling, health education, referrals and assessments, case management, life skills classes, interactive parenting classes, developmental evaluations of infants, and a well-child clinic. Ancillary services include a parenting for partners class, a family support group, and couples counseling.

Parents served by Epiphany Center attend interactive parenting groups with their infants and toddlers four days a week. These groups support maximal parental participation and secure emotional attachments between the infants and their mothers. Children’s desire to be held securely, comforted, talked to and interacted with contributes to their ability to form healthy attachments and trust in others. Children who are denied the earlier foundation of trust born of secure attachments risk failure in their school-age years (Benoit, 1994). However, Howard (1994) found that mothers who used drugs heavily were significantly less sensitive and responsive to their infants, and their children showed insecure attachments compared to low income families who did not use drugs.

Epiphany Center’s parenting groups offer a natural context for birth mothers to practice consistent and nurturing caregiving to form secure attachments, and to learn about developmentally supportive care. One of the most critical tasks that these mothers face is to support normal behavior patterns in irritable babies who exhibit poor sleep patterns and ineffective sucking that interferes with weight gain (Howard, 1994). When mothers at Epiphany Center learn how to read and respond to their infant’s behavior, they often report reduced irritability and better relationships with their babies. Given that women find satisfaction and a sense of worth through a “connection with others” (personal conversation with Carol Gilligan at Harvard University, 1982), it follows that Epiphany Center’s parenting classes focus on healthy relationships to allow women in recovery to feel valued and their babies to feel secure.

The play and child-oriented activities at Epiphany Center’s parenting groups teach mothers about typical child development and realistic expectations of their infants. Staff model ways to play with babies and to improve the quality of interactions. A music circle provides ideas about how to enhance listening and language skills, attention span, and self-esteem. All of these activities are performed in a relaxed manner that allows for optimal sharing among the staff, mothers and babies. Mothers also meet regularly with the psychologist to discuss any developmental and behavioral interventions that are identified in assessment and performed during parenting classes. Additionally, once a week, mothers attend a parent class to discuss issues such as raising a baby in recovery and their own childhood experiences.
Conclusion

The Epiphany Center staff are examining the relationship between addiction and parenting. Zuckerman (1994) found that support for each mother’s interest in her child helped to keep mothers in the drug treatment program, and the healthiest part of these mothers was their interest in caring for their children. The Epiphany Center staff are seeing that as the mothers learn to help their infants develop, they gain confidence in other parts of their lives which aids their own recovery. Overall, the staff believes that it is the integration of comprehensive services to both the infants and the birth parents which contributes to successful recovery, improved child development, and family reunification and preservation.

— Linda M. Perez, PhD
Psychologist, Epiphany Center

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Epiphany Center Integrates Early Intervention and Substance Abuse Treatment

Baby Juanita* was born at 35 weeks gestation with a positive toxicology screen for methadone and cocaine. Upon discharge from the hospital, she went to a foster home where she was noted to be a poor feeder and somewhat jittery, irritable and hypotonic (low muscle tone). At four months age, Juanita received a psychological evaluation which suggested delayed psychomotor development with truncal hypotonia and poor visual tracking. Because the baby’s birth mother, Rosario**, very much wanted to reunify with her daughter, Juanita was placed at the Epiphany Infant Program, and Rosario began receiving intensive day treatment services at the Epiphany Center Recovery Program.

When Juanita came to the program at eight months of age, she showed significant delayed gross motor development secondary to the hypotonia, and she had substantial ophthalmic problems. In response, the Epiphany staff provided Juanita with a number of early interventions. These initially included physical therapy to address her delayed motor development and low tone, and eye patching and corrective lenses to address her eye problems. Play groups were subsequently added as an intervention to strengthen her language skills and peer relationships.

In order to enhance her social emotional development and attachment behavior, Juanita was cared for by the same staff on a regular basis, and she attended daily parenting classes with her birth mother. She was also encouraged to play with other toddlers in the group and was taught various ways to comfort and soothe herself.

During the 16 months that Juanita received these services as part of her daily living activities, she was periodically assessed and monitored by a developmental psychologist and a physical therapist. According to test findings on the Bayley Scales of Infant Development II, Juanita showed below average normal intelligence and significantly delayed motor development prior to receiving these services. Currently, she demonstrates above average normal intelligence and very mild motor delays, and she has formed secure attachments with her birth mother and her primary caregivers at the center.

Rosario and Juanita (who is now two years old) recently began off-site and weekend visits in preparation for permanent full-time reunification. After reunification, Rosario and Juanita will both continue to participate in the Epiphany Center Program where Rosario will receive support for her recovery and parenting, and Juanita’s development will continue to be monitored.

* Names have been changed to protect privacy.
Excerpts from an AIA Teleconference with Stanley I. Greenspan, MD

On October 26, 1995, the AIA Resource Center hosted a national telephone seminar on Assessment and Intervention with High-Risk Infants and Toddlers, with Stanley I. Greenspan, MD. Approximately 120 professionals participated in this 90 minute teleconference. The following highlights of Dr. Greenspan’s presentation illustrate the framework he suggests for working with infants and toddlers who are prenatally drug exposed or otherwise at risk for developmental delay. This model of development considers the different influences on the child and how the environment and the infant's biology affect the way the caregiver and infant interact. These interactions, in turn, determine how well the infant will negotiate each of six stages of early development:

- forming patterns of attention
- forming patterns of engagement
- forming intimacy
- learning to communicate nonverbally
- learning to use symbols
- learning to think

Dr. Greenspan noted that, based on studies of animals, there is reason to believe that the environment can actually change the structure of a child's nervous system. He further noted that when babies born with very intact nervous systems (e.g., good motor planning and not overreactive to sensation) are reared in an environment that is richly responsive to their needs, their nervous systems develop in a way that supports their cognitive and emotional development. Conversely, babies born with more limited nervous systems may have a harder time negotiating the challenges of early development if their environment is not supportive.

Model of Development

Infant's Physical Differences in Sensory and Motor Development

1. Sensory system:
   - assess infant's reactivity to sensation, i.e., how the infant's sensory system responds in terms of reactivity (e.g., sound, touch, vision, smell). Look for patterns of overreactivity or underreactivity to sensations, checking each modality (e.g., sound and touch) separately. This can be done through observation and play.
   - assess infant's ability to process information (e.g., by 4 months you can see how they decode sounds and how well they respond to animated and complex facial expressions)

2. Motor system:
   - assess infant's motor tone (e.g., loose vs. stiff/tight, and degree of asymmetry)
   - assess infant's motor planning (i.e., the ability to sequence motor movements, e.g., getting its hand to its mouth or following caregiver with its eyes)

Note: With children prenatally drug exposed (PDE), there is no one pattern or type of physical differences in motor and sensory systems. Although these children are more likely than children not PDE to have some regulatory problems, i.e., with their reactivity, processing and motor planning, the specific pattern is not predictable.

Infant's Interactions with Caregiver

Assess how a caregiver and baby interact in light of the 6 different developmental stages the baby has to master. The baby brings his physical pattern into the interaction, and the caregiver brings her personality, family and cultural patterns into the interaction.

1. Does the caregiver help the newborn be calm, regulated and very attentive, i.e., to what extent does the caregiver tailor her or his approach to the baby's nervous system to teach regulation and attention?
2. Does the caregiver help the infant form patterns of engagement and bonding, i.e., how well does the caregiver nourish the baby and pull its interrelatedness into the world, and how consistent are they in their caregiving?
3. Does the caregiver help the baby develop two-way nonverbal communication/reciprocal give and take patterns, i.e., to what extent are caregivers motivated to interact in this way?
4. Does the caregiver help the 8-10 mo. old baby master complex interactive behaviors, i.e., how well do caregivers work with children toward fostering longer interactive sequences?
5. Does the caregiver help the toddler (18 mo.-2.5 years) use ideas, i.e., how well does the caregiver foster language and pretend play and encourage the toddler to use imagination?
6. Does the caregiver help the toddler (2.5 years-4 years) build bridges between ideas and begin emotional thinking?
active or underreactive to sensation at birth), are put in a chaotic environment, after one month, they look like they have regulatory problems (e.g., underreactive and low tone, or hyperreactive and oversensitive to touch and sound). Conversely, however, Dr. Greenspan emphasized that an energized, animated and well-coached caretaker, and a lot of therapeutic support, can help compensate for a baby’s physical limitations so that the baby can attempt to master the six stages of early development.

To help accomplish this, Dr. Greenspan suggested the following strategies:

- Get consistency of care for all kids, e.g., train foster parents to operate as grandparents so when the baby goes back to its biological parent, the foster parent continues to help out and provide support, consistency and respite care for the baby when needed; or, in institutional or child care settings, have one person act as the surrogate parent for each child and, to the extent possible, have the same caregiver follow a child through the first three years.

- Train all caregivers to become attentive and engaging to their infants and toddlers and interact with them, in the specific ways outlined, to help them master each of the six early developmental stages. Ideally, this training should be done through a combination of methods, i.e., group work for parents to discuss feelings and strategies, didactic training, and individual hands-on consultation/coaching.

In summary, Dr. Greenspan insists that, in order to help children overcome physical challenges, we must: (1) provide consistent care in a good, nurturing environment; (2) support them constructively through all stages of development (e.g., we cannot just help them master one stage and expect that they will continue to develop normally); and (3) coach caregivers to learn how to provide age-appropriate experiences and extra experiences to address a child’s special needs.

— Amy Price, MPA

Audiotapes of Dr. Greenspan’s teleconference are available for $10. For ordering information, please see the back page of the newsletter.

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**Will We Lose What We Gained in Early Intervention?**

Early intervention services have been expanded considerably in the last ten years, in recognition of the benefits for vulnerable infants and their families. However, current fiscal constraints and an increasingly literal interpretation of minimum requirements of state and federal laws are combining in a dangerous new trend toward providing limited rather than comprehensive services. More and more families are being referred only to individual providers in order to reduce service costs. Systems are abdicating their responsibilities to children rather than finding creative ways to do what is right.

Why is this a regressive direction in service delivery? One reason is that studies demonstrating the efficacy of early intervention are based on comprehensive early intervention programs, which integrate a range of services and appropriate disciplines into a structured approach for the benefit of child and family. There is no evidence that a more limited, single-service approach is effective in achieving optimal developmental outcomes.

A more basic reason is the unique developmental paradigm of infancy. Learning, communication, movement and emotion are not differentiated systems, but are almost completely integrated in the baby. Intervention which does not address and promote all areas of a baby’s development will not be effective.

What is an early intervention program? A widely accepted definition by Meisels and Shonkoff (1990) is as follows:

“Early intervention consists of multidisciplinary services provided for developmentally vulnerable or disabled children from birth to three years and their families. These programs are designed to enhance child development, minimize potential delays, remediate existing problems, prevent further deterioration, limit the acquisition of additional handicapping conditions, and/or promote adaptive family functioning. The goals of early intervention are accomplished by providing developmental and therapeutic services for children, and support and instruction for their families.”

Provision of anything less is short-sighted. Studies have shown that early intervention services are cost-effective and worth the investment. Failure to provide them will result in increased costs and the lost potential of children’s lives.

— Nika St. Claire, MS, Director Center for Care Center for the Vulnerable Child

— Nancy Sweet, Director Early Intervention Services Child Development Center Children’s Hospital Oakland
Play Therapy Interventions for Substance Exposed Infants and Toddlers

Play Therapy refers to a range of methods that are used with young children to help establish a relationship and assist children in expressing themselves. The various methods include: Direct Play Therapy, Indirect Play Therapy, Developmental Play Therapy, and Sandtray Play. These therapeutic techniques can be used alone or in combination, depending on the focus of the treatment needed. In order to determine the most appropriate method(s), the therapist must have some basic knowledge about the client he or she is working with, and the goals or desired outcome of the treatment.

Working with substance exposed infants and toddlers creates some choices for the therapist as this special population typically has a multitude of needs. These needs may, in some instances, be related to physical malformations and abnormalities coupled with growth deficiencies, and, more often, to central nervous system problems which affect behaviors and physical well-being. Also, these children may develop behavioral patterns including hyperactivity, restlessness, irritability, and moodiness. Some may have short attention spans, a lack of understanding of cause and effect, and limited impulse control. Children with these characteristics are more difficult to care for. This may affect the child and parent attachment processes and ultimately exacerbate a child’s behavioral and developmental problems.

A caregiver’s personal history and issues also affect parent/child bonding and attachment. Some parents who have abused drugs or alcohol speak of their difficulty in controlling their children or their dislike for their children. These parents have often experienced a family history of substance abuse, poor parenting skills, domestic violence, abandonment, and/or criminal behaviors. They frequently have a tremendous amount of guilt about the problems their children experience, and anger at themselves for subjecting their children to the substance to which they were addicted. All these issues make parent/child relationships more difficult.

When parent/child attachment is limited, serious long term problems may occur for the parent, child and society. Recent research compiled in Florida, for instance, suggests a direct correlation between violence in adolescents and poor bonding and attachment with primary caregivers as infants (Florida’s Children, et al., 1994). In addition, studies of the human brain show that the first three years of life is a significant time for brain development (Sharpe, 1994). The finding that “brain development is much more vulnerable to environmental influence than suspected” and that “this influence of early environment on brain development is long lasting” is of significant importance for play therapists who work with substance exposed infants.

A carefully designed play therapy program can significantly affect bonding and attachment with substance exposed children and their caregivers. Whereas Direct and Indirect Play Therapy is often helpful with these dyads, Developmental Play Therapy has proven most effective and expedient in work with substance exposed infants. This type of therapy reaches not only the child, but the primary caregiver who may never have bonded with his or her primary caregiver years before.

Six Principles of Developmental Play Therapy

Developmental Play Therapy is a specialized treatment which uses the most basic play to engage an adult and a child in bonding and attachment actions using touch as the underlying skill. This play is especially successful with children who have relationship problems, are violently acting out or exhibiting withdrawal behavior, have attention deficient qualities, and/or who have been or are at risk for abuse or neglect. There are six principles behind the adult/child interactions in Developmental Play Therapy (Brody, 1993):

1. A child who experiences being touched develops a sense of self. Many substance exposed infants and toddlers appear to lack awareness that they have both a physical and an emotional self. This is often seen in their acting out behaviors of hitting, biting, and attaching themselves physically to others. Consistently disciplining these children for their inappropriate behaviors helps them feel validated and “real” as though they exist and can feel their body as being attached to themselves.

2. In order for a child to experience herself touched, a capable adult must touch the child. This is often difficult for substance using parents to comprehend or to master. To touch a child physically, bond and attach, and give to the child is a unique notion to parents who have perhaps never experienced this concept firsthand when they were infants. Therefore, it is important for the adult to experience this type of touch first during the training phase, and then practice this touch with his or her child.

3. In order to be the toucher, the adult must first be willing to learn to be the one touched. It is imperative that training for caregivers be conducted prior to work with the children. Only when the caregivers are comfortable being touched will they be able to touch their children. It is also critical to provide on-going supervision which employs encouragement and support for the parent/child relationship.
4. In order to feel touched, a child has to allow herself/himself to be touched. For children who have no "core self," this may be an emotionally painful process that will need to be monitored and slowly integrated for the child to be able to bond and attach. Play is an excellent medium for children to accept touch and to feel it in an authentic way.

5. A child feels seen first through touch. This is a profound statement that arouses memories in most humans when we as adults realize that we didn’t exist unless we were first touched. Closing your eyes, and asking someone to touch you or outline your facial features will give you a sense of what an infant may sense when being seen through touch. As Brody (1993) once said, “the skin never forgets.”

6. To provide the relationship a child needs to feel touched, the adult controls the activities that take place in a Developmental Play Therapy session. Setting limits is a crucial part of Developmental Play Therapy sessions. This gives the child a security that lasts life long if repeated consistently and lovingly. It is also the beginning of building children’s self-esteem and sense of self. There are six vital ingredients of self-esteem: physical and emotional safety, a sense of identity, a sense of belonging, a sense of competence, and a sense of mission (Youngs, 1991). Developmental Play Therapy sessions incorporate all six elements.

Components of Developmental Play Therapy

There are several components to the Developmental Play Therapy Program for substance exposed infants and toddlers and their primary caregivers. They include: parent training, pre-session caregiver preparation, caregiver/child time, group time, and post-session caregiver work. All of these components are essential in order to improve the overall well-being and development of both the caregiver and the child, and to continually define the process and needs of all concerned. Each play therapy program, however, is individualized and can be held at a central location or in the caregiver’s home.

Sculpting and massage are two of the techniques used during play therapy sessions. These techniques help caregivers use touch as a soothing and comfortable way to interact with their substance exposed infant or toddler. Touching body parts (e.g., facial features, nose, toes) begins the process of moving into sculpting and massage as the child can participate and feel some control and reassurance that the touch is “good.” Caregivers are also encouraged to chant or sing as they sculpt or massage their children.

Cradling is another technique often used in the last part of a Developmental Play Therapy session (Brody, 1993). Cradling gives a child an opportunity to be the center of attention and force out all other stimuli except for that of the caregiver and the child. During cradling, substance exposed infants and toddlers will often experience crying and sobbing, or complete peace while constant eye contact and smiles are shared.

Conclusion

Experience indicates that by the eighth session of a Developmental Play Therapy Program, a noticeable positive difference can be seen in the interaction pattern of the adult and the substance exposed infant or toddler. Play therapy helps establish the adult/child attachment needed for children to build other relationships. This foundation is critical in order for children to overcome physical and environmental risk factors and progress toward normal childhood development. Developmental Play Therapy should, therefore, be considered an integral part of any early intervention program for substance exposed children.

— Glenda F. Short, LCSW
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Call For Articles

The AIA Resource Center is soliciting articles for the Fall 1996 issue of The Source, which will focus on Cultural Competency and Sensitivity in Working with Families Affected by Substance Abuse or HIV/AIDS. The Resource Center invites individuals to submit articles that describe effective practices, innovative programs or current policy in this area. Specifically, we are looking for articles on: (1) effective strategies for making services and agencies culturally and ethnically sensitive and appropriate; (2) conducting culturally competent outcome evaluation of programs serving families affected by substance abuse or HIV; (3) managing a culturally diverse staff; and (4) what it means to be culturally sensitive and competent, i.e., cutting through the plethora of literature and information on cultural competency. As always, an AIA program will also be featured in this issue. Staff from any AIA program which employs specific strategies for providing culturally competent services, or for training staff in cultural competency, are encouraged to submit a proposal. Articles should describe the AIA program and its activities related to the theme of the newsletter.

To be considered for publication in this issue, please send/fax a brief (150-200 words) abstract of your proposed article to the AIA Resource Center no later than Friday, April 19, 1996. Authors of accepted articles will be notified within two weeks of the deadline. Final manuscripts should be between 1,000 and 2,500 words, and are due June 21, 1996.

Send/Fax abstracts to:
Amy Price, Editor
The Source
National AIA Resource Center
1950 Addison Street, Suite 104
Berkeley, CA 94704-1182
Fax: 510-643-7019
Phone: 510-643-8383
Engaging Foster Parents in Early Intervention Services for Infants and Young Children

Entering foster care is a traumatic experience. Pulled away from all that is familiar and placed with a stranger who is running both a home as well as a business, children in foster care are confronted with assumptions and expectations that differ vastly from their previous home(s). In this new environment they are required to adjust to a new day-to-day lifestyle with new family rituals. Many have been drug-exposed in utero, and most have been neglected. Some have been physically abused and most have been emotionally abused. As a result, they typically suffer with limited coping strategies, and usually have difficulty adapting to their new home.

Overcoming Challenges to Engaging Foster Parents

It is clear that to help these children receive the understanding and services they need, we must engage their foster parents. This is often difficult because providing ongoing care for these children is time intensive and never ending. However, when the foster parent becomes a willing participant in this process, the child is more likely to receive services that are needed, to make appointments that are scheduled, and to feel cared for and supported. When the foster parent does not participate willingly, the child typically receives intermittent care. They miss medical appointments and speech and language evaluations, and eventually their behavioral problems become exacerbated.

In order to provide quality care for a child in care, then, the foster parent must develop a thorough understanding of that child’s needs. Of equal importance, the foster parent must be able to modify her or his parenting over time in response to the changing needs of the child. However, there are many obstacles which prevent this positive parenting from occurring.

One major problem is that the foster parent rarely is given the complete history of the child. She or he may know of dramatic moments such as the precipitating incident that led to the removal of the child, but may not know about the child’s previous environment. Only very sophisticated foster parents attempt to perceive the child’s worrisome behaviors (e.g., clinging, night terrors, overfeeding or pushing away food) as the result of past emotional trauma. Guiding a foster parent towards understanding and empathizing with the child’s history helps nurture a commitment towards meeting the child’s needs.

“There to engage foster parents, it is critical not only to offer them educational opportunities but also to treat them as professionals.”

There are also systemic issues which affect the quality of care that a foster parent can provide in a home. It is essential that the home be assessed not only based on the quality of the foster parent but also on the children already in the home. A family with six children, for example, will have great difficulty in meeting the needs of all the children, much less if more than one has special needs. In addition, foster parents are often given contradictory information about the needs of a particular child. Therefore, it is important to provide a bridge between the child welfare worker, the clinician providing services for the child and the foster parent. This collaboration aids in ensuring that every person involved with the family has the same information.

Cutbacks in the departments of social services create other challenges due to the consequent increase in the level of abuse that must be seen before a child can be removed from its biological home. As a result, children entering foster care increasingly tend to have more severe symptomology. Caregiving for a more disturbed child not only requires more sophistication, but more stamina as well; and the more needs the child has, the more time the foster parent must spend attempting to meet those needs. Therefore, the foster parent can benefit from being part of a team which is working together to meet the needs of the child.

To engage foster parents, it is critical not only to offer them educational opportunities but also to treat them as professionals. There are times when helpful guidance can be appropriate. At other times, encouragement is all that is needed. And most of the time, it is helpful to acknowledge the foster parent’s accomplishments with their foster child. Using the mental health profession as a model is one way to address these issues. In that context, the foster parent can be asked: how they feel about their work, what is most difficult about a particular child, and how they can provide the support they need for themselves so that they can avoid burn-out. Then they are more likely to actively participate in meeting the developmental needs of the children in their care.

A Model Program

The Center for the Vulnerable Child at Children’s Hospital Oakland offers a model program which provides a select group of foster children and their foster families early intervention services. This Foster
Care Program, funded by the National Institute of Mental Health, is assessing the benefits of providing early intervention to foster children.

Results indicate that providing services to the children is only effective when services are provided to the foster family as a unit, and that successful early intervention demands a multitude of services that provide for the physical and emotional stability of the child. These services include: a continuity clinic to provide the children with ongoing medical care; case management services to help link the child with needed resources; developmental education and assessments to gain an overall understanding of the child’s strengths; educational training and support groups for the foster parents; parties and events to encourage the development of a foster care community; and one-on-one encouragement and support for the foster parents.

The Foster Care Program’s in-depth services are provided by a staff of professionals, from varied backgrounds, who are constantly looking for appropriate resources for the clients. The program’s mission is to provide children with the services they need, and foster parents are seen as the link to these services. Research underscores the program’s experience that it is essential for the foster parents to become advocates for the children in their homes. Consequently, not only do they need to be informed of the services available but they also need to be aware of how to be active consumers. Once they are familiar with these resources, they are more likely to follow-through with the necessary services.

Another key component of the program is to provide participating foster parents with information on child development in general and on foster children in particular. Infant development specialists offer information on normal developmental milestones and attachment. All children in the program receive the Bayley Scale of Infant Development II, a nationally standardized comprehensive assessment of a child’s development, to provide a baseline and ongoing understanding of their development. The tester also meets with the foster parents to review the information that was provided from the assessment, and to answer any questions that the foster parent may have. Preliminary analysis of the Bayley Scale results at baseline indicate that many of the foster children have developmental lags. As a result, many of the foster parents who believe that their foster child is developmentally on target discover that their foster child has some developmental problems. Foster parents then require education and support so that they can provide the necessary services for the child.

Supporting Foster Parents

The Foster Care Program seeks to enhance the foster parent’s sense of personal and community support for the work that they are doing. Many of the foster parents feel isolated in their work. This is exacerbated by the continual demands on their time to provide the children with needed services. To address these concerns, program staff continually develop strategies to help maintain the foster parents’ sense of professionalism and connection with the field, and support in their work. Some of these supports have included creating a neighborhood directory which lists foster parents from each area. In this way foster parents can turn to another for childcare or support. Future plans include helping the foster parents set up toddler play groups in each neighborhood.

Another way to address the isolation foster parents feel is by providing them with respite care. Because respite services in Alameda County (where the program is located) are typically only offered for medically-fragile infants, play groups and other respite services fill a much needed gap in resources available to the foster parents. Foster parents are encouraged to develop play groups with other foster parents in order to get a break in caregiving. These play groups have an added function—providing care for children who most child care workers consider to be too disruptive.

In order for the foster parent not to feel isolated, ongoing agency support is essential. The Foster Care Program commonly uses phone support to provide resource information, and to help foster parents talk through a particularly trouble-

— Reyna Cowan
Center for the Vulnerable Child
Children’s Hospital Oakland

Conclusion

Over the years, the Foster Care Program staff has developed close supportive relationships with many of the foster parents. The staff has also advocated for children in the program by informally educating the Department of Social Services about the psycho-educational needs of children in foster care. Through these connections with both the county workers and the foster parents, the program has seen tremendous improvements in the relationship between participating foster parents and children.
Children prenatally drug-exposed (PDE) represent a heterogeneous group whose range of regulatory problems at birth do not predict later development (Greenspan, 1995). Among these children, there is a high incidence of slow expressive language development, which is often accompanied by delays in receptive language abilities, deficits in phonological/articulation skills and/or deficits in self-regulation and socialization. Although a number of children PDE are at risk for persistent language-learning problems, early experiences can shape and alter their development.

Language development in children is relevant to three issues: (1) genetic influences, i.e., familial history of speech/language delays and learning disabilities which may predispose the child; (2) environmental influences, i.e., the nature and magnitude of environmental effects on the neural specialization for language in the earliest stages of development; and (3) plasticity, i.e., the extent to which the immature brain is capable of compensating for the potentially damaging effects to specific brain areas which result in mild to severe regulatory problems at birth.

Knowledge of these three issues and their influence on language development is important for creating change through assessment and intervention. This article provides a brief review of assessment components and intervention strategies, and addresses considerations which draw from research on slow expressive language development.

Early Language Acquisition

Language acquisition starts well before a child says its first words. Locke (1994) describes two early phases of language development which occur during the first year of life and are primarily affective and social in nature. The first phase is vocal learning, a time when the infant begins to recognize and interpret his or her caregiver’s behavior. In this phase, the infant is oriented towards voices and faces, learning about their prosodic (i.e., tonal and musical) qualities and affective messages. The infant begins to coordinate the timing of its vocalizations in relation to the speech of others (Ginsburg & Kilbourne, 1988) and keeps track of what others are looking at while talking.

A positive correlation has been reported between the amount of vocalizations an infant makes at 4 to 6 months of age and later language development (Camp, Burgess, Morgan, & Zerbe, 1987). Subsequently, Stoel-Gammon (1989) reported that babies who have high babbling levels at 9 months of age enter the meaningful speech stage earlier than those with low babbling levels. It is important to assess attention, arousal, motivation and social interaction behaviors, which contribute to early vocal learning. Such behaviors are necessary for adaptation to social environments.

The second phase of development described by Locke (1994) has to do with utterance storage. Prosodic patterns that include words and phrases are associated with the emotional experiences and behaviors an infant shares with its caregiver. This phase reflects early language comprehension and lexical development. Recent evidence indicates that a typical 8 month old can comprehend an average of 36 words (Bates, et al., 1994). If a child does not have enough words in storage, there will not be enough to draw from for early talking, and a decreased vocabulary will affect the later phases of development involving grammar, discourse skill, and creative language use. Locke (1994) suggests that a 24 month old child with a small vocabulary may have been storing fewer words than expected during the previous 16 months.

These two phases provide a motivating force in early language development and reflect the underlying continuity of care and stimulation the infant receives. Training caregivers in infant massage has proven to be a powerful tool for addressing the early communication and physical characteristics of a child. In addition, the Hanen Parent Program, which can be adapted to meet the parenting level of any adult, trains caregivers as language facilitators to help children communicate to the best of their abilities (see Table on page 14).

Late Talkers

Recorla (1989) has identified toddlers as 'late talkers' if they have less than a 50-word productive vocabulary or no multi-word combinations at age two. Follow-up studies indicate that more than half of the toddlers identified as late talkers at age two fail to catch up to their peers by age three. For children prenatally drug-exposed and from unstable environments, the chances for catch up may be more difficult without timely intervention. Even if a child does appear to catch up, other interrelated skills may be negatively affected by slow development. For example, delayed lexical development may affect metalinguistic knowledge (word awareness and phonemic segmentation) that is involved in literacy development, social-emotional development, caregiver-child relations, and representational play skills (Ellis Weismer, et al, 1993).

Slow expressive language development may impact the retrieval of stored symbolic representations. Thal and Tobias (1994) suggest that "late talkers appear to have difficulty using their symbolic capacity spontaneously and flexibly in situations that require more abstract applications of that symbolic ability" (p. 167). It is not surprising, then, that children prenatally drug-exposed with slow language development often have a delay in symbolic play skills (Clarke, 1993).
In order to help children retrieve stored symbolic representations, mediated learning has proven useful. According to Feurstein (1979), mediated learning involves an experienced adult who "mediates" between the child and the world by "framing, selecting, focusing, and feeding back environmental experiences" so as to create "appropriate learning sets and habits" (p. 35). Linder (1993) and Greenspan (1992) have provided useful guides to intervention within this natural context (see Table on page 14).

**Language and Relationships**

The interactions and transactions children have with their caregivers and family, as well as the influence of wider societal factors, influence language competency (Garcia Coll, 1990; Walker, et al., 1994). The early relationships and learning opportunities offered in the home and community establish much of what may be learned, how and when it will be taught, and the rate of learning (Heath, 1989). Many studies of individual child-caregiver dyads demonstrate the interactive, bidirectional nature of early communication. The high incidence of language delay accompanying disordered child-caregiver relationships suggests that when the appropriate threshold of social support is unavailable, the child’s capacity for language acquisition is affected (McCune, 1992). If a caregiver is ineffective in reading a child’s emotional and communicative cues, or is inconsistent in response to their communicative attempts, important language-learning opportunities are missed.

The best prevention of language delays is to facilitate early communication by working on the relationship between the caregiver and the child. Greenspan (1995) defines the ‘caregiver’ as the person or persons familiar with the child and capable of providing the most consistent care to assure security. In cases of shared custody, this may include a team of caregivers who receive the same coaching to ensure this consistency. The Hanen Parent Program, again, is extremely valuable in these situations, as are the intervention strategies offered by Greenspan (1992) and Donahue-Kilburg (1992) (see Table on page 14).

**Environment**

Environmental conditions that make perception of speech more difficult (e.g., living in a crowded, noisy area) or that promote reliance on more primitive but effective forms of communication (e.g., pointing, whining, and grunting) may also constrain language development (Whitehurst, et al., 1992). Inadequate language learning results from too little adult input, too many commands or directives, and not enough good questions, comments, and implicit corrections. Studies of vocal interaction in low SES families suggest low rates of conversation and limited vocal repertoires that are not reflected in structural (grammatical) deficiencies, but in vocabulary usage (Hart & Risley, 1992). Disadvantaged families reportedly play fewer games that are conducive to early language learning and typically ask their children less often for language.

It is important to look at the communicative style of the home environment, but intervening to change caregiving practices requires sensitivity. Dixon (1994) advises that we meet caregivers at their level and try to influence their interest and engagement. Solution Focused Brief Intervention Family Therapy is useful in affirming the strengths of caregivers to meet the needs of their children (Berg, 1994). This model, which helps caregivers develop skills that come from solutions they identify as useful to their situation, has been very effective with substance-abusing families.

**Coping and Resiliency**

Coping is the process of making adaptations to meet personal needs and to respond to the demands of the environment (Zeitlin & Williamson, 1994). Effective coping facilitates the acquisition of developmental skills, so that the more effectively children cope with the demands of daily life and the environment, the more they learn.

Children who are delayed tend to be less effective in their coping behavior. Zeitlin and Williamson (1994) identify certain coping attributes as areas of particular vulnerability for children with delays or regulatory problems: self initiation, flexibility, independent problem solving, generalization of learning, management of change and transitions, social reciprocity, and/or regulation of mood and affect. One or more attributes may indicate that these children are less resilient to the stresses of daily living, but does not imply that their mechanisms for coping are immutable. Until children learn to cope or regulate their behavior, however, they may have limited language skills and exhibit behaviors which have negative outcomes (e.g., temper tantrums, withdrawal). Conversely, a child’s limited vocabulary and expressive abilities may contribute to the aggressive and disruptive behaviors often reported in children prenatally drug-exposed. Zeitlin and Williamson (1994) and Greenspan (1992) have outlined effective intervention practices to enhance coping strategies and resiliency (see Table on page 14).

**Summary and Conclusions**

This is a brief overview of considerations for creating change in early language development through assessment and intervention. In order to determine intervention entry points, assessment of language development in children birth to three should involve transdisciplinary team members, caregivers and families, and should include:

1. Current knowledge of child’s developmental phases or stages.
2. Family history of speech/language delays and their level of stress, support and risk.
3. Infant’s vocal communication, sound production and communicative intent.
4. Emerging social, affective, cognitive, and linguistic domains through play.
5. Communicative interactions between caregiver and child.
6. Infant’s early coping deficiencies and strengths.
7. Child’s medical history of otitis media effusion.

The resources described in the following table will be useful in developing appropriate interventions based on ongoing comprehensive assessments. The key is to intervene early and robustly (Greenspan, 1995); to focus on
relationships; and to use existing, well-researched programs which facilitate language development and meet caregivers at their level. Perhaps through early intervention we can best equip children to overcome the adverse effects of prenatal drug exposure and to better adjust to the stressful world into which they have been born.

— Jane C. Clarke, PhD, SLP
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REFERENCES


A technique that promotes bonding between the infant and caregiver and promotes early communication development by training caregiver to read emotionally communicative cues.

Resources for Language Development Intervention

<table>
<thead>
<tr>
<th>RESOURCE</th>
<th>DESCRIPTION</th>
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<tbody>
<tr>
<td>Brief Solution-Focused Family Therapy (Berg, 1994; de Shazer, 1985)</td>
<td>A guide to developing parenting skills that come from solutions parents identify as useful to their situation.</td>
</tr>
<tr>
<td>Hanen Parent Program (Watson, 1995)</td>
<td>A family focused approach to language intervention with young children which addresses: • importance of caregiver’s participation in the intervention process • the need to provide services to families as early as possible. Can be used with day care providers, foster parents, and/or extended family.</td>
</tr>
<tr>
<td>It Takes Two to Talk (Manolson, 1992)</td>
<td>Three Hanen Centre publications for caregivers and child-care providers of children who are at risk or who are already identified as language delayed.</td>
</tr>
<tr>
<td>You and Your Baby: Building Communication (Girolametto &amp; Ushkey, 1989)</td>
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<td>You Make the Difference (Manolson, Ward &amp; Dodington, 1995)</td>
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<tr>
<td>Transdisciplinary Play-Based Intervention (Linder, 1993)</td>
<td>The transdisciplinary play-based intervention is a natural extension of TPBA and is effective for children from infancy to 8 years of age. It is designed to provide guidelines for caregivers and other facilitating adults.</td>
</tr>
<tr>
<td>Coping in Young Children: Early Intervention Practices to Enhance Adaptive Behavior and Resilience (Zeitlin &amp; Williamson, 1994)</td>
<td>Intervention is directed toward increasing the effectiveness of a child’s transactions with the environment. It is targeted for children who have limited coping abilities or who live in high stress environments to build on strengths to foster resilience.</td>
</tr>
<tr>
<td>Family-Centered Early Intervention for Communication Disorders: Prevention and Treatment (Donahue-Kilburg, 1992)</td>
<td>Provides a useful basis for family-centered intervention that emphasizes the role of affect and human relationships in language development.</td>
</tr>
<tr>
<td>Infancy and Early Childhood (Greenspan, 1992)</td>
<td>A model of the psychotherapeutic and preventative intervention process which addresses the developing child, child/caregiver interactions, and family patterns.</td>
</tr>
<tr>
<td>Infant Massage Training</td>
<td></td>
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April 11 - 13, 1996
■ Building on Family Strengths
Research and Training Center on Family Support and Children's Mental Health
and Portland State University
Portland, OR
This national conference is a forum for the examination and dissemination of state-of-the-art research and program models in the areas of family support and family-centered care. Cost: $195.
Contact: Kay Expo, Conference Coordinator, Research and Training Center on Family Support and Children's Mental Health, Regional Research Institute, Portland State University, P.O. Box 751, Portland, OR 97207-0751, (503) 725-5558

MAY 1 - 4, 1996
■ Changing the Way America Works for Families
Family Resource Coalition
Chicago, IL
This national conference provides opportunities for practitioners, advocates, policy makers and academics to network and attend workshops and seminars on topics related to family support practice and policy. Cost: $289 - 396 (by Jan. 31), $329 - 399 (after Jan. 31).
Contact: Juju Lien, Family Resource Coalition, 200 South Michigan Ave., 16th Floor, Chicago, IL 60604, (312) 341-0900, ext. 134

MAY 29 - JUNE 1, 1996
■ HIV/AIDS '96: The Social Work Response
Boston College Graduate School of Social Work, Tulane University School of Social Work, San Jose State University School of Social Work, Syracuse University School of Social Work, & the University of Michigan School of Social Work
Atlanta, GA
This eighth annual international conference on social work and HIV/AIDS will offer a range of rich continuing education opportunities for AIDS care social workers. The approximately 125 workshop sessions will include AIDS and the end of life; counseling issues of dying clients, loved ones and professionals; and frontiers of HIV/AIDS therapies. Cost: $185 (before April 15); $210 (after April 15); $100 (student).
Contact: Dr. Vincent Lynch, Boston College Graduate School of Social Work, Chestnut Hill, MA 02167, (617) 552-4038; Fax (617) 552-3199

ALSO...
MotherNet America is hosting a series of regional training workshops on Building Successful Lay Home Visiting Programs. These two-day forums will be held throughout February, March and April in Washington, DC; Chicago, Los Angeles and Jacksonville. They are intended to provide practical information on how to recruit, manage and train lay home visiting staff; create welfare-to-work programs; develop partnerships with community colleges; work with the state Medicaid office; and build partnerships in the community. Cost: $225.
Contact: INMED, 45449 Seven Way, Suite 161, Sterling, VA 20166, (703) 444-4477; Fax (703) 444-4471

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Optimizing Emotional Development
In simplest terms, health care professionals can assist caretakers in optimizing the emotional development of their children by helping those caretakers to create safe, consistent, predictable physical environments, and to provide warm, consistent and nurturing emotional environments. In reality, however, this is a complex process which must address the unique characteristics of the children and their caretakers at a number of levels. Careful assessment must be made of the stages of development and the unique patterns of strengths and weaknesses in the children. Such assessment must include the children's levels of emotional functioning and any history of potential psychological trauma. When shared with caretakers, this information can serve as a starting point for helping caretakers to develop a more empathetic understanding for what their children can and cannot do and for why their children sometimes act the way they do.

This information can also be used to assist caretakers in developing environments which are responsive to and appropriate for the developmental abilities and limitations of their specific children. Such information is essential for all caretakers whether ATOD abusers or not. In fact, information about the distinctive developmental needs, abilities, and limitations of specific children is particularly important to have in foster care settings. Communication of such information among caretakers from placement to placement helps to create more consistency across placements for children, thereby reducing some of the emotional trauma of multiple placements. For many children, even those exposed to psychologically traumatic events, the creation of a safe, consistent, nurturing environment will be enough to foster healthy emotional development. Some children, however, may require individual therapy to help them redefine themselves and to learn to express and respond to emotions more appropriately.

Providing information about their children to caretakers is one of a number of essential components to optimizing the emotional development of children. A second crucial component concerns the abilities of caretakers to comprehend and to put into practice the information provided and to address the emotional needs of the child. For some caretakers this will include an assessment of the patterns of parenting received by, and the present psychological functioning of, the caretakers. Some caretakers may require intensive therapy and considerable assistance working through their own issues before they will be adequately meet the physical and emotional needs of their children. Finally, careful assessment must be made of the existing patterns of interaction between emotionally at risk children and their caretakers. Dysfunctional communication and interactive patterns must be identified and replaced with more appropriate patterns which negotiate the needs of caretakers and children alike.

Working every day with at risk children, health care workers sometimes become almost paralyzed by the apparent hopelessness created by the overwhelming array of biological and emotional risks faced by so many children. To ease this tendency, it is critical to remember two things. Children are incredibly resilient, and early identification of problems combined with early intervention can greatly amplify that natural resiliency.

— Dan R. Griffith, Ph.D.

REFERENCES
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IN THIS ISSUE:
Assessment/Intervention Strategies for Infants and Toddlers Affected by Maternal Substance Abuse
PAGE 1

The Epiphany Center
PAGE 3

Excerpts from an AIA Teleconference with Stanley I. Greenspan, MD
PAGE 6

Play Therapy Interventions for Substance Exposed Infants and Toddlers
PAGE 8

Engaging Foster Parents in Early Intervention Services for Infants and Young Children
PAGE 10

Language Development in Children Prenatally Drug Exposed
PAGE 12

Resource Reviews
PAGE 15

Conference Listings
PAGE 17

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