PR & USVI ATTC

FIRST NATIONAL CONFERENCE

May 9-11, 2001
Conference Proceedings

The Hispanic/Latino Family in the New Millennium

Strategies to Prevent and Treat Substance Abuse among Children and Adolescents

Knowledge, Skills, Attitudes, Innovative Methods

Presented by:

puerto rico & us virgin islands attc addiction technology transfer centers

FUNDED BY CENTER FOR SUBSTANCE ABUSE TREATMENT, SAMHSA

Universidad Central del Caribe-School of Medicine

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MCS HMO

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Mensaje de la Directora / Message from the Director

El uso y abuso de drogas es el problema sicomédico más critico del bienestar social, económico y familiar de Puerto Rico. El último estimado epidemiológico indica que al menos 134,139 residentes de PR necesitan tratamiento contra el abuso de substancias.

Estudios realizados entre adolescentes de las escuelas públicas y privadas señalan que el uso de alcohol, cigarrillos y marihuana ha aumentado signíficativamente desde los años setenta. Otros estudios han señalado que el uso de estas drogas está altamente asociado al posterior abuso y adicción de substancias tales como la cocaína y la heroína. En Puerto Rico, el acceso a las drogas ha aumentado, particularmente en los municipios más pequeños, zonas rurales y en todo tipo de comunidad, tanto de bajos recursos así como en las de clase media y alta, según los hallazgos más recientes.

Las ciencias neurológicas han comprobado que la adicción es una enfermedad compleja que requiere una atención formal y científica. El PR & USVI ATTC se dedica al estudio sistemático de la adicción y promueve el uso de métodos científicamente validados para tratar esta enfermedad. Con este catálogo queremos presentarnos a usted dejándole saber quiénes somos, qué hacemos y sobre todo, cómo podemos servirle a usted y a su organización en el manejo de esta condición que tanto impacta nuestras vidas.

Drug use and abuse is Puerto Rico's most critical psycho-medic problem affecting the population's social, economic, and family well-being. The last epidemiological estimate indicates that at least 134,139 Puerto Rican residents need substance abuse treatment.

Studies among private and public schools adolescents indicate that alcohol; cigarette and marihuana use has increased significantly since the 1970's. Other studies indicate that drug use is closely related to later use or abuse of drugs such as cocaine and heroin. Access to drugs in Puerto Rico has increased, particularly in smaller municipalities (equivalent to counties), rural areas and in all social-economic groups, from low to high income, according to the most recent findings.

Neurological sciences have proven that addiction is a complex illness, which requires formal and scientific attention. The PR & USVI ATTC's objective is to study addiction systematically and encourage the use of scientifically validated methods to treat this illness. With this catalog, we introduce ourselves, aiming to give you a glimpse of who we are and what we do, but primarily, to demonstrate how we can serve you and your organization in treating this life changing condition.

Rafaela Robles
Director
Center for Addiction Studies

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Our most cordial appreciation to our all our colleagues for their valuable assistance during this Conference

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The PR & USVI ATTC First National Conference gives its heartfelt thanks for the attendance and support of our Special Guests

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Our most sincere appreciation for all your support

H. Westley Clark, MD, JD, MPH, CAS, FASAM
Director, Center for Substance Abuse Treatment

Alan Leshner, PhD
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A Special Recognition also to our Masters of Ceremonies

Carlos León Valiente, MD

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Carlton Erickson, PhD

Wednesday, May 9, 2001
Pre-Conference

Neurobiology of Addiction: Simplified

Facilitator: Nereida Díaz, PhD
Recorder: María Noelia Miranda, RN, MHS
Language of the Presentation: English

Carlton Erickson, PhD
Biographical Sketch

CARLTON (CARL) K. ERICKSON, a research scientist, has been studying the effects of alcohol on the brain for over 25 years. Carl received his Ph.D. degree in pharmacology from Purdue University in 1965. He has held tenured teaching and research positions at the University of Kansas and the University of Texas since 1969. He presently is the Parke-Davis Centennial Professor of Pharmacology and Director of the Addiction Science Research and Education C–enter in the College of Pharmacy at the University of Texas at Austin. He is a member of the Research Society on Alcoholism (RSA), the College for Prevention of Drug Dependence (CPDD), and the American College of Neuropsychopharmacology (ACNP).

Carl is broadly knowledgeable about the alcoholism research literature, since he is an active scientist and Science Editor of the new Betty Ford Center newsletter, *Findings*. Publisher of over 150 scientific and professional articles, he is also co-editor of the book, *Addiction Potential of Abused Drugs* and *Drug Classes* (Haworth Press, 1990), and co-author of *Your Brain on Drugs* (Hazelden, 1996), and *Drugs, The Brain and Behavior* (Haworth Medical Press, 1998). He formerly wrote a regular commentary called "Voices of the Afflicted" for, and is now an Associate Editor of, the scientific journal *Alcoholism: Clinical and Experimental Research*. He has participated in the Professionals in Residence program at the Betty Ford Center in Rancho Mirage, CA and is a recipient of the Betty Ford Center Visionary Award (2000). As a neuroscientist, Carl believes that alcoholism and other addictions are neurochemical disorders which present themselves clinically as different subtypes, each related to a different neurochemical pathology which produces the primary symptom of compulsive drug taking.

Carl believes that scientists need to understand the addictive diseases and their treatment, so that the few available research funds in this area can be used to answer questions that will soon help the alcoholic and other drug addicts. To this end, he has tried to learn as much as possible about these diseases from recovering individuals and treatment programs. Conversely, those in the treatment field must learn the latest research findings so that newer methods of treatment can be utilized as soon as possible. Finally, if those working to help the alcoholic and other drug addicts band together to destigmatize these diseases and increase public knowledge about the need for more research and treatment, then more funds will become available to understand and treat these diseases. Public education in these areas is thus extremely important.

SOURCES FOR MORE INFORMATION

National Clearinghouse for Alcohol and Drug Information (NCADI)
1-800-729-6686 (Hablamos Español), TDD 1-800-487-4889 http://www.health.org

National Institute on Alcohol Abuse and Alcoholism (NIAAA)

(Alcohol Alert, free publications: 301 443-3860) http://www.niaaa.nih.gov

National Institute on Drug Abuse (NIDA)

http://www.nida.nih.gov/NIDAHome.html, NIDA Notes, 301-294-5401, nidanotes@hq.row.com

University of Texas Addiction Science Research and Education Center

http://www.utexas.edu/research/asrec

Betty Ford Center –1-800-854-9211 (Resource Development Department, for the newsletter)

Join Together Online -http://wwwjointogether.org

Physician Leadership on National Drugs Policy - http://www.caas.brown.edu/plndp

The Alliance Project - www.defeataddiction.com

THE NEUROBIOLOGY OF ADDICTION: SIMPLIFIED

Abstract

Public and professional stigma against addictive diseases is a major social problem when dealing with conditions that have traditionally been dealt with by behavioral and spiritually-based programs. Reduction of stigma is critical, since negative attitudes adversely affect the level and quality of patient care, as well as funding for prevention, education, and research. Until now, the "field" of drug addiction treatment and prevention has drifted aimlessly, based upon the lack of sufficient research evidence that addictions are diseases, and about the pharmacology of addicting drugs. Much of the confusion is based upon an incomplete understanding of the differences between intentional drug abuse and addictive drug disease. There is also a great deal of misinformation about the pharmacology of addicting drugs. This picture is changing rapidly, based upon new neuroscience research which strongly indicates that the pleasure pathway (medial forebrain bundle) of the brain is affected by all addictions, particularly in the pharmacological qualities of euphoria, craving, and a theoretical concept of "drug need". "Drug need" is the psychological correlate of behavioral "impaired control". Although its neuroanatomical and neurochemical bases have yet to be demonstrated in the laboratory, the research technology is now at hand to test such hypotheses. Everyone who cares about the victims of addiction needs to become more scientifically literate about the implications of new research findings, and to "spread the news" that biomedical research is on the threshold of proving what recovering people already know - that drug addictions are medical diseases that deserve parity in present and future national health care programs. Addiction must also be "handled" differently than drug abuse in terms of responsibility and culpability in the law enforcement environment.

Description

This workshop will cover the latest research, in lay language, on the neurobiology of addictions, including how the brain's pleasure pathway works; the differences between chemical abuse and chemical dependency; the latest therapies for drug dependency; and research methodologies that promise even more exciting breakthroughs in understanding addictions in the future. This information has important implications regarding prevention and education of the public regarding the true causes of drug problems, and how society can best deal with such problems.

Learning Objectives

At the end of the presentation, attendees will be able to:

1. differentiate chemical abuse from chemical dependency, and identify the different types of treatment for each,
2. identify the neuroanatomical and neurophysiological substrates for drug action, including reward mechanisms activated by mood-altering drugs,
3. list the past, present, and future drug therapies for chemical dependence, and
4. describe the mechanisms by which new treatments help drug addicts by affecting brain chemistry dysfunction present in the brain's pleasure pathway (medial forebrain bundle).

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(512) 471-5198 erickson.carl@mail.utexas.edu

WORKSHOP PLAN

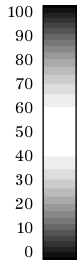
- provide facts for addiction as a disease
- provide usable information
- put old ideas in perspective with new research findings
- explain why research is great and why we need more!

We need more research!

- There is lots of disagreement and misinformation in our field.
- This is a result of not having all of the facts.
- Facts come from good scientific research.

RESEARCH VALIDITY ESTIMATE (RVE)

(A Thoughtful Appraisal of High-Quality Scientific Research)



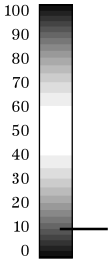
High RVE

- many large, well controlled studies
- replicable results
- much peer-reviewed, published literature

Low RVE

- few replicable studies
- highly speculative results
- little peer-reviewed, published literature

Low RVE Example

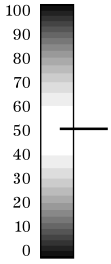


New Research: 007

- James Bond: "Shaken, not stirred."
  - more to it than a tastier drink?
- Antioxidant effect of alcohol may reduce CD, stroke, and other age-related diseases.
- Shaken martinis were found to have higher antioxidant activity: healthier?

Trevithick et al., 1999

Moderate RVE Example



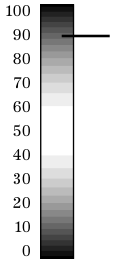
Nicotine and Dopamine

- Inhaling smoke containing nicotine increases the firing rate of dopamine nerve cells in the mesolimbic system in rats.
- This mesolimbic dopamine activation may be relevant to tobacco addiction.

Mauro Fa' et al., 2000

High RVE Example

Methadone Effectiveness



- All opiate-dependent people should have access to methadone under legal supervision.
- There is a need for improved training of physicians and other professionals.
- Coverage of methadone programs should be a required benefit in public and private insurance programs.

National Consensus Panel, 1998

We have some problems....

There are some myths out there:

- Club drugs won't harm you.
- New smokable heroin is non-addicting.
- Everyone who uses cocaine or heroin is addicted.
- Caffeine is highly addicting.
- it takes a history of heavy smoking to produce addiction to nicotine.
- Alcoholics can stop drinking - all they have to do Is go to A.A. meetings.

TWO CRITICAL DEFINITIONS*

The First One

- abuse - intentional overuse in cases of celebration, anxiety, despair, or ignorance. Making bad choices about the use of drugs. Declines with adverse consequences, supply reduction, or change in environment. ("A problem to solve")
- important because drug abusers produce a major economic impact on society (e.g. alcohol = about 60% of alcohol-related costs to society)

TWO CRITICAL DEFINITIONS*

The Second One

- dependence - impaired control over drug use, probably caused by a dysfunction in the brain's "pleasure pathway"
- this is the disease of "addiction"
- it requires formal therapy or Twelve Steps and may require drug therapy ("A disease to conquer")

* Based on the Diagnostic and Statistical Manual-IV-TR (DSM-IV-TR)

DSM-IV dependence = "addiction"

alcohol dependence = alcoholism (NIAAA, but others use the term very loosely)

abuse (U.S.) = misuse (England)

(Note: NIDA is misnamed - should be National Institute on Drug Abuse and Dependence)

Here are some terms to avoid....

- physiological dependence*
- psychological dependence*

  * 1950 W.H.O. definition

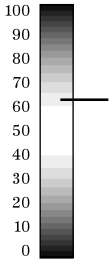
- physical addiction
- psychological addiction
- "substance abuse" (weak, wimpy, confusing, inaccurate, misleading)

The essential feature of dependence is <u>impaired control</u>

<u>Two components (Ch. 2, Big Book)</u>

1. loss of control (within an episode)
2. inability to abstain (between episodes)

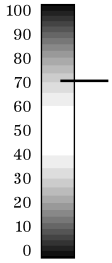
ADDICTION POTENTIAL*



Highest	Lower
• heroin	• methadone, Vicodin
• nicotine	• benzodiazepines
• cocaine/crack	• marijuana
• alcohol	• anesthetics
• amphetamines	- PCP, ketamine

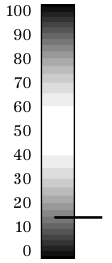
- subjective dependence liability associated with drug use, based upon many factors

NO ADDICTION POTENTIAL



- caffeine (?)
- hallucinogens, such as LSD (?)
- SSRIs, such as Prozac
- lithium
- haloperidol (Haldol)
- naltrexone
- naloxone (Narcan)

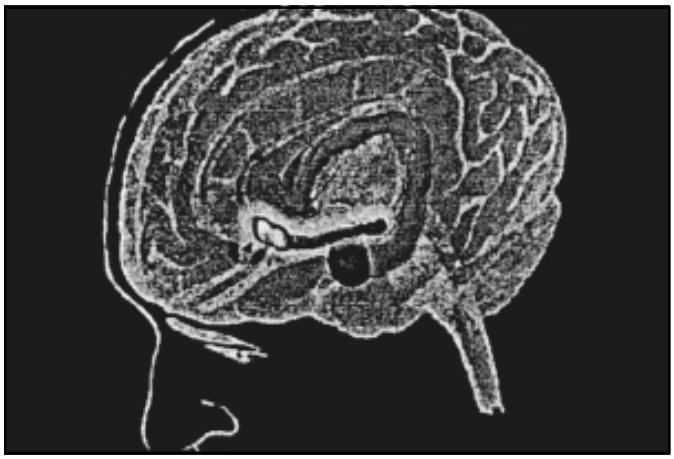
CLUB DRUGS - ADDICTION POTENTIAL



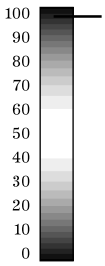
- methamphetamine (mesh, ice, crank) - high
- flunitrazepan Rohypnol, roofies) - moderate
- ketamine (Special K, Vitamin K) - low?
- MDMA (Ecstasy, X, XTC) - unknown
- gamma-hydroxybutyrate (GHB, G) - unknown
- lysergic acid diethylamide (LSD, acid) - none

(fact: these are <u>not</u> new drugs)

THE MEDIAL FOREBRAIN BUNDLE (MFB*)
*** Mesolimbic Dopamine System**



MEDIAL FOREBRAIN BUNDLE



- ventral segmental area (VTA)
- lateral hypothalamus (LH)
- nucleus accumbens (ACC)
- frontal cortex (FC)
- (amygdala, AMYG)

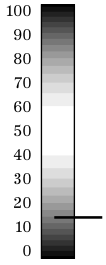
IMPORTANT POINT!

- The major site of action of addicting drugs is the subconscious MFB, not the conscious cortex.
- This is strong evidence that addictions are <u>not primarily</u> under conscious control!

Responsibility vs. Culpability

- Drug <u>abusers</u> make decisions to use drugs. When they hurt others, they deserve appropriate punishment.
- Drug <u>dependent</u> individuals have responsibility for their actions under the influence of drugs, and they have responsibility for their own treatment. Should they be punished, treated, or both?

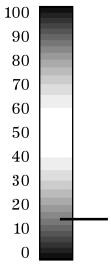
MODEL OF IMPAIRED CONTROL (1993)



<u>Two MFB Circuits</u>

- <u>Circuit #1</u>: LIKE (pleasure) circuit. LIKE circuit activity is associated with initial drug use.
- with overuse, misuse, or abuse the LIKE circuit shows tolerance.

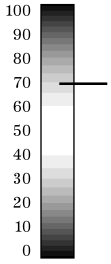
MODEL OF IMPAIRED CONTROL (1993) - continued



- Circuit #2: WANT (craving) circuit. The WANT circuit is a different MFB area than the LIKE circuit.
- Sensitization of the WANT circuit causes addiction!

-Robinson & Berridge

IMPROVED MODEL OF IMPAIRED CONTROL (2000)



Three MFB Circuits

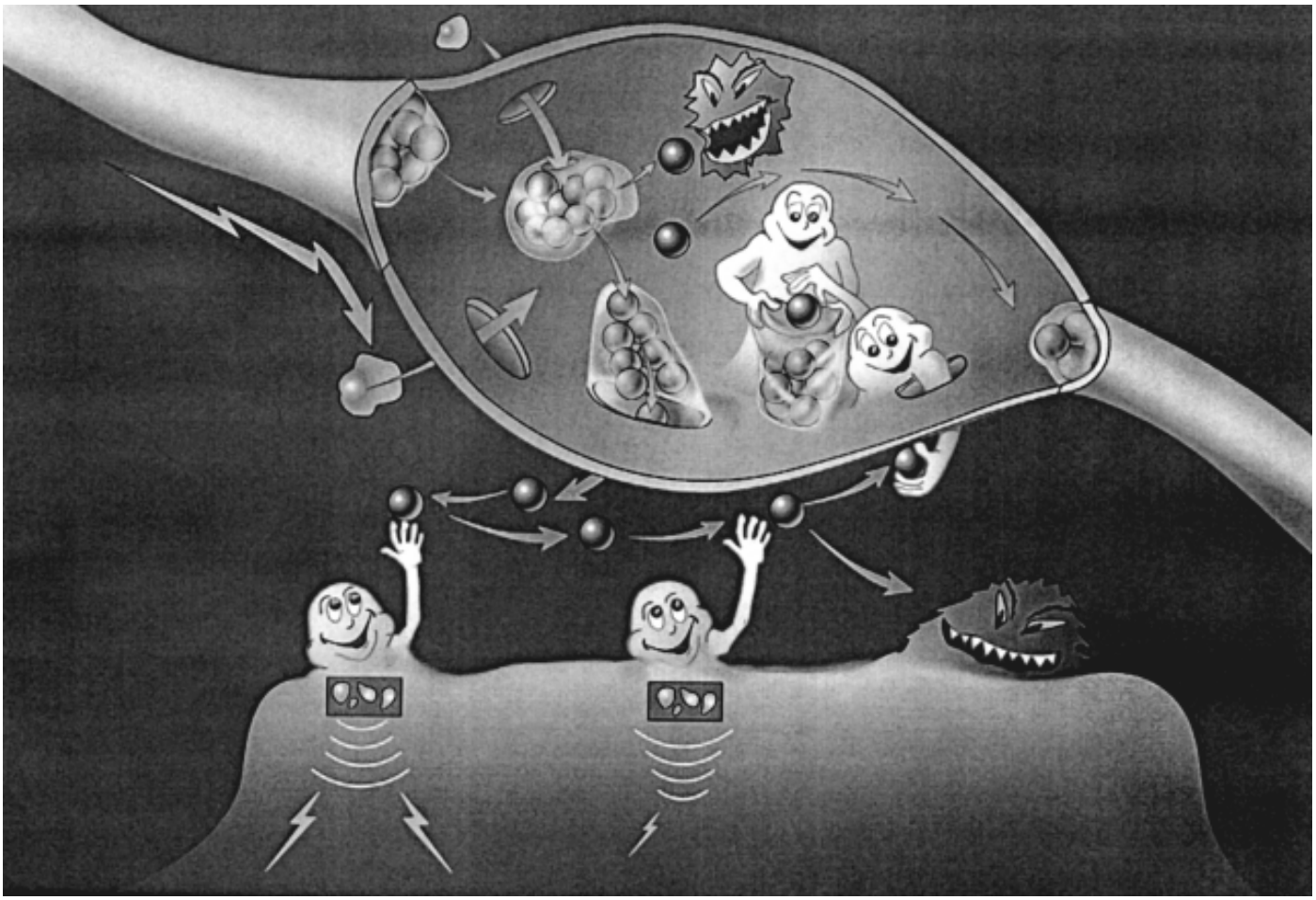
- Circuit #1: LIKE (pleasure) circuit.
- Circuit #2: WANT (desire, urge) circuit.
- Circuit #3: NEED (pathological desire, demand) circuit. This is associated with sensitization (severe dependence).

Features of the "Need Circuit"

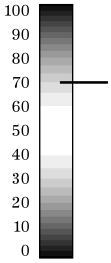
- We know where it is (MFB)
- How does it become sensitized?
- Some people talk about an

"addictive switch" – is this it?

- Let's look at the neurochemistry



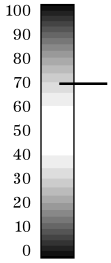
DOPAMINE TRANSPORTER



"Knock-out" mice

- no DA transporter (DAT)
- DA stays in synapse 100 times longer than in normal mice
- mice w/o DAT are 5-6 times more active than normal mice
- cocaine, amphet, ADHD, mania

NEUROTRANSMITTERS INVOLVED IN "ADDICTION"



Probable functional dysregulation:

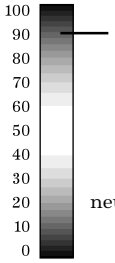
- Dopamine (DA)
- Serotonin (SER)
- Endorphins (END)
- Gamma-aminobutyric acid (GABA)
- Glutamate (GLU)
- Acetylcholine (ACh)

(THIQS are no longer popular)

What Goes Wrong With The Neurotransmitter System(s)?

- genetic "malfunctions"?
- drug-induced changes?
- other aspects of the environment, besides drugs?

RATIONALE BASED UPON GENETICS



abnormal genes abnormal proteins

abnormal transmitter synthesizing enzymes

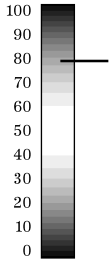
abnormal transmitter breakdown enzymes

abnormal receptors

neurotransmitter dysfunction In the pleasure sure pathway

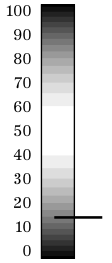
impaired control

A BRAIN CHEMISTRY DISEASE!



- addicting drugs seem to "match" the transmitter system that is not normal
- abstinence is the first step in the total treatment process, In order to access the "wreckage of the past"
- methadone and nicotine maintenance is evidence that some people require a chemical to overcome the non-normal transmitter system

Are Addictions an Obsessive-compulsive Disorder Subtype?



- Who has a problem with controlling behavior: OCD, addicts, Tourette's, schizophrenia?
- Are these OCD or addiction?

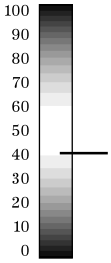
-pathological gambling

-compulsive shopping

-hypersexual behavior

-smoking

Are Addictions an Obsessive-compulsive Disorder Subtype?

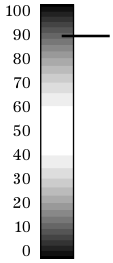


- drug dependence satisfies all DSM OCD criteria
- 50% of cocaine addicts have compulsive "foraging"
- 11% of heroin addicts have OCD
- in treatment-based abstinence: patients still use other drugs (i.e., they are not fully abstinent) – thus patients are compulsive in their drug use! Are they also obsessed?

Former Options (circa 1970)

- Alcoholics Anonymous
- Psychiatric hospitals
- Some inpatient treatment programs

Today's Options



- 12 step programs (abstinence)
- inpatient/outpatient/aftercare (insurance?)
- new meds to enhance abstinence
- harm minimization, MM, methadone
- brief motivational counseling, CBT, MET, SO-involved therapy, vouchers, vaccines

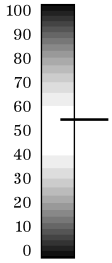
(M M= Moderation Management CBT= cognitive behavioral therapy MET= motivational enhancement therapy, S0 = significant other)

Tomorrow's Options

(In probable order)

- anti-craving medications
- some neurochemical-normalizing medications
- gene therapy ("fixing bad genes")
- prevention through gene alteration

NEW DRUGS FOR ALCOHOL DEPENDENCE



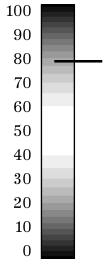
Effective - Human studies

- naltrexone (END) - ReVia
- acamprosate (GLU) - exptl
- nalmefene (END) - exptl
- ondansetron (SER) - exptl

Promising - Human studies

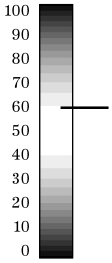
- several antidepressants, such as Prozac, Norpramin, etc. - work best in depressed alcoholics

NALTREXONE (ReVia)



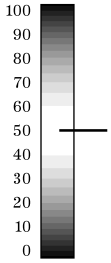
- it is not a cure for alcohol dependence – designed to aid behavioral therapy
- it is an abstinence enhancer
- it reduces relapse severity and frequency in ~50% of alcoholics tested (double-blind studies)
- It is absolutely non-addicting with low toxicity: 20 years' use in heroin addicts
- injectable slow release form: Naltrel

SUMMARIES



- HEROIN - emphasis on detox with drugs; then 12-step (N.A.) for some; methadone, LAAM, buprenorphine
- NICOTINE - patches, gum, devices, bupropion (Zyban) - must also stop smoking, begin counseling
- COCAINE -12-step (C.A.), vouchers, vaccine, pharmacotherapies are under development (e.g., gamma-vinyl GABA, GVG)

SUMMARIES (cont.)



- AMPHETAMINES - similar to alcohol and cocaine - abstinence required
- MARIJUANA - supportive therapy for symptoms, no pharmacotherapy
- BENZODIAZEPINES – long-term withdrawal (tapering), 12-step
- TWO OR MORE DRUGS - depends on drug combos used

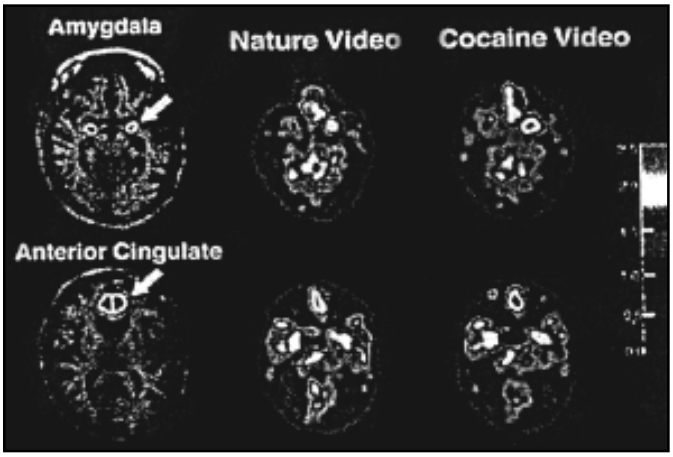
QUESTION:

What are the relationships

between psychosocial (behavioral) treatments and pharmacotherapies?

- in the way they're used?
- in the way they work?

**LOGIC SAYS:
BEHAVIORAL
THERAPIES PROBABLY
CHANGE BRAIN
CHEMISTRY!**



We have a secure website that only <u>you</u> can access for more information. Please make sure you have given us your e-mail address if you want to access this website to continue to learn about the neurobiology of addiction. It's FREE!

Table
Criteria for Drug Abuse and Dependence

Chemical (Drug) *Abuse*

I. A maladaptive pattern of drug use leading to impairment or distress, presenting as one or more of the following in a 12-month period:

1. recurrent use leading to failure to fulfill major obligations
2. recurrent use which is physically hazardous
3. recurrent drug-related legal problems
4. continued use despite social or interpersonal problems

II. The symptoms have never met the criteria for chemical dependence.

Chemical (Drug) *Dependence*

II. A maladaptive pattern of drug use, leading to impairment or distress, presenting as three or more of the following in a 12-month period:

1. tolerance to the drug's actions
2. withdrawal
3. drug is used more than intended
4. there is an inability to control drug use
5. effort is expended to obtain the drug
6. important activities are replaced by drug use
7. drug use continues in spite of negative consequences

II. Two types of dependence can occur:

A) with physiological dependence (including either items 1 or 2), or

B) without physiological dependence (including neither items 1 nor 2).

Source: Adapted from *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, 1994.

FRONTIERS IN NEUROSCIENCE: THE SCIENCE OF SUBSTANCE ABUSE

Addiction Is a Brain Disease, and It Matters

Alan I. Leshner

Scientific advances over the past 20 years have shown that drug addiction is a chronic, relapsing disease that results from the prolonged effects of drugs on the brain. As with many other brain diseases, addiction has embedded behavioral and social-context aspects that are important parts of the disorder itself. Therefore, the most effective treatment approaches will include biological, behavioral, and social-context components. Recognizing addiction as a chronic, relapsing brain disorder characterized by compulsive drug seeking and use can impact society's overall health and social policy strategies and help diminish the health and social costs associated with drug abuse and addiction.

Dramatic advances over the past two decades in both the neurosciences and the behavioral sciences have revolutionized our understanding of drug abuse and addiction. Scientists have identified neural circuits that subsume the actions of every known drug of abuse, and they have specified common pathways that are affected by almost all such drugs. Researchers have also identified and cloned the major receptors for virtually every abusable drug, as well as the natural ligands for most of those receptors. In addition, they have elaborated many of the biochemical cascades within the cell that follow receptor activation by drugs. Research has also begun to reveal major differences between the brains of addicted and nonaddicted individuals and to indicate some common elements of addiction, regardless of the substance.

That is the good news. The bad news is the dramatic lag between these advances in science and their appreciation by the general public or their application in either practice or public policy settings. There is a wide gap between the scientific facts and public perceptions about drug abuse and addiction. For example, many, perhaps most, people see drug abuse and addiction as social problems, to be handled only with social solutions, particularly through the criminal justice system. On the other hand, science has taught that drug abuse and addiction are as much health problems as they are social problems. The consequence of this gap is a significant delay in gaining control over the drug abuse problem.

Part of the lag and resultant disconnection comes from the normal delay in transferring any scientific knowledge into practice and policy. However, there are other factors unique to the drug abuse arena that compound the problem: One major barrier is the tremendous stigma attached to being a drug user or, worse, an addict. The most beneficent public view of drug addicts is as victims of their societal situation. However, the more common view is that drug addicts are weak or bad people, unwilling to lead moral lives and to control their behavior and gratifications. To the contrary, addiction is actually a chronic, relapsing illness, characterized by compulsive drug seeking and use (1). The gulf in implications between the "bad person" view and the "chronic illness sufferer" view is tremendous. As just one example, there are many people who believe that addicted individuals do not even deserve treatment. This stigma, and the underlying moralistic tone, is a significant overlay on all decisions that relate to drug use and drug users.

Another barrier is that some of the people who work in the fields of drug abuse prevention and addiction treatment also hold ingrained ideologies that, although usually different in origin and form from the ideologies of the general public, can be just as problematic. For example, many drug abuse workers are themselves former drug users who have had successful treatment experiences with a particular treatment method. They therefore may zealously defend a single approach, even in the face of contradictory scientific evidence. In fact, there are many drug abuse treatments that have been shown to be effective through clinical trials (1, 2).

These difficulties notwithstanding, I believe that we can and must bridge this informational disconnection if we are going to make any real progress in controlling drug abuse and addiction. It is time to replace ideology with science.

Drug Abuse and Addiction as Public Health Problems

At the most general level, research has shown that drug abuse is a dual-edged health issue, as well as a social issue. It affects both the health of the individual and the health of the public. The use of drugs has well-known and severe negative consequences for health, both mental and physical. But drug abuse and addiction also have tremendous implications for the health of the public, because drug use, directly or indirectly, is now a major vector for the transmission of many serious infectious diseases—particularly acquired immunodeficiency syndrome (AIDS), hepatitis, and tuberculosis— as well as violence. Because addiction is such a complex and pervasive health issue, we must include in our overall strategies a committed public health approach, including extensive education and prevention efforts, treatment, and research.

Science is providing the basis for

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such public health approaches. For example, two large sets of multisite studies (3) have demonstrated the effectiveness of well-delineated outreach strategies in modifying the behaviors of addicted individuals that put them at risk for acquiring the human immunodeficiency virus (HIV), even if they continue to use drugs and do not want to enter treatment. This approach runs counter to the broadly held view that addicts are so incapacitated by drugs that they are unable to modify any of their behaviors. It also suggests a base for improved strategies for reducing the negative health consequences of injection drug use for the individual and for society.

What Matters in Addiction

Scientific research and clinical experience have taught us much about what really matters in addiction and where we need to concentrate our clinical and policy efforts. However, too often the focus is on the wrong aspects of addiction, and efforts to deal with this difficult issue can be badly misguided.

Any discussion about psychoactive drugs inevitably turns to the question of whether a particular drug is physically or psychologically addicting. In essence, this issue revolves around whether or not dramatic physical withdrawal symptoms occur when an individual stops taking a drug, what is typically called physical dependence by professionals in the field. The assumption that often follows is that the more dramatic the physical withdrawal symptoms, the more serious or dangerous the drug must be.

This thinking is outdated. From both clinical and policy perspectives, it does not matter much what physical withdrawal symptoms, if any, occur. First, even the florid withdrawal symptoms of heroin addiction can now be easily managed with appropriate medication. Second, and more important, many of the most addicting and dangerous drugs do not produce severe physical symptoms upon withdrawal. Crack cocaine and methamphetamine are clear examples: Both are highly addicting, but cessation of their use produces few physical withdrawal symptoms, certainly nothing like the physical symptoms accompanying alcohol or heroin withdrawal.

What does matter tremendously is whether or not a drug causes what we now know to be the essence of addiction: compulsive drug seeking and use, even in the face of negative health and social consequences (4). These are the characteristics that ultimately matter most to the patient and are where treatment efforts should be directed. These behaviors are also the elements responsible for the massive health and social problems that drug addiction brings in its wake.

Addiction Is a Brain Disease

Although each drug that has been studied has some idiosyncratic mechanisms of action, virtually all drugs of abuse have common effects, either directly or indirectly, on a single pathway deep within the brain. This pathway, the mesolimbic reward system, extends from the ventral tegmentum to the nucleus accumbens with projections to areas such as the limbic system and the orbitofrontal cortex. Activation of this system appears to be a common element in what keeps drug users taking drugs. This activity is not unique to any one drug; all addictive substances affect this circuit (5).

Not only does acute drug use modify brain function in critical ways, but prolonged drug use causes pervasive changes in brain function that persist long after the individual stops taking the drug. Significant effects of chronic use have been identified for many drugs at all levels: molecular, cellular, structural, and functional (6, 7). The addicted brain is distinctly different from the nonaddicted brain, as manifested by changes in brain metabolic activity, receptor availability, gene expression, and responsiveness to environmental cues. Some of these long-lasting brain changes are idiosyncratic to specific drugs, whereas others are common to many different drugs (6-9). The common brain effects of addicting substances suggest common brain mechanisms underlying all addictions (5, 7, 9, 10).

That addiction is tied to changes in brain structure and function is what makes it, fundamentally, a brain disease. A metaphorical switch in the brain seems to be thrown as a result of prolonged drug use. Initially, drug use is a voluntary behavior, but when that switch is thrown, the individual moves into the state of addiction, characterized by compulsive drug seeking and use (11).

Understanding that addiction is, at its core, a consequence of fundamental changes in brain function means that a major goal of treatment must be either to reverse or to compensate for those brain changes. These goals can be accomplished through either medications or behavioral treatments [behavioral treatments have been successful in altering brain function in other psychobiological disorders (12)]. Elucidation of the biology underlying the metaphorical switch is key to the development of more effective treatments, particularly antiaddiction medications.

But Not Just a Brain Disease

Of course, addiction is not that simple. Addiction is not just a brain disease. It is a brain disease for which the social contexts in which it has both developed and is expressed are critically important. The case of the many thousands of returning Vietnam war veterans who were addicted to heroin illustrates this point. In contrast to addicts on the streets of the United States, it was relatively easy to treat the returning veterans' addictions. This success was possible because they had become addicted while in a setting almost totally different from the one to which they had returned. At home in the United States, they were exposed to few of the conditioned environmental cues that had initially been associated with their drug use in Vietnam. Exposure to conditioned cues can be a major factor in causing persistent or recurrent drug cravings and drug use relapses even after successful treatment (13).

The implications are obvious. If we understand addiction as a prototypical psychobiologicat illness, with critical biological, behavioral, and social-context components, our treatment strategies must include biological, behavioral, and social-context elements. Not only must the underlying brain disease be treated, but the behavioral and social cue components must also be addressed, just as they are with many other brain diseases, including stroke, schizophrenia, and Alzheimer's disease.

A Chronic, Relapsing Disorder

Addiction is rarely an acute illness. For most people, it is a chronic, relapsing disorder. Total abstinence for the rest of one's life is a relatively rare outcome from a single treatment episode. Relapses are more the norm. Thus, addiction must be approached more like other chronic illnesses – such as diabetes and chronic hypertension – than like an acute illness, such as a bacterial infection or a broken bone (1). This requirement has tremendous implications for how we evaluate treatment effectiveness and treatment outcomes. Viewing addiction as a chronic, relapsing disorder means that a good treatment outcome, and the most reasonable expectation, is a significant decrease in drug use and long periods of abstinence, with only occasional relapses. That makes a reasonable standard for treatment success–as is the case for other chronic illnesses–the management of the illness, not a cure (1, 2).

Conclusion

Addiction as a chronic, relapsing disease of the brain is a totally new concept for much of the general public, for many policymakers, and, sadly, for many health care professionals. Many of the implications have been discussed above, but there are others.

At the policy level, understanding the importance of drug use and addiction for both the health of individuals and the health of the public affects many of our overall public health strategies. An accurate understanding of the nature of drug abuse and addiction should also affect our criminal justice strategies. For example, if we know that criminals are drug addicted, it is no longer reasonable to simply incarcerate them. If they have a brain disease, imprisoning them without treatment is futile If they are left untreated, their recidivism rates to both crime and drug use are frighteningly high; however, if addicted criminals are treated while in prison, both types of recidivism can be reduced dramatically (14). It is therefore counterproductive to not treat addicts while they are in prison.

At an even more general level, understanding addiction as a brain disease also affects how society approaches and deals with addicted individuals. We need to face the fact that even if the condition initially comes about because of a voluntary behavior (drug use), an addict's brain is different from a nonaddict's brain, and the addicted individual must be dealt with as if he or she is in a different brain state. We have learned to deal with people in different brain states for schizophrenia and Alzheimer's disease. Recall that as recently as the beginning of this century we were still putting individuals with schizophrenia in prison-like asylums, whereas now we know they require medical treatments. We now need to see the addict as someone whose mind (read: brain) has been altered fundamentally by drugs. Treatment is required to deal with the altered brain function and the concomitant behavioral and social functioning of the illness. Understanding addiction as a brain disease explains in part why historic policy strategies focusing solely on the social or criminal justice aspects of drug use and addiction have been unsuccessful. They are missing at least half of the issue. If the brain is the core of the problem, attending to the brain needs to be a core part of the solution.

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11. The state of addiction -both the clinical condition and the brain state– is qualitatively different from the effects of large amounts of drugs. The individual once addicted, has moved from a state where drug use is voluntary and controlled to one where drug craving, seeking, and use are no longer under the same kind of voluntary control, and these changes reflect changes in brain function. The exact mechanisms involved are not known. For example it is not clear whether that change in state reflects a relatively precipitous change in a singe mechanism or multiple mechanisms acting in concert, or whether the shift to addiction represents the sum of more gradual neuroadaptations. Moreover there are individual differences in the vulnerability to becoming addicted and the speed of becoming addicted. For some individuals, the metaphorical switch moves quickly, whereas for others the changes occur quite gradually (6-10)
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THE BENEFITS OF USING ANIMALS IN ADDICTION RESEARCH

Breakthroughs in medical science are usually the result of experiments and tests involving research animals. Consider these facts:

1. Greater than 90% of all animal research involves rats, mice, and other rodents. Only one research animal in 50 is a cat or dog. Many people do not understand that 13-15 million unclaimed pound animals are killed annually, and less than 1/1000 of this total are needed for biomedical research (1/7000 for brain research). Although smaller numbers of dogs and cats are being used today compared to ten years ago, there are special research needs for these species. Only animals already scheduled to be sacrificed by the pound are released for research. Rather than being killed needlessly, small numbers of these animals serve medical science in humane, nonsuffering laboratory research.

2 There exist very strictly regulated safeguards to protect and ensure the humane treatment of laboratory animals with minimum or no stress or pain. In most studies, allowing pain, stress, or ill health will lead to results that are biased because of this unwanted variable. For all responsible scientists, the use of healthy, unstressed animals is mandatory both for humane reasons and because healthy test animals are necessary for valid research results. It should also be remembered that researchers are motivated in their chosen fields by a desire to help and relieve suffering.

3. All ten of the leading treatments in medicine have involved animal research. The lag time was 10-20 years. The list includes polio vaccine, antihypertensives, heart surgery, antibiotics, and antidiuretics. In fact, virtually every advance in modern medicine either originated in basic animal research or involved animals in a key part of its development. Animal testing is indispensable for the safety of new lifesaving drugs and vaccines, since it is unethical to expose humans to unnecessary risks. Indeed, the Declaration of Helsinki, to which this country is a signatory, specifically prohibits the testing of new medications and other treatments on humans before their safety has been determined in animals. Finally, more than 80 medicines and vaccines developed for humans are now used to heal pets, animals, and wildlife. Thus, a great deal of progress in treating animal diseases and organic disorders in animals has evolved from research on animals themselves.

4. Since addictions are brain diseases and since brain neurochemistry cannot be directly measured in humans, animal research is required in the study of the causes of addictions. Animal studies have provided recent major advances in knowledge on the genetics of drug consumption, withdrawal, and tolerance, as well as new concepts of drug reward and euphoria and their site of action in the pleasure pathway of the mesolimbic system. If animal research were abandoned, there would be an immediate cessation of our knowledge about the causes of mental and neurological disorders (schizophrenia, depression, anxiety, autism, etc.) and addictive diseases. This would prevent future therapeutic innovations based upon such emerging knowledge of the causes of these diseases.

THE RELATIONSHIP BETWEEN MEDICINE, RESEARCH AND A.A.

"We also realize that the discoveries of the psychiatrists and the biochemists have vast implications for us alcoholics. Indeed these discoveries are today far more than implications. Your president and other pioneers in and outside your society have been achieving notable results for a long time, many of their patients having made good recoveries without any AA at all. It should here be noted that some of the recovery methods employed outside AA are quite in contradiction to AA principles and practice. Nevertheless, we of AA ought to applaud the fact that certain of these efforts are meeting with increasing success.... Therefore I would like to make a pledge to the whole medical fraternity that AA will always stand ready to cooperate, that AA will never trespass upon medicine, that our members who feel the call will increasingly help in those great enterprises of education, rehabilitation and research which are now going forward with such great promise."

(This is an excerpt from a talk by Bill W., the co-founder of Alcoholics Anonymous, to the New York Medical Society on Alcoholism in 1958.)

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addiction technology transfer centers
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Mentor:
A Guide to Evidence-Based Practice

The Neurobiology Addiction: Simplified

Presenter: Carlton Erickson Ph.D.
Affiliation/Organization: The University of Texas
Date of Presentation: May 9. 2001
Location of Presentation: San Juan, Puerto Rico

Why This Topic Is Important:

Research is changing what we think about the causes of chemical dependence ("addiction"). This new knowledge is leading to reduced stigma and new treatments to help those who do not or cannot recover with existing treatments and programs.

Key Points to Remember:

1. Two drug problems exist in the nation: a) willful abuse and b) pathological dependence. It is important to use proper terminology and to try to assess patients for these conditions.
2. Euphoria craving and physical withdrawal are associated with any drug use, not just addiction.
3. According to neurobiological research, addiction is a brain chemistry disease. The problem is not the drug, it is the "special connection'" to drugs caused by brain chemistry malfunction.
4. Genetics findings support the concept of dysfunctional genes producing defects in neurotransmitter function in the "pleasure pathway" of the brain. This is a primary cause of chemical dependency.
5. Research is an ally in the fight against chemical dependency disease. Knowing how research works can help identify good research from bad research.
6. Whereas animal research has/is contributing heavily to our understanding of the causes of addiction, human studies will someday provide the final answers.

addiction technology transfer centers
FUNDED BY CENTER FOR SUBSTANCE ABUSE TREATMENT SAMHSA

Mentor:

Considerations for Practice:

1. It is important to clarify the misinformation that patients have about addictions.
2. Not all mood-altering drugs produce drug dependence ("addiction").
3. Stigma can be reduced by remembering that the major site of action of drugs of addiction is strong evidence that addictions are not primarily under conscious control.
4. Just because behavioral (talk) therapy works doesn't mean addictions are "will power'" or "poor judgment" diseases. Talk therapy probably works by normalizing an addict's brain chemistry.
5. Pharmacotherapy (medication use) is a reality for the treatment of some types of chemical dependency. However. these medications work best when the patient has committed to abstinence or is undergoing counseling.

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Websites:

1. National Clearinghouse for Alcohol and Drug Information (NCADI) 1-800-729-6686 (Hablamos Español), TDD 1-800-487-4889 http://www.health.org
2. National Institute on Alcohol Abuse and Alcoholism (NIAAA) (Alcohol Alert. free pub: 301-443-3860) Http://www.niaaa.nih.gov
3. National Institute on Drug Abuse (NIDA) http://www.nida.nih.gov/NIDAHome.html NIDA Notes, 301-294-5401, nidanotes@hq.row.com
4. University of Texas Addiction Science Research and Education Center http://www.utexas.edu/researach/asrec/index.html

*This presentation addresses the following Addiction Counseling Competencies:

Transdisciplinary Foundation:	**Practice Dimensions:**
Understanding Addiction	Clinical Evaluation
Treatment Knowledge	Treatment Planning
Application to Practice	Referral
Professional Readiness	Service Coordination
	Counseling
	Client, Family & Community Education
	Documentation
	Professional & Ethical Responsibilities

Addiction Counseling competencies: The Knowledge Skills and Attitudes of Professional Practice (The Competencies/TAP21)

The Competencies/TAP21, published by the Center for Substance Abuse Treatment as Technical Assistance Publication No. 21, includes 2 sections. The first (Transdisciplinary Foundations) includes the knowledge and attitudes essential to all health and human service professional whose work brings them into frequent contact with substance abuse disorders. The second addresses eight Practice Dimensions that comprise the essential work of treatment specialties. This document has become a benchmark by which curriculum is developed and educational programs and professional standards are measured To Order, contact NCADI at 1-800 729-6686.

1-877-625-ATTC (2882) * www.nattc.org * Unifying research, education and practice to transform lives.

Harvey Milkman, PhD

Wednesday, May 9, 2001

Pre-Conference

Artistic & Coping Skills Interventions For High Risk Youth

Facilitator: Nedda Echevarría, MS
Recorder: C. Amalia Marrero, MPH
Presentation Language: English

Harvey Milkman

Biographical Sketch

Harvey B. Milkman, Ph.D. received his doctorate in 1974 from Michigan State University and is professor of psychology at Metropolitan State College of Denver (l974-present). He is founder and director of the Center for Interdisciplinary Studies (1987-present) Dr. Milkman is principal investigator and director of Project Self-Discovery (1992-present), a national demonstration model that provides high-risk youth with coping skills and artistic alternatives to substance abuse, crime and violence.

From 1969 to 1972 he conducted research with William Frosch at Bellevue Psychiatric Hospital in New York City, on the user's "*drug of choice*." In 1980-81 he studied addictive behaviors in Africa, India and southeast Asia; in 1985-86 he was recipient of a Fulbright-Hays Lectureship Award at the National University of Malaysia. He has represented the United States Information Agency as a consultant and featured speaker in Brazil (1987), Iceland (1989-92), Australia (1988-89), The Netherlands (1989), Turkey and Yugoslavia (1991). In 1996 Dr. Milkman was the featured speaker at a substance abuse conference in Lima, Peru. In March 1998, Dr. Milkman was the keynote speaker at *The 21st Annual Treating the Addictions Conference*, hosted by The Cambridge Hospital, in affiliation with Harvard Medical School.

Dr. Milkman is editor (with Lloyd Sederer) of *Treatment Choices for Alcoholism and Substance Abuse*, Lexington Books, 1990, and is also editor (with Howard Shaffer) of *Addiction: Multidisciplinary Perspectives and Treatments*, Lexington Books, 1985 (winner of the Choice Award for outstanding academic books). His multidisciplinary model for addiction, *The Chemistry of Craving*, written with Stanley Sunderwirth, was featured in the October 1983 issue of Psychology Today and fully developed in *Craving for Ecstasy: The Consciousness and Clemistry of Escape*, Lexington Books, 1987, 2nd edition, Jossey-Bass, 1998. He is author (with Stanley Sunderwirth) of *Pathways to Pleasure: The Consciousness and Chemistry of Living, Lexington Books, 1993. Dr. Milkman is author of Project Self-Discovery: Artistic Alternatives for High-Risk Youth* (with Dr. Kenneth Wanberg and Cleo Parker Robinson), a special monograph of the Journal of Community Psychology, 1996. Dr. Milkman is co author (with Dr. Kenneth Wanberg) of *Criminal Conduct and Substance Abuse Treatment*: *Strategies for Self-Improvement and Change*, Sage Publications Inc., 1998. He is co-author (with Stanley Sunderwirth) of *Orchestrating Health: Eight Choices for Optimal Living*, Center for Interdisciplinary Studies, Inc., 2000.

Artistic and Coping Skills Interventions for High Risk Youth
Project Self-Discovery

Abstract

Promoting alternative recreational activities, improving self-efficacy, building social competence, and providing broadening cultural experiences are the most effective strategies for delinquency and drug abuse prevention. There is a shift to a social competence model which includes a developmental, ecological and skills-based approach to working with the juvenile offender; with corresponding emphasis on the identification of skill deficits associated with delinquency and on the effective matching of programs to remedy these needs.

Intervention is predicated upon flexible use of Michenbaum's stress-inoculation approach involving *mental preparation, skill development and rehearsal*. Mental preparation is ongoing and designed to denormalize drug abuse and violence, while engaging youth in positive teaching, peer influence and mentoring relationships. Progress is reinforced upon successful completion of three stages of program participation: *Level I - Implementation* has a duration of 12 weeks, *Level II - the Graduate Program* is ongoing, and *Level III - Mentoring* allows graduate students who have demonstrated leadership skills, to serve as mentors to youth involved in the initial 12-week intervention program.

Five core factors are addressed throughout the 24 session coping skills curriculum: 1) meaningful engagement of talents; 2) social skills; 3) cultural adventure; 4) social support; 5) stress reduction. Whether HIV prevention, refusal training, negotiation skills, etc., all lessons address one or more of the above core protective factors. Each session uses modeling and role playing to first illustrate and then practice resiliency skills. The behavioral counterpart to the coping skills curriculum is artistic instruction. Changes in body image may be expressed through movement and dance; music provides a vehicle for the expression of emotional dissonance; art translates inaccessible inner experiences to outward visualizations that can be discussed.

Participants complete a *rites of passage* component where they are required to perform under challenging circumstances, culminating in a graduation ceremony that provides a platform for a public statement of short and long-term goals and demonstration of their artistic achievements.

Results: Since the program inception in January, 1993, Project Self-Discovery has received more than 1000 referrals from five different counties in the Denver metropolitan area. Thirty-seven different agencies and 120 youth service workers referred youth from schools, mental health agencies and criminal justice placements. Youths who completed 80 percent or more of the initial 100 hours at Project Self-Discovery showed a significant reduction in scores measuring risk factors for *negative peer involvement, sustained use of drugs and mental health concerns*.

Reference: Journal of Community Psychology: A Monograph in the Advances in Community Psychology Series, *Project Self-Discovery: Artistic Alternatives for High Risk Youth,* Milkman, H., Wanberg, K., Robinson C., 1996. 264 pages, ISBN # 0471162418; order from John Wiley & Sons.

Website: http://clem.mscd.edu/~psych/PSD/psd.htm

Harvey Milkman, Ph.D. is Professor of Psychology at Metropolitan State College of Denver and Director of Project Self-Discovery, Cleo Parker Robinson Dance (303) 830 8500; Fax (303) 830 8420; E-mail: milkmanfogg@msn.com

The Family in the New Millenium:
Strategies to Prevent and Treat Substance Abuse among Children and Adolescents

[Conference Notes]

Anotaciones de la mañana:

La introducción de este taller incluyó estadísticas relacionadas con el uso de drogas en jóvenes y el concepto de inteligencias múltiples. Además, se presentó la música y el arte como alternativas para competir con los motivos que los jóvenes tienen para empezar con el uso de drogas. Algunos de estos son buscar la aprobación de grupo, relarjarse y tener fantasías.

Apreciación: La mayoría de la audiencia estuvo atenta. Sin embargo, alrededor de 6 personas estaban un poco perdidas al principio, posiblemente porque no dominaban bien el inglés. No hubo oportunidad para que el facilitador o el mismo recurso detuvieran la sesión para traducir algunos conceptos.

Recomendación: Conceptos teóricos que sean relevantes deben proyectarse o escribirse para asegurarse que toda la audiencia está comprendiendo porque no necesariamente todas las personas sienten la confianza de expresar su dificultad con entender el inglés.

- Se presentaron algunas de las actividades utilizadas como parte del programa que el Dr. Milkman ha desarrollado en Colorado. Algunos de los asistentes del taller participamos de estas actividades.

Apreciación: La audiencia estuvo muy atenta e interesada de las diversas estrategias que se demostraron. En esta parte del taller también se proyectó la película “The Art of Being", y la audiencia mostró también bastante interés en la misma.

- Se presentó el marco conceptual del proyecto que desarrolló el Dr. Milkman (“Self Discovery”) y los instrumentos que se le administran al adolescente para tener un perfíl de sus factores de riesgo. Por ejemplo, posibles problemas de salud mental, problemas familiares, historial de abuso de alcohol, tabaco u otras drogas, influencia negativa de sus pares, conducta antisocial y problemas en la escuela.

Apreciación: La audiencia estuvo todo el tiempo atenta en esta sección, aunque no surgieron comentarios ni preguntas relevantes a la práctica.

Anotaciones de la tarde:

- Se presentó y discutió la lectura “Better than Dope”. Además se presentaron algunos conceptos relevantes de los libros: “Craving for Ecstasy” y “Pathways to Pleasure": The Consciousness and Chemistry of Optimal Living”.

- Se explicó el concepto de los “natural highs” y cómo lograr estados positivos en el ser humano provocados por la integración de pensamientos positivos, actividades y valores personales.

Apreciación: La audiencia estuvo muy atenta y siete personas participaron voluntariamente para representar cómo la droga puede causar problemas en el funcionamiento normal de los neurotransmisores. Entiendo que este tema fue de especial interés para la audiencia que también tuvo la oportunidad de recibir más información sobre esta tema por medio de la película que se presentó.

- Se explicó la parte operacional del proyecto "Self Discovery". Este le provee alternativas artísticas a jóvenes entre 15-18 años que tienen problemas con sus familias, en la escuela o en la comunidad. El proyecto consta de 24 sesiones que consisten principalmente en impartir destrezas para reducir el estrés, aumentar la integración y apoyo social, y el desarrollo de talento artístico. También se presentó el perfil de los participantes y el diseño que se sigue para la implantación del programa. Finalmente, se presentaron dos películas sobre la graduación de los jóvenes en el programa.

Apreciación: Excelente respuesta de la audiencia a las películas presentadas. También varias personas participaron de un ejercicio titulado "Images of My Life", donde compartieron información sobre algunas experiencias de vida. Sin embargo, 4 personas abandonaron el taller antes de esta actividad, posiblemente por que el mismo se extendió más tiempo de lo programado.

Recomendación, Hubiese sido relevante preguntar si existen programas similares en PR que utilicen algunas de las estrategias del programa "Self-Discovery" y cuál ha sido la experiencia.

Comentario: Como el material presentado en este taller fue bastante extenso no hubo suficiente tiempo para que el grupo se expresara en términos de cómo aplicar lo aprendido. La inclusión de material audiovisual y las actividades donde participó parte de la audiencia resultaron positivas para captar la atención de todos.

Apreciación General: Este taller brindó una información muy valiosa a las personas que en la práctica atienden jóvenes con problemas de adicción y otras condiciones de salud mental en PR. La mayoría estuvo atenta durante todo el taller y el hecho de que no se generaran preguntas relacionadas a la aplicación de estos conceptos pudo haber respondido a que:

- el grupo estaba más interesado en anotar y aprender la mayor cantidad de información posible
- el recurso no propició ese tipo de discusión debido a que el tiempo no fue suficiente para todo el material expuesto.

Notes

Carmen D. Zorrilla, MD

Wednesday, May 9, 2001
Pre-Conference

Drug Abusing Mothers: Health Consequences in Offspring

Facilitator: Lydia Santiago Andújar, PhD
Presentation Language: Spanish

Carmen D. Zorilla, MD

Biographical Sketch

Dr. Carmen Zorrilla is a well-known obstetrician and director of the CEMI Project *Centro de Estudios Materno Infantiles*. She is recognized for the extensive reseach she has done on HIV-positive women pregnant women.

Carmen D. Zorrilla, MD
Catedrática Obstetricía y Ginecología
Centro de Estudios Materno Infantiles CEMI

Drug Abusing Mothers: Health Consequences in Offspring

Abstract

Research has helped in designing better health management of HIV-positive women, thus reducing their risks as well as those of their children. The seminar will present and discuss examples of women who have achieved a better quality of life.

Uso de Substancias en el Embarazo: Efectos Post-natales

[Conference Presentation Slides]

Verdaderamente, cada problema parece sencillo luego de resolverse.

El mayor logro (que hoy parece sencillo) ha sido el resultado de una serie de pequeñas victorias que hoy pasarían por desapercibidas.

–Paulo Coelho

Uso de Substancias en el Embarazo: Prevalencia

* Un cernimiento universal de alcohol, opiáceos, cocaína, y cannabis durante el embarazo demostró que la proporción del uso de substancias ilegales era similar en las mujeres embarazadas irrespectivo del nivel socioeconómico ó la etnicidad/raza

* Las mujeres afroamericanas y/o pobres fueron reportadas más frecuentemente a las autoridades, reflejando sesgos o prejuicios

* Chasnoff, I.J., Landress, H.J. and Barret, M.E.(l990) *N Engl J Med* 322: 1202-1206

Uso de Substancias en el Embarazo: Los Bebés del Crack

* La Corte Suprema de EU recientemente evaluó el caso “Ferguson et al vs City of Charleston” (4ta enmiendel registro irrazonable)

* Los profesionales de la salud en USC selectivamente hacían pruebas de drogas en la orina de mujeres embarazadas, y se reportaban los resultados positivos a la policía, que luego arrestaba a la mujer en el hospital por posesión de drogas ilegales, entrega de drogas a un menor o abuso de menores

Exposición Prenatal a Cocaína: Sesgo en la Literatura Científica

* Un Meta-análisis de 6 estudios concluyó que hay una asociación con menor competencia en el lenguaje expresivo y receptivo
* Cinco (5) de los estudios fueron retrospectivos; dos no enmascararon las pruebas, y ninguno consideró el uso de cigarrillos, que se ha demostrado previamente que afecta el lenguaje
* Usando ese estudio se estimó que los bebés del crack costarían $42-$352 millones por año en servicios de educación especial

Exposición Prenatal a Cocaína

* Growth, Development, and Behavior in Early Childhood Following Prenatal Cocaine Exposure: A Systematic Review
* 36 of 74 articles met criteria for review: peer-review, comparison group, prospective, masked assessment, did not include many polysubstance users
* D. Frank, MD; M. Augustyn, MD; W. Grant, PhD; T. Pell, MSc; B. Zuckerman, MD JAMA, March 28,2001- Vol 285, No.12 p 1613-1625

"The Crack Babies"

* "The crack baby became the poster child for one side in each of two heated controversies in the USA: the war on drugs and the struggle over abortion."

  Wendy Chavkin, MD, MPH
  JAMA, March 28,2001

La Criminalización del Uso de Substancias (Drogas)

* Los EU ocupan el segundo lugar en la tasa de encarcelamiento en el mundo
* La duración de las sentencias se ha alargado, la proporción de presos recibiendo tratamiento de rehabilitación por uso de substancias se ha duplicado

La Criminalización del Uso de Substancias (Drogas)

* Aunque la mayoría de los presos son hombres, la tasa de mujeres encarceladas ha aumentado dos veces más que los hombres
* Este aumento es mayor para mujeres de minoría
* De 1986 a 1991 el número de mujeres encarceladas por delitos de drogas aumentó 828% en las afro-americanas, 328% en las hispanas, y 241% en las mujeres blancas

Exposición Prenatal a Cocaína

* No hay efectos en el crecimiento físico al controlar por uso de alcohol y cigarrillos
* No se han encontrado efectos adversos en pruebas de desarrollo (infancia hasta los 6 años) con el uso de cocaína independiente de otras substancias
* No hay efectos en las pruebas de lenguaje en los niños hasta los 3 años

Exposición Prenatal a Cocaína

Los efectos motores que se atribuyeron previamente a la cocaína se deben al uso de cigarrillos en mayores cantidades

* Con la excepción de un estudio, no se ha encontrado relación con problemas de conducta que se puedan identificar con las pruebas rutinarias
* Se encontraron diferencias en expresión afectiva (menor interés, alegría o tristeza)

Otros Factores Asociados

Siete estudios demostraron que factores como: el responsable del cuido (madres biológicas vs familia vs padres de crianza); si el responsable del cuido recibió servicios de manejo de caso o visitas al hogar; la calidad del ambiente del hogar; y la inteligencia (IQ) de la madre, correlacionaron con las pruebas de desarrollo psicomotor y cognoscitivo

Cocaína vs Cigarrillos

* Los mecanismos de acción de la nicotina y la cocaína en el cerebro son similares: vasoconstricción, hipoxia, y alteración de la red de los neurotransmisores
* El uso de cigarrillos se ha asociado a mortalidad infantil, desarrollo cognoscitivo afectado, y problemas de conducta (que se pueden detectar con pruebas de rutina)
* El bajo peso al nacer asociado al uso de cigarrillos cuesta $263 millones anualmente en cuidado neonatal solamente

Cocaína vs Cigarrillos

* Si embargo, no hay campañas para esterilizar a las mujeres que fuman cigarillos; ninguna mujer se ha acusado de maltrato de menores por fumar en el embarazo; ni los maestros tienen el temor de tener un “niño del tabaco” en su salón

Metadona

* Los niños de mamás en mantenimiento con metadona no demostraron diferencias en los índices de búsqueda de proximidad
* Demostraron mayores índices de conducta desorganizada, esquivando, y manteniendo menor contacto que el grupo de comparación
* La percepción materna del futuro nivel de aburrimiento de los niños correlacionó con mayores índices de mantener contacto, y menor grado de esquivamiento

Exposición Prenatal al Alcohol

La exposición prenatal al alcohol se asoció a uso de alcohol en la adolescencia

* También se ha asociado a menor peso, estatura, circumferencia de cabeza, y proporción de grasa corporal a los 10 años

Alcohol

* Hay una relación entre el uso de alcohol en los padres y en los hijos
* 82% de las familias “bebedoras” tienen hijos jóvenes que beben, y 72% de las familias “abstemias” tienen hijos jóvenes que no beben
* Hay una relación de uso relacionada al sexo (madre-hija; padre-hijo)
* Madres e hijas usan tranquilizantes y analgésicos, mientras que los varones usan alcohol y cigarrillos

Síndrome de Alcohol Fetal

*Asociado a ingesta elevada de alcohol

*Disfunción del sistema nervioso central, facies anormales, déficits de conducta, déficits de crecimiento

*Anormalidades físicas, hiperactividad, retraso mental, EEG anormal

Alcohol

* Estudios en gemelos encuentran mayor frecuencia de alcoholismo en gemelos idénticos que en los fraternos (concordancia)
* Los hijos biológicos de alcohólicos, adoptados por otros reflejan mayor frecuencia de alcoholismo
* Los hijos adoptados por alcohólicos también reflejan mayor uso de alcohol

Alcohol: ¿Predisposición genética?

* Se postula que los hijos de alcohólicos (HDA) pueden tener desbalances químicos que faciliten el abuso de substancias
* Los HAD demuestran mayores niveles de acetaldehido, mayor sensación de placer y relajación con el alcohol; menor tensión muscular en respuesta a la ingesta de alcohol; menor sensación de intoxicación con los mismos niveles de alcohol comparados con hijos de no-alcohólicos

Alcohol: Estudios de Familias

En las familias que mantienen los rituales durante los períodos de exceso de consumo de alcohol, se ve menor transmisión de alcoholismo que en las que alteran los rituales

Las familias de alcohólicos reportan mayores niveles de conflicto que las de no-alcohólicos

La posibilidad de cumplir un sueño es precisamente lo que hace la vida interesante.
Paulo Coelho
El Alquimista

Hacia una Nueva Visión

* En el estado de NY, el gobernador y la legislatura han propuesto modificar las leyes de drogas, para reducir las sentencias obligatorias, ofrecer alternativas de tratamiento, y devolver a los jueces las opciones en las sentencias
* La Proposición 36, aprobada en California el pasado noviembre, sustituye el tratamiento en lugar de prisión, para los convictos de delitos de posesión no-violentos
* El ex-presidente Clinton ha propuesto una reconsideración de las sentencias obligatorias en los delitos federales de drogas

Salud y Ciencia

* *Como ciudadanos privados podemos favorecer cualquiera de las posiciones en el debate sobre las drogas o el aborto. Pero, como proveedores de salud y defensores de la salud publica, debemos levantar calmadamente nuestras voces en favor de la ciencia y las terapias.*

–Wendy Chavkin, MD, MPH,
JAMA, March 28, 2001

Cuando tú deseas algo, el Universo conspira para que se cumplan tus deseos.

–Paulo Coelho
El Alquimista

Notes

Growth, Development, Behavior in Early Childhood Following Prenatal Cocaine Exposure
A Systematic Review

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

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

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

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

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

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

Conclusions Among children aged 6 years or younger, there is no convincing evidence that prenatal cocaine exposure is associated with developmental toxic effects that are different in severity, scope, or kind from the sequelae of multiple other risk factors. Many findings once thought to be specific effects of in utero cocaine exposure are correlated with other factors, including prenatal exposure to tobacco, marijuana, or alcohol, and the quality of the child's environment. Further replication is required of preliminary neurologic findings.

JAMA 2001; 285:1613-1625 www.jama.com

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

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

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See also p 1626.

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

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

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

METHODS

Data Sources

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

Study Selection

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

Justification of Selection Criteria

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

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

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

Procedures

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

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

Data Extraction

The conceptual framework for data extraction was provided by recent theoretical advances in human behavioral teratology[104, 105] delineating the implications of various methods of characterizing exposure to possible toxicants and of controlling for potential confounders Many cocaine-exposed newborns are clinically indistinguishable from their unexposed peers,[18,106] so identification of exposed infants depends on maternal report or measurement of co-

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

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

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

caine metabolites in biological matrices. Dose response is a critical issue in the study of all potential teratogens[105] but is difficult to ascertain for cocaine in human studies. Recently, infants' meconium and maternal hair have emerged as useful biological markers for estimating the dose of prenatal cocaine exposure.[97,107-111] However, at the time most cohorts available for study in the postneonatal period were recruited, assays of urine from mother or infant for benzoylecognine were the only biological indicators readily available. Urine assays do not reflect cumulative fetal drug exposure. Thus, researchers who address dose response rely on maternal interviews to classify levels of prenatal cocaine exposure, usually classifying 2 or more days a week during pregnancy as "heavier use."[63, 66, 85] For this review, we classified levels of prenatal cocaine exposure as heavier/ lighter or as exposed/ unexposed.

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

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

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

RESULTS

Physical Growth

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

Standardized Cognitive Assessment

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

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

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

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

The literature on prenatal exposure to cocaine has not shown consistent effects on cognitive or psychomotor development. However, 7 studies show that environmental factors such as caregiver (biological mothers vs kinship care or foster parents),[79, 89] whether or not that caregiver received case management or home visiting services,[78,89] quality of the home environment,[63,64,78,83] and maternal IQ[77] were statistically significant correlates of test scores.

Language Skills

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

Motor Skills

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

Behavior, Attention, Affect, and Neurophysiology

Heterogeneous techniques used to evaluate behavior, attention, affect, and neurophysiology following prenatal cocaine exposure are not readily

Study	No.	Cocaine Effect	Outcome measures	Assessment ages	Tobacco Use
Azuma and Chasnoff, [64] 1993	92 + 25 poly 45–	Both cocaine and polydrug exposed groups had lower OFC	Weight, height, OFC	3 years	R
Chasnoff et al, [70] 1992	106 45 poly 81 -	Both cocaine and polydrug exposed had lower OFC than unexposed at ail ages measured	Weight, height, OFC	3, 6, 12, 18 and 24 months	R
Coles et al,[71] 1999	25 preterm + 32 full term + 22 preterm – 26 full term -	Full-term negatives longer; otherwise, no cocaine effect	Weight, length, OFC	8 weeks corrected for prematurity	R
Hurt et al,[79] 1995	101 + 118 -	Cocaine associated with lower weight and OFC at all ages	Weight, OFC	6, 12, 18, 24 and 30 months	R
Jacobson et al,[84] 1994	86H 48L 330 -	Cocaine exposure associated with faster postnatal weight gain in first 13 months. no effect on length or OFC	Weight, length, OFC	6.5 and 13 months	DC Correlated with faster postnatal weight gain
Kilbride et al[89] 2000	111 + 41-	No cocaine effect	Weight, length, OFC	2, 12, 24, 36 months	C
Richardson et al[93] 1996	28 + 523 -	No cocaine effect	Weight, height, OFC	6 years	DC

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

comparable across studies (TABLE 5). In the first year of life, visual habituation (an indicator of recognition memory and learning) was negatively associated with higher levels of cocaine exposure in 1 cohort[85] but not in 3 others.[63, 88, 91] No cocaine effect was found on toddler play[80] or on observations of behavioral style during an infant motor assessment.[68] Problem-solving abilities did not differ between cocaine-exposed and unexposed preschoolers.[67]

Differences in affective expression have been correlated with prenatal exposure to cocaine in 4 studies from 3 cohorts of infants younger than age 2 years. Alessandri et al[62] found that 4- to 8-month-old cocaine-exposed children showed less arousal, interest, joy, or sadness during the learning task. In the same cohort, Bendersky and Lewis[66] reported no differences in maternal behaviors, but less joy and more negativity among 4-month-old infants with heavy cocaine exposure following a perturbation of the face-to-face interaction between mother and infant. Roumell et al[94] reported a bivariate association between prenatal cocaine exposure and decreased facial emotion after immunization, uncontrolled for other prenatal exposures. In studies of face-to-face interaction between mothers and infants, Mayes et al92 found heavy prenatal cocaine use correlated with less optimal maternal behavior and with decreased readiness for interaction among infants at age 6 months but not 3 months.

Diverse techniques have been used to assess neurophysiology in cocaine exposed and unexposed infants aged 13 months and younger. Cocaine exposed infants showed lower basal cortisol levels, but normal cortisol increase in response to the stress of venipuncture and no difference in amount of observed crying.[86] On electroencephalographic sleep studies at 12 months, cocaine-exposed children did not differ from unexposed children in sleep architecture, but infants whose mothers continued to use cocaine into the third trimester showed subtle reductions in spectral energies.[95] In 2 reports from a single cohort, assessments of heart and respiratory response to auditory, visual, and social stimulation at age 8 weeks found that cocaine-exposed children showed increased heart rate to social stimulation and a higher baseline respiratory rate, but were not more dysregulated in arousal modulation or observed behavioral state.[65,71] Full-term cocaine-exposed infants showed better arousal modulation than their unexposed counterparts.[65]

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

COMMENT

Before summarizing our findings, we must acknowledge the limitations of our approach. Studies that meet our

Alcohol Use	Marijuana Use	Selection/Matching Criteria	Controlled Variables	Other Effects
C Analyzed as single category		All drug users in prenatal care by 15 weeks and in drug treatment		
C Analyzed as single category		All drug users in prenatal care by 15 weeks and in drug treatment	Sex, gestational age	
R	R	Maternal age >/- 19, English speaking, singleton or first-born twin, no O_2 >28 days, no seizures, no grade III or IV IVH, not breatfed		
R	R	Medicaid, all >34 weeks' gestation		
DC Correlated with both shorter stature and slower postnatal weight gain if mother aged >30	DC	All black, low socioeconomic status, at least 2 prenatal visits, >32 weeks' gestation	Maternal age, welfare, education, parity, prepregnancy weight, birth weight, height, breatfed, prenatal visits, infant age, sex, gestational age	Breatfeeding associated with faster postpartum grown
C	R	All from same ZIP code, 36 weeks' gestation, no NICU care, women referred for drug treatment ecluded	Placement, gestationa age, maternal age and education, OFC at birth, birth weight	
DC	DC	All in prenatal care by 5 months of pregnancy	Age, sex, height, ethnicity, current drug/alcohol use	

methodologic criteria may still lead to overestimation or underestimation of cocaine's impact. Prospective studies may yield biased results if there is differential attrition.[99] Less dysfunctional caregivers may be more likely to sustain study participation, creating differential retention of children with more favorable outcomes. Alternatively, caregivers of children with obvious impairments may be more willing to return for repeated assessments, leading to an overestimation of risk for poor outcomes.

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

Study	No.	Cocaine Effect	Outcome Measures	Assessment Ages	Tobacco Use
Alessandri et al, [63] 1998	15H 19L 78-	No cocaine dose effect on PDI, no cocaine main effect on MDI, but interaction of heavy cocaine with age associated with lower MDI	BSID-II	8 and 18 months	DC
Azuma and Chasnoff,[64] 1993	92+ 25 poly 45-	No cocaine effect	SBIS	3 years	R
Chasnoff et al, [70] 1992	106+ 45 poly 81-	Cocaine exposed no different from other drugs, but lower on MDI and PDI at 6 months than unexposed	BSID	3, 6, 12, 18, and 24 months	R
Coles et al, [71] 1999	25 preterm + 32 full-term + 22 preterm - 26 full-term -	No cocaine effect	BSID	8 weeks corrected for prematurity	R
Graham et al, [77] 1992	30 + 20 poly 30 -	No cocaine effect	BSID	19.7 months	R
Griffith et al, [78] 1994	93 + 24 poly 25 -	Cocaine-exposed lower than controls on verbal reasoning	SBIS	3 years	R
Hurt et al, [79], 1995	101 + 118 -	No cocaine effect	BSID	6, 12, 18, and 24 and 30 months	C
Hurt et al, [82], 1997	71+ 78-	No cocaine effect	WPPSO-R	4 years	C Negative association with performance IQ
Hurt et al, [83], 1998	72+ 78-	Neither prenatal nor concurrent maternal cocaine use associated with full-scale IQ </- 90	WPPSI-R	4 years	C
Jacobson et al, [85] 1996	86H 48L 330 -	No cocaine effect	BSID	13 months	DC
Kilbride et al [89] 2000	111 + 41 -	No cocaine effect	BSID, SBIS	6, 12, and 24 months (BSID); 36 months (SBIS)	C
Mayes et al, [91] 1995	61 + 47 -	Cocaine univariately associated with PDI, but noT after multivariate control	BSID	3 months	C
Richardson et al,[93] 1996	28 + 523 -	No cocaine effect	SBIS, WRAT-R	6 years	DC
Singer et al, [96] 1994	41 + 41 -	Lower MDI and PDI among cocaine exposed	BSID	16 months corredted for prematurity	R

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

statistically "diluted" by over-aggregation of various levels of exposure into a single category.[114]

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

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

Prospective data in the language and motor domains are only available for children up to age 3 years.[69, 74-76, 78, 79, 81] No effects on standardized language measures have been shown. Less optimal

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

Alcohol Use	Marijuana Use	Selection/ Matching Criteria	Controlled Variables	Other effects
DC	DC	All with biological mothers	Environmental risk, neonatal medical risk, sex	Among lightly exposed, increased environmental risk associated with decreased MDI
C Analyzed as single category		All drug users in prenatal care by 15 weeks and in drug treatment	OFC, HSQ, perseverance, CBCL	Poor HSQ and poor perseverance associated with lower IQ
C Analyzed as single category		All drug users in prenatal care by 15 weeks and in drug treatment	Sex, OFC	Smaller OFC correlated with MDI at 12, 18, and 24 months, OFC at birth associated with PDI at 6 months and MDI at 24 months
R	R	Maternal age $\geq$ 19, English speaking singleton or first-born twin, no O_2 > 28 days, no seizures, no grade III or IV IVH, not breasted		
R	C	Tobacco, marital status, obstetric history, ethnicity, self-referred to Mother Risk Counseling	Maternal IQ	Maternal IQ associated with MDI
C Analyzed as single category; associated with decreased abstract reasoning		All dug users in prenatal care by 15 weeks and in drug treatment	Caregiver, child's sex OFC, CBCL, and Summative Attention Scale of SBIS	Drug-free environment associated with better scores on verbal reasoning among cocaine exposed
C	C	Medicaid, all > 34 weeks' gestation, cocaine use in at least 2 trimesters	Congenital syphilis, maternal age and education, foster care	Foster care associated with lower MDI at 18 months
C	C	Medicaid	Maternal age and education, gravidity, parity, prenatal care, sex, foster care	
C	C	Medicaid	HOME, PCIS, sex, child age, foster care, daycare/Head Start attendance, parental education, gravidity, parity prenatal care, current cocaine use	Higher HOME scores and better PCIS associated with full-scale IQs above 90
DC	R	All black, all received prenatal care	Maternal age and education, depression, prenatal visits, HOME, parity, examiner, sex, age at test, continued maternal drug use	
C	R	All from same ZIP code, 36 weeks' gestation, no NICU care, women referred for drug treatment excluded	Placement, gestational age, maternal age and education, OFC at birth, birth weight	Birth weight associated with MDI at 12 months; with case management, children cared for by biological mothers have higher SBIS verbal scores; children in care of relatives have highest overall scores
C	C	All with biological mothers	Maternal age and education, OCS, prenatal care, birth weight, birth length, and OFC at birth	
DC	DC	All in prenatal care by 5 months	Maternal Ethnicity, IQ, current maternal alcohol/drug use, self-esteem, HSQ, child's grade	
R	R	All black, all receiving AFDC, severity of BPD, all VLBW	Chronological age at testing, IVH, foster placement	

motor development before age 7 months but not thereafter has been found by some investigators[75, 76, 97] but not others.[74, 79, 89] Recent research suggests that motor findings attributed to cocaine may in fact reflect heavy prenatal tobacco exposure.[74]

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

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

When prenatal cocaine and tobacco exposure are compared dispassionately, it becomes clear how sociopolitical forces shape discrepant interpretations of simi-

Table 3. Language Skills

Study	No.	Cocaine Effect	Outcome Measures	Assessment Ages	Tobacco Use	Alcohol Use	Marijuana Use
Bland-Steward et al, [69] 1997	40 + 56 -	Delays in early semantic development, no effect on SICD-R score	SICD-R language sample	24 months	NR	NR	NR
Hurt et al, [81] 1997	28 + 22 -	No cocaine effect	PLS	2.5 years	NR	NR	NR
Kilbride et al, [89] 2000	111 + 41 -	No cocaine effect	REEL, SICD-R	6, 12, 24 months (REEL), 36 months (SICD-R)	C	C	R

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

Table 4, Motor Skills

Study	No.	Cocaine Effect	Outcome Measures	Assessment Ages	Tobacco Use
Dempsey et al,[74] 2000	40 + 56 -	No cocaine effect	Neurologic examination	6 weeks	DC High doses associated with huypertonia
Fetters and Tronick,[75] 1996	28 + 22 -	Higher total risk on the MAI at 7 months, lower mean percentile on AIMS at 7 months	AIMS, MAI, PDMS	1, 4, 7, and 15 months	C
Fetters and Tronick, [76] 1998	28 + 22 -	No difference on PDMS, significant differences on prone and standing subscores of AIMS and primitive reflex score of MAI at 7 months	AIMS, MAI, PDMS	1, 4, 7, and 15 months	C
Hurt et al, [79] 2000	101 + 118 -	No cocaine effect	Tones and reflexes	6 and 12 months	C
Kilbride et al, [89] 2000	111+ 41 -	No cocaine effect	PDMS	6,12, 24 and 36 months	C
Swanson et al, [97] 1999	48 + COC372 + COC12 186 -	Higher full-scale MAI total risk, COC3 associated with less optimal volitional movement than CC 12, COC3 at higher risk for neuromotor dysfunction than unexposed but COC12 is not	MAI	4 months	DC

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

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

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

Much is still unknown about the effects of prenatal cocaine exposure. Research on prenatal marijuana and to-

Selection/MatchingCritera	Controlled Variables	Other Effects
Age, sex foster care, maternal age and education		
Medicaid		
All from same ZIP code, 36 weeks' gestation, no NICU care, women refereed for drug treatment excluded	Placement gestational age, maternal age and education, OFC at birth, birth weight	Case management of children cared for by biological mothers associated with higher SICD-R scores

Alcohol Use	Marijuana Use	Selection/Matching Criteria	Controlled Variables	Other Effects
C	C	Birthweight>2000g, English speaking, maternal age >18, no NICU care	Ethnicity, adequacy of prenatal care, OFC gestational age, homelessness	
C	R	Maternal education, maternal age >18, health insurance, ethnicity, birth weight >2000g. no NICU care	Hobel score, cumulative risk index, child hospitalization and poor health, maternal education, ethnicity	
C	R	Maternal education, maternal age >18, health insurance, ethnicity, birth weight >2000g. no NICU care		
C	C	All from same ZIP code, 36 weeks; gestation, no NICU care, women referred for drug treatment excluded	Cogenital syphilis, maternal age, maternal age and education, OFC at birth, birth weight	
C	R	Maternal age >17, gestational age >/- 37 weeks	Prenatal visits, infant sex and age, parity, ethnicity, maternal age and education, marital status, income	Prenatal care decreased association between cocaine exposure and primitive reflexes and volitional movement to nonsignificant
DC	DC			

Table 5. Behavior, Attention, Affect, Neurophysicology*

Study	No.	Cocaine Effect	Outcome Measures	Assessment Ages	Tobacco Use
Alessandri et al [62] 1993	36 + 36 -	Cocaine associated with fewer positive emotions, less arousal, and less instrumental responding	Instrumental responses and facil expressions during learning	4, 6, or 8 months	R
Alessandri et al [63] 1993	37H 30L 169 -	No cocaine effect	Habituation	8 months	DC
Azuma and Chasnoff, [64] 1993	92 + 25 poly 45 -	No cocaine effect	CBCL externalizing scale	3 years	R
Bard et al, [65] 2000	27 preterm + 39 full-term + 23 preterm – 29 full-term -	None on behavioral state or heart rate; higher baseline respiratory rate and better arousal modulation in full-term infants, and poorer arousal moduation in preterm infants; preterm exposed are no more dysregulated than full-term unexposed	Arousal and arousal modulation in heart rate and respiratory rate	8 weeks corrected for prematurity	DC Associated with arousal modulation of heart rate
Bendersky and Lewis [66] 1998	24H 17L 66 -	Heavily exposed showed less joy and more negative expressions during reengagement	Still face paradigm	4 months	DC
Betancourt et al, [67] 1999	7 + 81 -	No cocaine effect	Goodman Lockbox	3.5 and 4.5 years	C
Blanchard et al,68 1998	26 + 23 –	No cocaine effect	Qualitative behavioral ratings during motor testing	1, 4, and 7 months	C
Coles et al [71], 1999	25 preterm + 32 full-term + 22 preterm – 26 full-term –	Increased heart rate to social stimulation	Heart rate response to auditory, visual and social stimulation	8 weeks corrected for prematurity	C
Delaney-Black et al ,[72] 1998	27 + 75 –	1-Tailed cocaine effect on problem behaviors and daydreaming, but no effect on Conners Scale total	Conners Teachers Rating Scale and Problem Behavior Scale	72-90 months (6-7.5 years	C
Delaney-Black et al ,[73] 2000	201 + 270 –	None with standard scoring method, but higher Externalizing-Internalizing Difference Score in cocaine exposed	Teacher Report Form of CBCL	6 years	DC
Graham et al, 77 1992	30 + 20 marijuana 30 –	No cocaine effect	Vineland Social Maturity	18 months	R
Griffith et al, [78] 1994	93 + 24 poly 25 –	Similar to polydrug effects, but both show more aggressive and destructive behavior	CBCL	3 years	R
Hurt et al, [80] 1996	83 + 93 –	No cocaine effect	Free play	18 and 24 months	C
Jacobson et al [85] 1996	86H 48L 330 –	Heavy cocaine exposure associated with poor visual memory on Fagan Test at 6 and 12 months and faster responsiveness on Visual Expectancy at 6 months	Fagan Test of Infant Intelligence; Vsual Expectancy Paradigm	6 and 12 months	DC
Jacobson et al, [86] 1999	29 + 57 –	Cocaine exposed had lower basal cortisol prestress, but no poststress level	Cortisol levels before and after venipuncture	13 months	DC
Johnson et al, [87] 1999	53 + 37 –	No cocaine effect	CBCL	24 months	NR
Kamel et al, [88] 1996	46 + 147 – 162 – with CNS injury	No cocaine effect	Arousal modulated visual attention	4 months corrected for prematurity	NR
Leech et al, [90] 1999	26 + 582 –	Cocaine associated with increased errors of omission	CPT	6 years	DC Associated with errors of omission
Mayes et al, [91] 1995	61 + 47 –	No effect on visual habituation, more cocaine-exposed too irritable to start procedure	Visual habituation	3 months	C
Mayes et al, [92] 1997	43 + 17 poly 21 –	Less readiness for interaction at 6 months	Face-to-face interaction	3 and 6 months	C
Richardson et al, [93] 1996	28 + 523 –	No cocaine effect	Teacher Reprt Form of CBCL	6 years	DC
Roumell et al, [94] 1997	14 + 16 –	Cocaine associated with less facial emotion	Facial Expression coding after inoculation	18 months	R
Scher et al, [96] 2000	37 + 34 –	Third-trimester exposure associated with reduced spectral 0 energies; no sleep effects	Quantitative EEG	Day 2, 1 year	DC increased indeterminate sleep, increased arousal

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

Alcohol Use	Marijuana Use	Selection/Matching Criteria	Controlled Variables	Other Effects
R	NR	Sex, birth, order, maternal age, all with biological mothers, all receiving AFDC, all black, all with <-high school.	Beck Depression Inventory and Life Events Survey	
DC	DC	All with biological mothers		
C	C	All drug users in prenatal care by 15 weeks and in drug treatment		Smaller OFC associated with more externalizing behavior
DC	DC	Maternal age ≥19, English speaking, singleton or first born twin, no O_2 >28 days, no seizures, no grade III or IV IVH, not breastfed	Quality of caregiving, maternal psychosocial resources, term status	Term status associated with higher arousal and with arousal modulation of respiratory rate and arousal of heart rate
DC	DC	All with biological mothers	Maternal vocalization, maternal sensitivity, Environmental Risk Score, Contingent Responsivity Score, neonatal medical complications	Maternal sensitivity associated with both joy and negative expression; neonatal medical risk and maternal vocalization associated with joy
C	C	Medicaid, all >34 weeks' gestation	Gestational age, birth weight, IQ, preschool experience	
C	C	Maternal education, maternal age > 18, health insurance, ethnicity, birthweight >2000 g. no NICU care	Maternal age, parity	Child age associated with examiner's persistence and maternal parity with interruptions
C	C	Maternal age >/- 19, English speaking, singleton or first-born twin, no O_2>28 days, no seizures, no grade III or IV IVH, not breastfed	Caregiving potential, quality of caregiving	Caregiving instability explained more variance than cocaine exposure, preterm drug-exposed had least optimal response
DC	NR	All black	Child's sex	
DC associated with higher total score, increased attention problems, more delinquent behavior	C	All black, all with prenatal care, children with mental retardation excluded	Child's sex, custody changes, exposure to violence, current lead level, current caregiver drug use. Socioeconomic status, marital status	Child's sex male, current lead level, exposure to violence older age, custody change, caregiver marital status, and current caregiver drug use associated with less optimal scores
R	C	Marital status, obstetric history, ethnicity, self-referred to Mother Risk Counseling	Maternal IQ	
C analyzed as single category, associated with aggression	All drug users in prenatal care by 15 weeks and in drug treatment	Child's sex, drug-free caregiver		
C	C	Medicaid	NICU admission, age at testing, foster care	
Dc	R	All black, all received prenatal care	Maternal age, depression, prenatal visits, HOME, parity, examiner, infant's sex, age at test	
Dc Related to higher basal cortisol, heavy exposure to poststress elevation	DC	All black, all received prenatal care	Milk, teething, pacifier, birth size, maternal verbal ability, age at test, postpartum drug use, ego maturity, caregiver depression	New teeth, maternal depression, AFDC associated with higher basal cortisol; age at visit, maternal verbal ability with poststress cortisol
NR	NR	All Hispanic or black	Ethnicity, maternal stress and social support, maternal depression, child's sex	Maternal stress and social support associated with total internalizing nd externalizing behavior; depression with externalizing behavior problems
NR	NR	Cocaine-exposed had normal BAER and cranial ultrasounds	Arousal condition	CNS injury associated with neonatal pattern of attention
DC	DC associated with more errors of commission, lower of omission	All in prenatal care by 5 months	Ethnicity, child's sex, illnesses, hospitalizations, SBIS IQ, HSQ, maternal work status, life events, hostility, maternal age, male in household, current caregiver alcohol/drug use	Omission predicted by lower child SBIS IQ and age, and mother more hostile and not working; commission predicted by child's male sex, male in household, and lower SBIS IQ
C	C	All with biological mothers	Maternal age and education,, OCS, prenatal care, birth weight length, OFC	
C	C	All with biological mothers	Maternal age and education, infant's sex, OCS, infant size at birth	
DC	DC	All in prenatal care by 5 months	Ethnicity, child's IQ and greade, current maternal alcohol/drug use	
R	R	Hospital payment, maternal education, all black		
DC decreased indeterminate sleep and _ energies, increased REM and spectral correlation	DC increased arousal, decreated ß energies	Full-term, Apgar score >5, mother in prenatal care by 5 months, no general anesthesia	Child's sex and age, ethnicity, number of hospitalizations, maternal age.	

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

*References 64, 65, 70, 74, 78, 84, 86, 90, 95
†References 63, 64, 66, 68, 71, 73, 77-79, 83, 84, 86, 87, 89, 90

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Funding/Support: This work was supported by grant DA 06532 from the National Institute of Drug Abuse (Dr Frank).
Acknowledgment: We thank Ruth Rose-Jacobs, ScD, David Bellinger, PhD, Howard Cabral, PhD, Tim Heeren, PhD, and Marjorie Beeghly, PhD, for their thoughtful comments. We also thank Ivana Hanson, BA, and Elizabeth Soares, BS, for their assistance in the preparation of the manuscript. We would particularly like to thank Lisa Blazejewski MS, for her expert bibliographic and editorial assistance.

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Notes

Harry Aponte, MSW

Friday, May 11, 2001

Conference Plenary Session

The Significance of Spirituality in Today's Therapy

Harry J. Aponte

Biographical Sketch

Harry J. Aponte, MSW, is a family therapist with a special interest in the treatment of the poor, and all the social issues associated with poverty, including race, ethnicity and culture. His eco-structural approach combines family therapy with a community perspective.

Focusing on the socially disadvantaged has led him to explore and write about the relationship between therapists' personal lives and their therapy. He trains therapists to work with the similarities and differences between themselves and their clients in socio-economic status, personal life experience and values. His work on the person of the therapist helps therapists make full use of their socio-cultural backgrounds, family of origin experience and their personal spirituality in their therapy with families.

Mr. Aponte's writings have been published in a variety of languages. He is an advisory editor to journals in this country and abroad, and lectures and conducts workshops and training nationally and internationally.

Along with his writing and lecturing, Mr. Aponte maintains a private practice, has an appointment as Associate Clinical Professor at Hahnemann University of Health Sciences in Philadelphia, and is the Director of the Family Therapy Training Program of Philadelphia. He has been Director of the Philadelphia Child Guidance Clinic, and a teacher and supervisor at the Menninger Clinic in Topeka, Kansas.

He has published *Bread & Spirit* through Norton, a book that puts families' life choices based on their ethnicity, culture and spirituality at the heart of their therapy, an issue of particular importance in the work with today's poor.

The speaker is the author of *Bread & Spirit: Therapy with the New Poor–Diversity of Race, Culture & Values*

Following is a review of the book by Danel Golemen of the New York Times (March 5, 1995)

"In 'Bread & Spirit: Therapy With the New Poor. Diversity of Race, Culture, and Values', an impassioned book that is part sociology and part sermon, Mr. Aponte notes that the poorest Americans have too often lost much of their original culture, and consequently the spiritual sense of meaning that went with it."

Stressing culture, community, and choice, this book speaks to therapy for the new poor, a people poor more because they have lost their spirit than because they lack bread. The author's perspective arises from the theory and techniques of structural family therapy, but he goes beyond that view to reach for meaning in people's identities, traditions, and legacies. He urges therapists to recognize and work with spiritual forces in the poor and to avoid opportunistic practical solutions that assume that they are too poor, hungry, and downtrodden to care about meaning and purpose. Going beyond touting the importance of recognizing diversity in race and ethnicity Aponte shows specifically how this can be done in therapy. Transcripts of his clinical work bring warmth, life, and reality to this work. These vignettes show the subtle process of connecting with people, respecting their experiences and their values, helping them locate strengths and resources both within themselves and within the community, and making the changes that will restore health not only to individual families but also to the community. Often this therapy takes place at the interface of family and school or agency or child protective services; rather than seeing these bureaucracies as unmoveable, the author makes them part of the cultural change. He also proposes a training program to enhance awareness of diversity of race, culture, and values in the person of the therapist.

Abstract

In secular and diverse times, with a disjoined society and community, personal spirituality is more relevant than ever in the fmily and in the individual's health. Considerations on the meaning of spirituality in therapy will be discussed.

Session Notes

Spirituality in relation to prevention and therapy confronts us with the challenge to incorporate into our professional roles as therapists a topic we've been trained to keep out of our professional roles. Why this approach?

The US makes up a 5th of the world's population, but consumes 50% of the world's cocaine. Drug consumption is epidemic; it goes beyond individual pathology; it's a social pathology; it involve the entire community. But today the US is the leader of a new type of culture, one of individuals that emphasizes individual wealth, personal power, and personal rights. One that does not emphasize community or spirituality. The new American culture has undermined family. The emphasis on personal power, personal fulfillment, and rights leaves people preoccupied with taking care of themselves. We have a serious problem of people not knowing how to commit to one another, to family, to personal relationships. And when people fail, they tend to be on their own, with a corresponding greater degree of stress and anxiety.

What has this to do with our youths? When, as in times past, there existed a common culture and set of values, this common perspective on life gave people a frame of reference to what is appropriate behavior, what is ideal. It provided a structure for norms and standards. This structure, conformity, was incorporated into youths' own psychology and personal standards. There was freedom, but it was attenuated by responsibilities to others or society.

This is not the society we have today. Today's youths have infinite information available through television and the Internet. They have access to an entire universe of different sets of norms and values, and they can make their own decisions rather than adhere to norms of their particular society. Today's youth are independent –and on their own.

Parents no longer have the control and influence they once had. No matter what they say, children get messages from the TV and Internet. The result is that they are less clear about morals, standards and values of life. When confronted by problems, they are less prepared and more vulnerable.

People who live in poverty are also more vulnerable, because they are much more dependent on society. Wealth can buy better schools, medical treatment, etc., but poverty depends on what society provides for support. If society does not make itself responsible for them, ... then the poor become vulnerable. They, like the canaries in the mines, provide advance warning of a breakdown in the system. Addiction is not surprising in this context.

Drugs are anesthesia, but they also offer another culture. Addicts have a social organization, a language and a way of thinking of their own... a new family.

In this environment, if we are to talk about prevention and treatment, we need to be taking into account the whole person, all his realties, including spirituality.

What do we mean by spirituality?

Four elements make up Dr. Aponte's definition:

1) World view, that is philosophical base or perspective of life. (an example is the view of the nature of love: One view is that love is something that gratifies us. If someone makes me happy, I want to be with that person; if he/she fails to make me happy, I don't want to be with him/her anymore. Another view is very different: Love is a commitment to someone else, with all that involves. Two

very different perspectives resulting in drastically different approaches.)

2) Morality, standards of right and wrong

3) Community Our spirituality defines our relationship to other people. It puts us in a particular context and speaks to our obligations and responsibilities to the group.

4) Religion a formal expression of spirituality

To sum up, spirituality is our world view, morality, relationship to one another and religion.

Relationship to Therapy

A therapist's role was always to help clients function better in society as it stood. If society meant no divorce, no homosexuality, a patient was treated in this context.

Today therapists can't do that. If a family or an individual brings a problem in, the therapists cannot assume values, morality or life view of the patient. The therapist does not know the context within which the issue or problem exists. "I have AIDS, can you help me to die?" is not such a rare request in today's society. Homosexuality can be either a lifestyle or a sin. But therapists did not used to have to face questions like these involving morality.

Today a therapist must know how to address issues of morality, philosophy and people's responsibility for one another. Therapists' training taught them not to speak about morality, spirituality or religion, but people come to them raising questions such as "what's the right way to do this, How do I handle this? What is the right thing to do? But we're not being prepared.

Society as a whole, materialistic, individualistic, has removed an overall structure, so it allows the vulnerable to fall through the cracks.

In therapy, how do you take into account people's spirituality?

If you are not clergy, your job is to help people solve problems, not to be their spiritual advisors.

Step 1: Therapists must begin with therapeutic objective.

Step 2: Take the problem and put it in the patient's context: the patient's spirituality, world view, culture, socio-religious context.

Step 3: Give thought to value platform on which treatment will be based.

Agree on problem, agree on goals, agree on way to approach problem: This requires some understanding of their perspective and values. Agreement on values supports the work therapists do, but this agreement must be negotiated.

Step 4: Must think of a human person as having free will.

You may disagree in the sense that outside factors caused the addiction, but if an addict has no control at all, you are just offering a treatment that takes complete control of him and fixes him. An essential part of therapy identifies *where* addict has free will –control of this part of life– and works from there. Once you talk about freedom, you are talking about spirituality (what is good, what is bad...morality)/

Step 5: Use spirituality as a resource. (eg If prayer helps a person transcend life's problems, or adds value to life, it gives that person a whole other place to go. Why not use this as a resource?!)

Our Own Spirituality

If we make the decision to work therapeutically with spirituality, the we must address our own spirituality. What is our social context, what morality do we base our decisions on? If we cannot understand/ relate to our own spirituality, we cannot relate to our clients'. If we are not conscious of how it works in our lives, we cannot perceive how it works in the lives of our clients.

We cannot solve drug addiction case by case; We must address it on a society level. This is a complicated process. In our society we are intolerant of each others differences when it comes to values. If we cannot talk about it, we cannot incorporate it in our therapy.

We need to have tolerance and acceptance, to talk safely about values, morality and religion. Because only with discussion can you come up with solutions.

It is a healthy part of society to allow religious practices to come together. We should support religious-based programs also.

Notes

José Szapocznik, PhD

Friday, May 11, 2001

Conference Plenary Session

Families in the Prevention and Treatment of Co-occurring Adolescent Disorders

José Szapocznik

Biographical Sketch

José Szapocznik will participate in all NHSN national meetings (National Steering Committee, national conference and National Network meetings) and provide leadership and service to the Steering Committee.

The current Center Director, and Principal Investigator for the proposed contract, Dr. José Szapocznik, has been appointed to begin as a member of the NIDA National Advisory Council on Drug Abuse at the February 2001 meeting. Dr. Szapocznik's academic credentials in Hispanic drug abuse and mental health are also reflected in his history of funded research from NIDA and NIMH in prevention and treatment clinical trials, NIMH and NIDA IRG service, appointment to the NIDA Extramural Science Advisory Board, and appointment to the Search Committees for the Directors of NIDA, NIMH, CSAT, CSAP, FDA, and to the NIH Office of Behavioral and Social Sciences Research. During his appointment to the NIDA Extramural Science Advisory Board, Dr. Szapocznik was instrumental in demanding, and being heavily involved in, the development of the first ever behavioral interventions strategic plan for NIDA.

In addition to appointment to the NIDA Council, Dr. Szapocznik was the first behavioral scientist to be appointed to the first ever NIH-wide AIDS Program Advisory Committee, with responsibility for oversight of all NIH AIDS-related research ranging from basic sciences to vaccines, medications and behavioral interventions. Dr. Szapocznik also served on the NIMH and CSAP National Advisory Councils. On the NIMH Council, Dr. Szapocznik was a leader in prevention and was a major force in the reformulation of prevention research. The report that instituted this new view of prevention, "Priorities in Prevention Mental Health Research," was approved by the full Council. In this effort, the definition of mental health prevention was expanded from the narrow realm of universal and selected interventions to include indicated interventions as well as prevention of relapse, disability and co-morbidity. Moreover, based on Dr. Szapocznik's research and advocacy, the NIMH is moving toward adopting a policy calling attention to the need to test prevention interventions not only for efficacy but also for safety (i.e., undesirable side effects).

For his academic work, Dr. Szapocznik has received numerous national and international awards, including the Presidential Award of the Society for Prevention Research, the Mentoring Award from the American Family Therapy Academy, the Distinguished Professional Contributions Awards from the 120,000 member American Psychological Association, the Outstanding Publication Award from the American Association for Marriage and Family Therapy, and Life Time Scholarship awards from the Latino Behavioral Health Institute in Los Angeles and the Hispanic Professional Mental Health Association in New York. For academic excellence, Dr. Szapocznik has also received a Merit Award from NIMH and the National Leadership Award for Academic Excellence from the COSSMHO.

Abstract

This talk for clinicians, supervisors and policy makers is based on solid scientific evidence. A review will be presented of research on the nature of co-occurring adolescent behavior problems such as delinquency, drug use, risky sexual behavior, and other risk taking, disruptive, or antisocial behaviors. Co-occurrence of risky behaviors will be explained in terms of shared risk and protective factors. Emphasis will be made on Hispanic immigrant cultural processes that, through their effect on the family, increase the risk for adolescent problem behavior.

Session Notes

When we are dealing with programs for violent behavior, pregnancy prevention, delinquency, drug abuse, we tend to treat all these problems separately. But research shows that they tend to occur in the same child. That is, when we are treating a drug abuser, the child is likely to demonstrate aggressive behavior, delinquent behavior, conduct problems at school, risky sexual behavior. He is like to have unstable friendships throughout adolescence which don't last so long, but are usually replaced with other deviant or anti-social friendships.

When one works (as at the Center) with moderate to sever drug abuse, we work with kids who have many of these problems at the same time. Other kids use drugs, but if they don't get in trouble, they don't come to our attention. But once kids come to the attention of a clinic for a severe problem, they are likely to have a whole bunch of these problems. If they have a few of them that go untreated, they are likely to develop the rest of these symptoms.

Disorders are co-occurring; It's the nature of the phenomenon.

Why do they co-occur? Why do you get anti-social, deviant problem behaviors in the same child? Why do the occur together and not separately>

We have to look at the factors involved that can either be risky or protective...

1. **Parental involvement in child's life**. Involvement in child's world: school, friends, neighborhood.
2. **Quality of communication**: specific or not. Example is general statement: "You are bad" vs. specific statement: I don't like it when you...."
3. **Communication about risky behavior**. Parent must have broad range of topics they talk to kids about (movies, weather, school) in order to establish a **highway of communication** that lets their messages about risky behavior get through and get listened to.
4. **Child's connection to this family, these parents**. Do they feel a part of the family.
5. **Parental monitoring of children's behavior and relationships** with school, with their peers and their neighborhood. There is an old belief that adolescents need "space" and "privacy". Research disagrees. The more monitoring, the less likely children are to engage in risky behavior.
6. **Parental management**: Establishing clear rules and consequences. All families have disagreements. It is skills and ability to manage conflict and resolve disagreements that is an important protective factor for children.
7. **Negativity in family communications**. Angry, blaming, accusative, retributive communications are damaging to connectedness and communications. We see in cases where there is moderate to severe problem behavior, negativity is usually present and must be corrected. If there is high negativity, and you do not bring the level down, the family doesn't stay for treatment.

The risk and protective factors for children are not only in the family. Others:

1. **Friends** – social and anti-social and their beliefs and attitudes
2. **Connectedness to School** If not doing well often don't feel a part of things. Size of school important. Ideal size has been shown to be about 300. If a school has 3,000 kids, only a very limited number of ways they can get involved on teams, the band, etc. With 300, just about every kid can get involved in a role that gives him a special place. Believe that in all the cases of mass school murders, the schools were big. Kids get lost.
3. **Crime in neighborhood /Availability of drugs**. If crime is high, parents don't let kids out.

Protective factors;

1. **Connectedness of community**.
2. Economic Resources
3. **Social Capital**: Amount of networking/collaboration that exists in the neighborhood. Research from Chicago recently showed: 2 neighborhoods with the same demographics, one has crime, drugs, violence; the other has not. The difference is in social capital which works to overcome poverty, poverty of culture, lack of resources, racism, etc.

How can you attend so many different factors when treating a problem?

If you watch a child develop from babyhood to adolescence you see the factors that work together. From toddlerhood where the mother is rewarding negative behavior, to the effects of that behavior in school, ostracism, association with other anti-social kids, risky behaviors.... The mistake is to go after a single behavior and not to understand the entire context. One problem (such as poor academic achievement) is only one marker.

Parenting and Prevention:

If you rank parents from: Over-controlling to Moderate to Permissive, and child gets an anti-social friend, parents ranked at either extreme of the scale will result in antisocial behavior from the child. Parents, particularly in high crime, high drug neighborhoods must fall in the middle, in other words, practice "**Precision Parenting**."

Another similar measure: Parental Warmth. Overly-involved on the one hand or under-involved on the other will each have detrimental effect.

What can Parents do?

1) **Speak to children and listen to them** Those who talk to children in many contexts ("build communications highway") tend to have children who share their values and beliefs.

2) **Reinforcing positive behavior** strongly influences (a child ignored except when misbehaving will misbehave.

3) **Reinforcing effort**. Not all children are achievers. Many therapists believe that reinforcing *effort* rather than achievement will have the more positive effect. Children internalize making the effort rather than seeking external approval.

4) **Clear rules and consequences**: If a parent could choose only one of these factors, the important one would be establishing **consistent application of clear rules and consequences**. Children receive lots of messages, inconsistent messages. But setting clear rules and consequences also means setting limits on parents, so they don't either over-react to or ignore behavior.

5) **Peers and neighborhoods**. Parents must be active in involving kids in healthy activities. (Neighborhoods have lots of bad stuff). Parents have to know their child's world. That is the first step in monitoring, and helps in setting limits.

6) Parents must **learn signs and symptoms of troubled youths**.

This is not a therapy that about content of communication (such as to have or not to have curfews); it is about **patterns of family interaction**. Parents need the skills to negotiate conflicts; e.g. don't tell them what curfew to apply, but help them solve their interaction problems so they can arrive at solutions.

Notes

Hortensia Amaro, PhD
Rita Nieves, RN, MPH

Thursday, May 10, 2001
Conference Workshop

Dilemmas in Substance Abuse Treatment and Recovery Among Latino Women

Facilitator: Evadne McCleary, RN, MHS
Recordr: Omar Pérez del Pilar, PhDc
Presentation Language: English

Hortensia Amaro, Ph.D

Biographical Sketch

Hortensia Amaro, Ph.D., is professor of Social and Behavioral Sciences and of Maternal and Child Health at the School of Public Health at Boston University. Over the last 15 years, Dr. Amaro's work has focused on improving the connections between public health research and public health practice. Her research has resulted in over 55 scientific publications on epidemiological and community-based studies of alcohol and drug use among adolescents and adults; on the effectiveness of HIV/AIDS prevention programs; and on substance abuse and mental health treatment issues for women.

She has been the principal investigator of over 19 public health research grants totaling over $13.3 million dollars. She currently is Principal Investigator and collaborator on six research projects on gender specific substance abuse treatment, trauma informed service delivery models for substance abusing women with mental health disorders, gender and culturally specific HIV prevention programs, and population based HIV behavioral indicators. She also directs a Faculty Development Program on substance Abuse Prevention at BUSPH.

She was appointed by Boston Mayor Tom Menino to the Board of the Boston Public Health Commission and serves as vice chair. She serves as an appointed member of the National Advisory of the National Institute on Drug Abuse. She has served on the editorial board of the American Journal of Public Health as Associate Editor of the Psychology of Women Quarterly, and on the US Department of Health and Human Services National Advisory Committee on Vital and Health Statistics.

Her professional contributions have been recognized by numerous professional and government organizations. These awards include: an Honorary Doctoral Degree in Humane Letters from Simmons College; the American Psychological Association's Early Career Award for Contributions to Psychology in the Public Interest; the APA Award for Women's Health Research; the Association of Women in Psychology's Publication Award; the Mass. Public Health Association's Alfred Frechette Award for Contributions to Public Health; the Hispanic Mental Health Professional Association's Rafael Tavares Award for Research, and the Boston Healthy Start Award for Contributions to Maternal and Child Health. She was selected as a Distinguished Visiting Professor in Women's Health at Ben Gurion University in Israel.

Rita Nieves, RN, MPH

Rita Nieves, RN, MPH, of the Boston Public Health Commission, is the Director of the Division of Women and Children's Services and of the Entre Familia Program.

As Entre Familia Program Director she is responsible for the implementation and oversight of a 35 bed Residential Substance Abuse Treatment program for Latina women and their children including: hiring and training 25 staff members, development of program infrastructure, systems, policies and procedures, physical facility, linkages and collaborative relationships with collateral agencies.

Dilemmas in Substance Abuse Treatment and Recovery Among Latina Women

Hortensia Amaro, Ph.D. and Rita Nieves, RN, MPH
Boston University School of Public Health and Boston Public Health Commission

Abstract

This workshop presents findings from a study of over 100 Latina women receiving services in a residential substance abuse treatment program that was originally developed to address cultural and clinical issues pertinent to this population.

Methods: Information on participants was gathered via a baseline interview upon program entry, at 3-month intervals during treatment, and at 6 and 12 months post-treatment completion or termination. In addition, in-depth life history interviews were conducted with 36 participants to gain further insight into gender and cultural factors and the relationship of these to drug use initiation and addiction histories, and the recovery process.

Findings: Data will be presented on factors that affected treatment stay, client outcomes one year after treatment termination, and predictors of treatment outcomes. Findings from the life history study will be presented that highlight the dilemmas faced by women regarding their roles as mothers, the demands of a residential treatment context, and the impact of a lifetime of trauma. Workshop presenters and participants will discuss the implications of findings for future research and clinical practice with Latina women.

Bilingual program for Latina women and their families

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Office: 617.534.2922
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Entre Familia is a residential chemical additions treatment program for Latina women and their children. This new national model is funded by the Center for Substance Abuse Treatment. The mission of the program is to improve the overall outcome for each woman, the health and development of her children, and the well-being of the family as a whole. The program provides:

- comprehensive, linguistically and culturally appropriate treatment;
- a gender-specific approach that responds to the reality of Latina women's lives;
- a family-centered model responsive to women, their children, and family members

Philosophy

Three critical features of Latina women's lives frame successful substance abuse treatment:

- their culture, language, and ethnic identity;
- their experiences as women;
- the critical influence and role of families.

Services

- a twelve-month residential treatment program;
- a twelve-month aftercare and relapse prevention program;
- substance abuse counseling, support groups, family therapy, case management, health education and access to health services, educational and vocational counseling, and job training;
- services for children, including child care, case management, and access to health, mental health, and specialized education services;
- program support services, which include transportation and clothing for women and children.

Eligibility Criteria

The program is open to women who:

- live in Massachusetts;
- need bilingual (Spanish/English) and bicultural substance abuse services;
- have children up to ten years of age;
- complete a screening interview with the Entre Familia program staff.

Volunteer and Internship Opportunities

- Become a volunteer by contributing your time and talents. The program has immediate need for volunteers who are interested in childcare, fundraising, recreational, and job training activities.
- Internships are available in a range of fields, including mental services, childcare, nutritional services, and social work.

Donations

Entre Familia is in the continual process of creating a comfortable and enjoyable environment. You can help by donating household items (furniture, equipment, and artwork) and items for children ages one through ten (toys, cribs, games, art supplies, car seats and age-appropriate furniture). Monetary contributions are also welcome. All donations are tax deductible.

Entre Familia es un programa residencial de tratamiento para la adicción, creado para mujeres Latinas y para sus hijos. Es un modelo nuevo nacional que recibe fondos del "Center for Substance Abuse Treatment". El objetivo del programa es demostrar que un tratamiento residencial que tome en cuenta la realidad de la mujer y su contexto cultural, da mejores resultados para cada mujer, para la salud y el desarrollo de sus hijos, y para el bienestar de la familia. El programa ofrece:

- Un tratamiento integral coordinado, adecuado al lenguaje y a la cultura de la clienta;
- Un enfoque especial dirigido a la mujer, que responde a la realidad de la vida de la mujer Latina;
- Un modelo de cuidado basado en la familia, el cual responde a las necesidades de las madres, sus hijos y los miembros de su familia.

Filosofía

Tres aspectos muy importantes en la vida de la mujer Latina deben tomarse en cuenta para que tenga éxito un tratamiento de recuperación:

- Su experiencia diaria y continua con la cultura, el idioma y la identidad Latina;
- Su comportamiento o condición social como mujer;
- La influencia tan grande e importante que tiene la familia en el proceso de recuperación.

Servicios

- un tratamiento residencial de 12 meses;
- un programa de cuidado posterior de otros 12 meses que ayuda a prevenir una recaída;
- servicios de consejería para problemas de abuso de drogas, grupos de apoyo, terapia familiar, educación sobre la salud, de salud mental, y de educación especial
- servicios de programas de apoyo que ofrecen, entre otras cosas, ropa y transporte para las mujeres y los niños.

Get informed

Women Affected by Trauma, Addiction, and Mental Illness

Violence is Common in the Lives of Women Who Seek Services

Women who have been abused as children or as adults are more likely to become addicted to alcohol or drugs, suffer anxiety or depression, and/or become victims of domestic violence. According to recent studies, many women seeking mental health, addiction or homeless services, or entering the criminal justice system have experienced sexual or physical abuse over the course of their lives:

- 40-80% of female patients diagnosed with a serious mental illness
- 55-99% of substance addicted women
- 50-90% of female prisoners
- 97% of homeless women with both mental health and substance abuse problems

If you work in these service systems, you have contact with women who may have a history of childhood abuse or may be in an abusive relationship.

Symptoms and Problems

A woman who has a history of abuse is at greater risk for:

- Depression, making it difficult for her to get out of bed in the morning, take care of her children, hold a job, form relationships or eve do routine tasks
- Post-Traumatic Stress Disorder (PTSD)
- Low self-esteem
- Suicide or suicidal behavior
- Eating disorders of all kinds, including obesity
- Self-inflicted injuries such as cutting or burning herself

Women who have experience abuse often have physical problems that can impact their ability to live their lives. Since the body holds the pain of trauma, a woman with a history of trauma can have chronic medical problems including headaches, muscle pain, pelvic pain, stomachaches, frequent infections, difficulty sleeping, bad dreams and fatigue.

Impact of Trauma on Women's Lives

When a woman experiences violence early and/or often, it changes the way she thinks about the world. She may see the world and people as dangerous. She can become disconnected from other people and from her own feelings. She may also believe that she doesn't deserve to have a good life.

Women's Ways of Coping with Trauma

Women often develop two extreme forms of coping with trauma, either completely shutting down or engaging in impulsive and self destructive actions. A traumatized woman may cope with being disconnected from her body by cutting herself as a way to feel alive. Other women may connect to others through risky sexual behaviors.

Current symptoms of behaviors may have begun as attempts to cope with trauma. A woman who feels she doesn't have many options may choose unhealthy solutions. A woman who feels like she's jumping out of her skin, for example, may have a drink, do drugs or eat to calm herself down.

Trauma and Substance Abuse

Girls and women suffering from trauma may turn to substances to cope with their overwhelming feelings and memories, particularly if they have no one safe to talk to such as a family member, teacher, or pastor. They use different substances to either feel some things or not feel others. They relieve symptoms of avoidance and numbing by using cocaine or other stimulants to become more sociable and have more energy. They use alcohol, heroin, sedatives and other depressants to sooth symptoms of nightmares and flashbacks or hyperarousal symptoms such as sleeping problems or agitation. Substance abuse,

however, can make symptoms of PTSD (such as anxiety, depression and numbing) worse.

Substance use reinforces poor coping, putting a woman in risky situations that make her more vulnerable to being victimized or experiencing further trauma. For example, a young woman who is sexually or physically abused at her home may run away to the streets and get involved with a man who says he'll take care of her. Before she knows it, she is using drugs, selling her body and being beaten again.

Screening and Assessment

Addiction, trauma and mental illness are chronic, progressive, relapse-prone conditions that need treatment. Clients in substance abuse treatment, mental health, homeless or domestic violence services need to be assessed and treated for these co-existing conditions. Screening and assessment must be done in a manner that validates a woman's experience, promotes her trust, and minimizes her anxiety.

While women have said that a provider should ask about abuse, some women may not feel comfortable talking about their abuse history on the first visit. For this reason, a provider should ask a client about childhood abuse at different times during treatment. Her responses may be more complete later in treatment when some trust with her provider has been developed, and she can handle feelings associated with these experiences.

Treatment and Recovery

Since trauma shapes a woman's worldview, recovery involves her feeling secure enough to see the world as a safe palace. A woman's physical and emotional safety must be ensured. Early recovery for a woman with a history of trauma is a very vulnerable time during which she can become overwhelmed, suicidal and relapse.

Recovery also involves learning that people can be trusted and that trust develops slowly over time. The heart of treatment and recovery for a woman is being able to build a collaborative, nonexploitative relationship with her provider. A central feature of successful treatment is a provider's ability to stay connected with a woman who is experiencing powerful feelings of rage, grief and sadness.

A woman needs a safe relationship where she can cry or rage and where she can talk truthfully and freely about her abuse experience and her feelings. A woman needs to be reassured that the abuse was not her fault. She also needs to learn positive ways of comforting herself and have a support person she can call.

A provider can make a big difference in the lives of abused women by listening, assuring them that help is available, and referring them to services where they can receive help. A provider can help a woman to understand that it's okay to believe that the abuse really did happen and that the worst is over since it already happened.

Resources

Programs that offer service for women affected by these issues:

Substance Abuse Treatment Programs
Entre Familia
(Residential for Latina women) 167.534-2922
MOM's Project (Outpatient) 617.534-7411
Griffin House (Residential) 617.296-0405
Substance Abuse Services
Central Intake 617.534-5554
Substance Abuse Helpline 1-800-327-5050

Domestic Violence Programs
Elizabeth Stone House 617.522-3417
Casa Myrna Vázquez
(English/Spanish)..... 1-800-992-2600

Boston Consortium of Services For Families in Recovery

Boston Consortium of Services For Families in Recovery
249 River Street, Mattapan MA 02126
9385-9385-9385 • 617-534-9231

Notes

Ema Genijovich, Lic.

Thursday, May 10, 2001
Conference Workshop

Hidden Treasures of Healing

Ema Genijovich

Biographical Sketch

Ema Genijovich is a psychologist, born and raised in Argentina. She lived and worked for many years in Mexico City and for the last 17 years has been living in New York and working with Dr. Salvador Minuchin. Ema is a founding member, and member of the board and faculty of the Minuchin Center for the Family in New York. She is also affiliated with the New York University Medical Center and is a visiting professor at many universities all over Latin America. Ema Genijovich works in New York as a program consultant for Mental Health Centers, Child and Family Services, Substance Abuse Programs, Foster Care Agencies and the Board of Education. In working with families and larger systems, she has developed main areas of interest in working with poor immigrant families with multiple problems and issues of diversity, including cultural differences and gender issues. Ema developed video-tapes with her work with families for training purposes and just finished developing a Training Manual for workers in the Criminal Justice System dealing with drug abusers. Besides developing training programs and teaching in the States, Ema travels to teach and give workshops to many countries in Latin America and Europe.

Conference Workshop: Hidden Treasures of Healing

Abstract

The prevailing approach in drug treatment programs is to focus on the individual, regardless of her/his connections with the family and friends. In this presentation we will shift the focus from the individual to the family and from pathology to strengths, allowing us to discover the “hidden treasures” of the individuals and the family. As we know, adolescents are at risk of becoming substance users and more so in families where one or more of the adults are substance abusers. As a way of preventing this from happening, it is important to create a context in therapy where the rage, violence, pain and anxiety of the adolescent in relation to the family situation can be expressed. To illustrate this we will present a video-taped consultation with a Puerto Rican family in New York. The consultation will present an approach dealing with a variety of issues:

l) working with diversity in culture;

2) a new kind of family;

3) eliciting adolescents voices for healing; and

4) understanding the effect of the larger system ideology in the course of treatment.

The therapist's use of the self as an instrument to facilitate change will be emphasized. (The video-taped consultation is in English with Spanish subtitles)

Workshop: Hidden Treasures of Healing

[Notas sobre el taller]

1. El Taller dio comienzo a las 2:15 p.m. con la presentación por parte del Dr. Francisco (Paco) Torres. La presentación se ofreció en español.
2. Hubo un total de 21 participantes.
3. Ema comenzó su presentación explicando que presentará su modelo teórico y luego iba a presentar un video donde se ve la intervención familiar.
4. La presentadora hizo una dinámica de presentación entre los participantes.
5. Ema hizo el comentario que en la composición del grupo hubo muchos varones; usualmente las mujeres predominan.
6. El modelo utiliza el movimiento para la compresión del estructuralismo. Lo Llamó enfoque y no modelo, porque la realidad en que vivimos es que las familias han cambiado.
7. Años '50 – familia típica era padres e hijos. Actualmente es madre con hijos.
8. Las estructuras familiares han cambiado.
9. Tratamiento individual saca al individuo de su familia para "curarlo" vs. tratamiento familiar en el que el enfoque es el individuo dentro de su familia.
10. Por el abuso de drogas puede haber maltrato emocional, físico y negligencia, específicamente el de mujeres adictas que maltratan a sus hijos.
11. Ema hizo la pregunta de cómo se trabaja aquí el tratamiento para mujeres con niños. Una persona contestó que en Santa Cruz había un programa donde reubican a las madres con hijas (hasta 3 niños). Un participante dijo que en Puerto Rico la corte envía a la mujer al tratamiento y le remueve los niños. "No hay enfoque familiar."
12. Ema llamó maltrato cuando el gobierno decide cual tratamiento le conviene a la persona.
13. Habló empleada de ASSMCA que trabaja en programa de metadona. Ella explicó que ahora obligatoriamente el "adicto" debe entrar a tratamiento, porque sino le quitan su hogar (en las residencias públicas específicamente). La idea es sacar a las personas al cabo de 2 años.
14. Ema dijo que en su experiencia las familias no se deben trabajar dictándole ordenes; debe ser un facilitador en la familia. Esto es así porque la familia "sabe" lo que necesita.
15. Ema hizo un ejercicio. ¿Qué decía un colega en el trabajo? ¿Qué decía un amigo de ustedes? Y ¿Qué decía un papá o mamá acerca de ustedes? Luego de 2 minutos de las personas reflexionar, se abrió la discusión con los participantes. Contestaciones

Comentarios:

Participante 1 – competente, leal, terca

Participante 2 – alegre, espiritual, buen hijo

Participante 3 – trabaja bien en equipo, da apoyo, distante

Participante 4 – justo pero severo, buen amigo, buen hijo

16. Ema contó su historia personal sobre cómo se llevaba con sus amigos y su madre.

17. El ejercicio se traduce a que en la misma persona, pero en distintas relaciones, aparecen partes distintas de la persona. Lo comparó con una “pizza” que tiene distintos pedazos.

18. (observación) Los participantes del taller se mostraron atentos durante la primera parte del taller.

19. (Premisa # 1) Los “tesoros escondidos” son las partes escondidas de las personas y cómo los miembros de la familia pueden traer esos tesoros ocultos a la hora de la terapia.

20. (Premisa # 2) Por lo tanto, los “paradores” son los miembros de la familia (porque son los que tienen los tesoros ocultos).

21. Cree que hay colaboración y responsabilidad de un miembro a otro.

22. La “palanca” para ayudar a un “adicto" son los hijos.

23. Enfoque de trabajo – se enfatiza el “nosotros” (no se trabaja individualmente).

24. “En el conectarte con tus hijos, te estás ayudando a ti”.

25. Los modelos terapéuticos son masculinos y buscan desconectar a las mujeres de sus familias.

26. Las mujeres “adictas” tienen auto-estima baja y han perdido poder.

27. (Permisa # 3) Concepto de co-construcción significa cuando pedimos ayuda a otro. El impacto de este concepto se da a nivel verbal y no-verbal –Se llama “complementariedad”.

28. Al trabajar con la persona “adicta” hay que verla en el contexto de sus relaciones.

29. (observación) En general, no hubo muchas interrupciones durante el taller. Algunos participantes salieron y entraron del salón.

30. No se pueden imponer los valores del terapeuta. Hay muchas formas de ver las cosas.

31. Modelo Estructural – enfoca en cambios en conducta y lenguaje en el “aquí y ahora”. Las sesiones dentro del modelo son cargadas emocionalmente.

32. En el modelo de Minuchin se observa la "danza" de la familia.

33. Los tesoros escondidos existen en la mirada del terapeuta. Hay que buscar tesoros y no los problemas. Las tesoros son las fortalezas de las familias. El terapeuta debe creer en que hay tesoros escondidos.

34. El terapeuta es un instrumento limitado de cambio porque sólo podemos llegar hasta donde la familia nos permita llegar.

35. Rol del terapeuta es traer cosas nuevas y desarrollar sorpresas, creando intensidad emocional.

36. El modelo cree y el proceso de sanación se da cuando la víctima (el que ha sido sometido a negligencia) puede expresar al adicto sus sentimientos). Esto es confrontación.

37. Un participante hijo un comentario –cuando ella trabajaba en New York tuvo un caso en que la madre tuvo una recaída y tuvieron que reportarlo ¿Qué hacemos en esa situación?

38. lema – 1) evaluar nivel de riesgo; 2) tratar de no reportar (si es posible); 3) trabajar en colaboración con los oficiales de probatoria.

39. El enfoque no está en la recaída, sino en la tensión que puede llevar a la persona a la recaída.

40. (comentario) Participante preguntó si con una persona adicta ¿se debe enfocar en sus valores y no en la adicción per sé?

41. Ema – dijo que sí, debe haber una relación con la familia.

42. (comentario) Participante dijo que el adicto ha carecido de los valores y todo lo enfocamos negativamente.

43. Participante preguntó qué hacer cuando los parientes del "adicto" se sienten que tienen la culpa de la adicción del paciente.

44. Ema –dijo que era comentario importante.

45. Trajo el concepto de horizontal (relaciones con familiares) y vertical (responsabilidades individuales). La persona debe ver sus opciones porque es combinación de las relaciones y de la responsabilidad individual

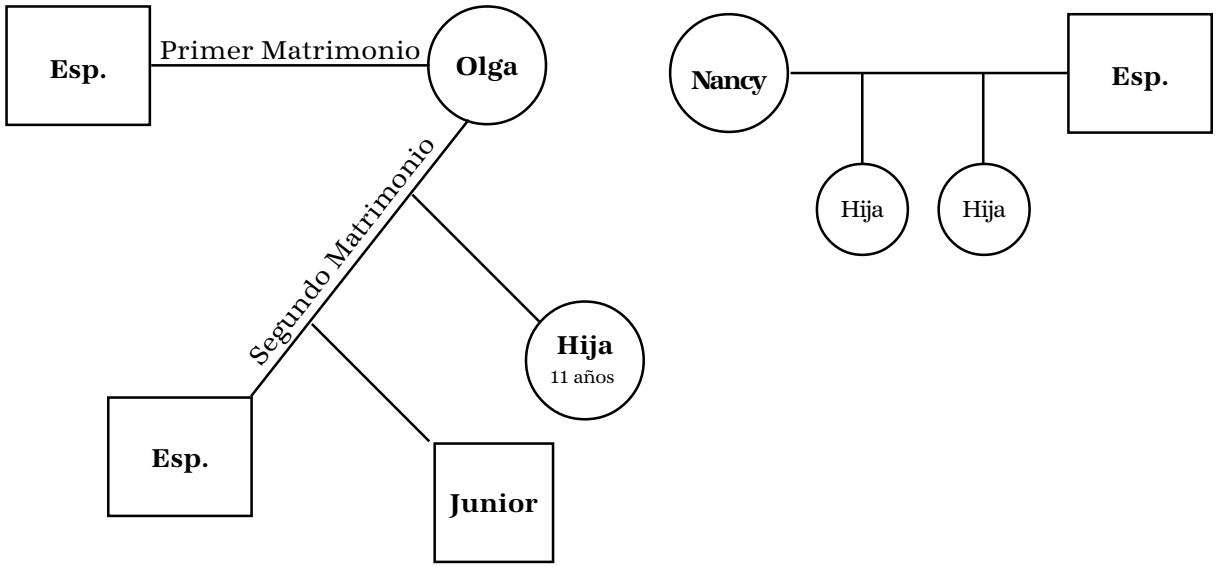
46. (comentario) Participante dijo un ejemplo de un caso que está atendiendo: padres evangélicos con hija de 16 años que le gusta salir mucho. Los padres le echan la culpa a la hija, pero la hija cree que el problema es de sus padres que no la entienden.

47. (comentario) Participante preguntó si utilizaba valores psicoeducativos con las familias. Ema dijo que no –ella no le explica, hace que la familia lo practique.

48. "Coffee break" y VIDEO

1. Sobre consulta (1 sola vez) con una familia en el Centro Minuchin en New York.

2. La composición es:



Problema:

Nancy tiene a Terry y Junior en su casa mientras que Olga está con su hija en un centro de rehabilitación. Nancy está pidiendo a Terry a través de la corte. Nancy y Olga se están peleando. Junior tiene problemas de conducta.

Consulta –

3. (comentario) Participante pregunta qué hacían con las niñas de Nancy. Ema dijo que ella no sabía de la existencia de las hijas.
4. (comentario) Participante preguntó porqué Nancy no pidió la custodia de Junior. Ema dijo que Nancy pidió a Terry porque el papá de Terry había aparecido y quería su custodia.
5. El terapeuta debe dejarse llevar por lo que el cliente hace. Esto se llama contra-trasferencia en el modelo psicodinámico.
6. La familia se comportará distinta frente a cada terapeuta. Esto porque nosotros hacemos que ellos se comportan de una manera u otra.
7. El objetivo en la terapia es dar voz a cada miembro de la familia (específicamente en familias "adictas"). Esto porque hay una prohibición de hablar lo que se sienten.
8. (NOTA) Se dejó de grabar en el momento del video porque era confidencial.

Discusión del video

1. Ema dijo que al hacer preguntas aparecen los tesoros escondidos. Ema creó la nueva historia para redefinir el problema. Además plantea una confrontación.
2. Se forman alianzas entre padres e hijos contra un tercer miembro.
3. Reflejo de Oro – nunca entrar en lucha por el poder en la terapia.
4. El proceso de sanación comienza en la sesión terapéutica.
5. (comentario) Participante comentó sobre el acercamiento del terapeuta a la familia. El énfasis es en el proceso y no en el contenido.
6. (comentario) Participante ¿Qué hubiese pasado si los 3 permanecían sin hablar? Ema dijo que no sabe. Junior pudo hablar porque ellos vieron que Olga y Nancy hablaban frente a los hijos.
7. Hay que expandir la solidaridad entre los miembros de la familia.
8. (comentario) Participante dijo que Junior estaba más desesperado que los otros 2 hermanos.
9. Ema – se sorprendió de cómo actuó Junior ante la situación – Tesoros ocultos.
10. (comentario) Pte – Junior fue el salvador de la familia y por eso la madre comenzó a llorar cuando Junior le dijo lo que sentía.
11. Ema dijo que el terapeuta debe promover que aparezcan los tesoros ocultos.
12. En el proceso, la familia hace que el terapeuta cambie su perspectiva de la familia.
13. Ema cambia su perspectiva de la madre adicta. Le dice cosas positivas.
14. Ema hace que los hijos le digan a su madre lo que sienten.

15. El terapeuta facilita que se den los procesos.
16. La idea es que el terapeuta haga un desafío = invitación a que hagan algo diferente porque tienen tesoros escondidos.
17. El proceso de sanación se da en la familia.
18. El terapeuta hace mínimas intervenciones que pueden ser útiles.
19. (comentario) participante – ¿Cómo que no trabajas con la verdad?
20. Ema – no hay una verdad absoluta, busco intervenciones para que hablen y no busco las razones de porque la mamá se drogaba.
21. Las premisas son las mismas pero las familias son diferentes. El terapeuta co-construye en cada familia sus intervenciones.
22. Ema dice que cada uno debe expresarse pero no lo fuerzas.
23. (Comentario Participante – ¿Si Olga estaba bajo las sustancias, usarías la misma técnica? Ema dijo que si, ella siempre los va a reunir como familia, aunque sí podría verlos individualmente.
24. (Comentario) El Participante dijo que cuando al adicto se le dice cosas positivas, se conmueven.
25. Ema anunció sus seminarios en español en el Centro Minuchin en Nueva York.

Conclusión: El Dr. Torres hizo un resumen y recalcó la importancia de llenar la hoja de evaluación

Notes

Iolie K. Walbridge, MA

Thursday, May 10, 2001
Conference Workshop

Adolescent Depression and Suicide

Facilitator: Mildred Viera, PhD
Recorder: H. Ann Finlinson, PhD
Language of Presentation: English

Sponsored by: Sección de Pediatría Asociación Médica de Puerto Rico

Iolie K. Walbridge, MA

Biographical Sketch

Iolie Wlbridge, MA, is a licensed psychologist and family therapist with 25 years of clinical outpatient and inpatient experience working with children, adolescents, families and couples. Ms. Walbridge is a faculty member of the Family Therapy Training Center of the Philadelphia Child Guidance Center.

Adolescent Depression and Suicide

Abstract

This workshop will identify the symptoms of depression in adolescents, diagnostic considerations and treatment strategies with the individual, the family and in collaboration with other professionals. Focus will be given to the signs and risks of suicide in adolescents and methods of managing and treating such symptoms safely.

[Workshop Notes]

This workshop was organized into 1) a verbal presentation of information about developmental challenges in adolescence, epidemiological data about adolescent suicide, differences between male and female youth in behaviors related to suicide, indicators of potential suicide attempts, and structural family theory as a basis for assisting adolescents who attempt suicide, and their family; 2) a video of a counseling session that illustrated psychological dynamics and therapeutic techniques in an initial interview by a psychiatrist with an adolescent admitted to an inpatient facility after a suicide attempt, and her mother; 3) a time of "questions and answers" which followed the verbal presentation and the video.

The following questions were raised during the workshop:

1. What happens when substance abuse is involved in youths who engage in suicidal ideation or attempt suicide?
2. What happens if a youth tries to hide a suicide attempt from a parent?
3. How does one work with young children (age 7-10) who attempt suicide? How is this different from working with older youths?
4. How do you account for the fact that, while many people suffer from depression, relative few are treated?
5. Does a therapist inform parent(s) or authorities if a child reveals that he/she is planning a suicide attempt or a violent act against another person?
6. Are there good screening instruments for identifying youths at-risk for suicide ideation or attempts?
7. How do Black Americans and Whites compare in terms of rates of suicide attempts?
8. Do you also have clients who are Latino or Puerto Rican?
9. Can an initial interview or session be conducted in ways that are different from the one illustrated by the video?

Some of these questions seek background information about suicide and depression (e.g., involvement of substance abuse, comparison of suicide rates among Black Americans and Whites), while others seek specific information about the therapist's role and responsibilities in working with suicidal youth.

Ms. Walbridge has worked for many years with Black American and White youths in Philadelphia, and the video she presented illustrated a case of a 13 year old Black American girl and her mother who was a single parent. Since the conference theme was the Latino family, I sense that the workshop can be strengthened by presenting information about depression and suicide as it applies to Latinos in general or to specific Latino groups (e.g., Puerto Ricans, Mexican Americans). This can be accomplished by reserving part of Ms. Walbridge's workshop for discussion of this topic, or by inviting a workshop presenter who regularly works with young Latinos.

Potential resource for future workshops:

1. The Puerto Rican Family Institute, Inc. of New York (pamphlet attached). Personnel at this organization include a psychiatrist specializing in child and adolescents (Dr. Christine Reyes).

Mental Health Solutions for Youth Program

[Brochure]

Mental Health Solutions for Youth...

is an outpatient community-based mental health services program for court-involved youth who reside within the borough of Manhattan. Court involvement can either mean that a youth has been charged with a criminal offense(s) or that parents have filed a PINS petition against their child. Its mission is to facilitate the court-involved youth's ability to modulate their affect and behavior in socially acceptable ways so that they can begin to live more fulfilling, productive lives. Utilizing a team treatment approach, we not only identify real or potential obstacles that may interfere with a youth's possibility for growth and change, but we also target strengths that can be used to overcome them.

Part of this process includes focusing on the comprehensive needs of a youth as he relates to various systems in his life. Our goal is to eliminate a youth's risk for involvement in criminal activity.

Services are free-of-charge; they include but are not limited to the following:

- Individual, family, group and play psychotherapy
- Case management services
- Diagnostic assessments and treatment planning
- Psychiatric Evaluation
- Psychiatric follow-up and pharmacotherapy
- Crisis intervention

Guidelines for making appropriate referrals to this program are as follows:

- Must be from 7 to 15 years of age at the point of admission
- Must be a resident of the borough of Manhattan
- Must not have an extensive and consistent history of extremely violent or assaultive behavior
- May have been diagnosed as severely emotionally disturbed
- Court-involved incident may have been a result of family dysfunction
- May be exhibiting symptoms of depression, post-traumatic stress disorder, bereavement reactions or any behavior which may indicate emotional distress

Treatment is provided within a culturally sensitive environment that offers bilingual Spanish / English speaking services.

MENTAL HEALTH SOLUTIONS FOR YOUTH PROGRAM
PUERTO RICAN FAMILY INSTITUTE INC.
145 W. 15th St. 5th Floor New York, New York 10011

To make referrals,
Please call:
(212) 229-6980

Notes

Harvey Milkman, PhD

Thursday, May 10, 2001
Conference Workshop

Craving for Ecstasy vs. Natural High: Life-Skills Training for High-Risk Youth

Facilitator: Ramonita Echevarría, RN
Language of Presentation: English

Harvey Milkman, PhD

For biographical sketch, please see Pre-Conference Section: "Artistic and Coping Skills Interventions for High Risk Youth"

Craving for Ecstasy vs. Natural High: Life-Skills Training for High Risk Youth

Abstract

At-risk teens experience traditional talking therapies as invasive and persecutory. We have discovered that adventure-based counseling, using hands-on games and physical challenges – like walking on stilts to "feel ten feet tall" – *without drugs* – are far more engaging than standard lecture presentations. Drives for thrill seeking and novelty (often gratified through gang violence) can be satisfied by on-stage performance of poetry, hiphop or rap. Almost magically, the conga, paintbrush or guitar can become formidable substitutes for a pistol or joint.

IT IS NO SECRET, however, that teenagers can participate in recreational activities while simultaneously abusing drugs. Some youth may smoke marijuana before listening to music, doing artwork or even playing basketball. The necessary complement to artistic, athletic, or adventure based alternatives to drugs, crime and violence is *learning to restructure habitual patterns of thoughts and feelings* that trigger destructive actions. We perpetually raise the question, *"What else is possible?"* To this end we have developed *"Pathways to Self-Discovery,"* a 24 session cognitive-behavioral curriculum, which is of parallel and equal importance to recreational alternatives.

THE CENTRAL GOAL of the *Pathways* curriculum is to increase *coping stills* and to *stimulate positive thinking.* There are five core factors addressed throughout the curriculum: 1) *meaningful engagement of talents; 2) social skills; 3) cultural adventure; 4) social support; 5) stress reduction.* All lessons –whether focused on refusal skills, anger management, HIV prevention, racial or gender stereotyping– address one or more of the five core protective factors.

This workshop provides hands-on demonstration of how *games, modeling and role-playing* form the basis for effectively teaching vital life-skills to high-risk youth.

Workshop Objectives:

1. To develop the ability to teach HIV prevention, refusal and negotiation skills, anger and stress management techniques to high-risk teenagers.

2. To learn the skills to introduce, demonstrate and facilitate group activities and learning assignments in the area of life-skills instruction to high-risk youth.

3. To develop the skills to positively engage high-risk youth in a curriculum that promotes restructured thoughts and behaviors around high-risk situations.

Journal of Community Psychology
Raymond P. Lorion, Editor
JoCP Presents
A Monograph in the Advances in Community Psychology Series
Harvey Milkman, Kenneth Wanger and Cleo Parker Robinson, Authors

Project Self Discovery: Artistic Alternatives for High Risk Youth

This special topic monograph of JoCP provides a comprehensive description of Project Self Discovery (PSD), a national demonstration model that uses artistic alternatives as a vehicle for transforming the lives of high-risk teens. Themonograph presents the theoretical and empirical bases for program development; strategies for accessing and retaining target youth populations. ethnographic and quantitative methods of client assessment and program evaluation; detailed operational model for program activities including participant guidelines, curricula, and essential elements for an effective counseling stance; and results of comprehensive assessment/evaluation efforts. The extensive "covert" client population identified by PSD is receptive to intervention services, providing that the means for engagements are perceived as non-judgmental, adventurous. and creatively rewarding. The implications of PSD's success clearly favor replication in other settings across the nation. The cost of conventional outpatient services and/or correctional placement far exceeds the per capita expenses of self discovery in a community-based setting.

CONTENTS

Feature / By Harvey Milkman, Ph.D.

BETTER THAN DOPE

Living is a word David never understood. To him living meant running for his fife from gangs and guns. It meant trying to avoid drugs and drinking. It meant being afraid. When he was growing up, he lived in a bad neighborhood. Down the street from him was a group of the worst people you would ever want to meet. He had to walk pass them every day. In his neighborhood, death was an everyday thing; he fall asleep to the sound of gunshots.

AT HOME, HIS MOTHER WOULD IGNORE DAVID and his sisters. She loved to drink with her men friends. When she let one of them move in, he would beat everyone up. Going to school was no better. He figured the only way to fit in was by using drugs and drinking. When he joined the Junior Reserves Officers Training Corps (JROTC), he found the common link was doing drugs. Because of his habits, he was failing his classes. During his sophomore year, he went to class a total of nine days. Soon enough, he just didn't go. He hated himself so much he even attempted suicide. He tried hanging himself and overdosing on aspirin.

At about that time he also started to eat a lot. In less than a year, he had gained over a hundred pounds. He was so alienated from his family that he barely spoke to his mom. Whenever she asked to talk he would tell her to go to hell. Then at the age of 16, David had a mild heart attack. Drugs were the reason behind his heart problems. Right then he decided to quit.

After that summer, he enrolled into school. His guidance counselor told David about our program, Project Self Discovery. PSD is a community-based after-school program that provides artistic alternatives to teenagers who have problems with school, their families or the community. Participants use music, art and dance to reach their goals. David signed up for the music program. Although his story is unique, his needs are similar to the majority of those who participate in the project. Artistic activities have proven to be powerful antidotes to emotional distress, drug abuse, crime and violence. In fact, PSD has evolved into a model for treating a broad spectrum of teenage problems.

At PSD, you will find youth with varied backgrounds and behaviors. Betty Jo, a 15-year-old African American, describes her mother as "a bitch" and "evil," and Betty Jo has attempted suicide twice. Her art teacher says she is interacting nicely with other students and "demonstrates an orderly, precise and methodical way of working on projects."

Rosa, a 15-year-old Latina, has decided to never again "bang" with her sect of the gang Gangster Disciples. Five of her close friends have died or have been murdered during the past year. She is considered highly motivated by her music teacher.

The usual outcome for these kids is enormous frustration and definite failure. These teenagers have different types of mental disorders and behavioral problems and come from radically diverse back-

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"The most common causes of death among young adults are homicide and suicide"

grounds. In the United States 10% to 20% of the 30 million youths between ages 10 and 17 experience emotional and/or behavioral problems. Forty percent of their waking time is "discretionary." In fact, the majority of teenage crimes are committed between three in the afternoon and midnight. For these teenagers a form of positive self-expression is vital.

The inspiration for PSD came from viewing substance abuse as just one of many forms of dangerous pleasure-seeking behaviors. Any action that deposits dopamine in the brain's reward center–be it alcohol, sex or cocaine–can trigger addiction. Yet rather than drugs, people can actually bring about self-induced changes in brain chemistry. The most important psychological challenge of our time is to bring about these changes through optimal living or natural highs.

Drugs and alcohol are really just "chemical prostitutes," counterfeit molecules that compromise the clockwork of nature's most complex and delicate entity–the human brain. According to the annual Monitoring the Future Survey, more than 40% of high-school 10th graders reported having "been drunk" sometime in the past year. About 35% of high school seniors engaged in binge drinking (having five or more drinks at a time), and approximately 20% of high school seniors smoked pot.

PSD was founded in September 1992 as the result of a national grant through the Center for Substance Abuse Prevention. The grant was awarded to Cleo Parker Robinson Dance, whose mission is to provide cross-cultural arts expression to audiences, artists and students. The project was designed to show that natural highs could serve as viable alternatives to drug abuse and associated high-risk lifestyles. Teenagers have been targeted because of their extreme vulnerability to substance abuse, crime and violence. The most common causes of death among young adults between ages 16 and 24 are homicide and suicide. Here, Juan talks about his brush with death:

THE 'HOOD

They came up the dirt hill. There were eight or nine of them and there was just six of us. My homeboy gave me a .25. It was already landed, cocked and ready to bust some caps. So I went up to them and said, I know you, the punk motherfucker who tagged up my locker. You disrespected my hood. Just kill me, motherfucker. Get it over with." So he pulls out this crowbar. And I pulled out the .25. I put it to his head and said, "What 'hood you from?" He said "CMG Blood." And I said "WHAT FUCKING 'HOOD YOU FROM?" And he said. "CMG Blood.' Then he said, "Crip." I made that fool cry and shit. When you got a strap, you feel like you got the power to do anything in the world. You can make anybody scared of you with a strap.

THE FAMILY

He's my father I don't even know what that means. I don't even know what a father is. I used to think he was someone who took me fishing or maybe camping. Someone who I could talk to who took care of me. But if you ask me, I'd say a father is someone who beats up his family. A father is someone who screams yells and cusses out his family A father is someone who breaks things, smashes things, ruins things. I HATE HIM! I HATE THIS HOUSE. WHEN HE'S IN IT! Its like a war zone and he is the enemy Every second I'm looking over my shoulder to see if he's coming after me. He didn't tear up my drawings. He tore up my dreams. I HATE HIM! I hate it when he beats on my mom. I hate seeing my mother on the floor, I hate feeling like I have to protect her from the enemy and I HATE THAT THE ENEMY IS HIM. WHY AM I PROTECTING THE ENEMY? He's my father. I love him.

While dance connects us to sensuality, music provides a safe vehicle for the expression of emotional unrest. Painting and drawing provide an opportunity to visualize topics initially too difficult for words. In Paul's script, it is evident that through writing and drama she is discovering important means to transcend the wounds of her childhood.

Self expression through thought is a PSD mainstay.

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At-risk teens experience traditional talk therapies as invasive and persecutory. We have discovered that adventure-based counseling, hands-on games and physical challenges –like walking on stilts to "feel ten feet tall" –are far more engaging than standard lecture presentations. A kid who has a strong drive for thrill-seeking and novelty can avoid gang violence by satisfying his needs through the performance of poetry, hiphop or rap. Almost magically, the conga, paintbrush or guitar can become formidable substitutes for pistols or joints.

It is no secret that people who are hopelessly dependent on drugs can still participate in the creative process. But the necessary complement to artistic development is learning to restructure habitual patterns of thought and feelings that trigger destructive actions. To this end all PSD youth participate in Pathways to Self Discovery, a 24-session life-skills curriculum. Teenagers discover improved means to cope with frustration, disappointment and anger.

David describes the course: "We gathered in a theater and talked about our past experiences with gangs, drugs and all the other things that teens face. We also talked about ways we could avoid these situations. I tried to be quiet, but my mouth would just shoot open. When it came to bad situations, I thought that I had a lot to offer the group."

David was making great progress. He had successfully embarked on the first stage of our three tier program, each phase providing the foundation for the next level of growth and change. The three parts include the intervention program, the graduate program and the mentorship program. The last program allows graduate students, who have demonstrated leadership skills, to serve as facilitators and mentors to youth in the initial intervention program.

Another such course designed to transform is the Rites of Passage. In this adventure-based course, the kids are hooked up to a rope that's connected to a wire between two large poles. The object is to proceed from one end to the other. "The ropes course really scared me," says David. "I kept thinking, 'I am going to die.'" When David hooked up his harness, though, everyone in the group started to cheer for him. "I got the strength to hurry through the course and when I got down, it felt as though a huge weight had been lifted off my shoulders."

Instructor Harston can put a student with no musical experience on stage within three months.

The results of PSD have been impressive. In the past nine years the project has received 1,255 referrals from Denver-area youth advocates. We have shown that artistic endeavor and adventure-based counseling are effective antidotes to drugs and other high-risk behaviors. Not only do participants show test scores reflecting improved mental health and family functioning; they also reveal decreased reliance on negative peer influences and decreased drug and alcohol use. These positive outcomes are sustained long after graduation.

As David puts it, because of PAD he has "become a better person." He has learned how to care for others and himself. "Without this experience, I would probably be living on the streets using drugs," he says. Today David shares a house with a friend, has a full-time job, and visits his mother once a week. He has also started boxing to relieve stress and lose weight. And for the last four years, he has been completely drug-free. He plans to go on to college and major in business and computer science. "PSD showed me that the world is full of possibilities. The program also showed me that when a door is closed a window is open. What does living mean to me now? Living is knowing that you are not alone."

Harvey Milkman, Ph.D., is professor of psychology at Metropolitan State College of Denver. He is principal investigator and director of Project Self-Discovery. For more information, call (303) 830-8500 or e-mail milkman@mscd.edu.

READ MORE ABOUT IT

PATHWAYS TO PLEASURE: The Consciousness and Chemistry of Optimal Living. Harvey Milkman, Stanley Sunderwirth (Lexington Books, 1993)

CRAVING FOR ECSTASY: The Consciousness and Chemistry of Escape. Harvey Milkman and Stanley Sunderwirth (Jossey-Bass, 1998)

Psychology Today March/April 2001

Braulio Montalvo

Thursday, May 10, 2001

Conference Workshop

Case Study: Treatment of Substance Abuse with a Family Approach

Facilitator: Edna Quiñones, PhD
Recorder: Delia Patricia González, PsyD
Presentation Language: Spanish / English

Braulio Montalvo

Biographical Sketch

Braulio Montalvo, a family therapist who has focused his professional activity on enhancing the understanding and therapy of families, and the education and supervision of those who serve famlies. Collaborated with Salvador Minuchin to pioneer innovative interventions with multi-problem families in urban slums. With Minuchin, he produced the classic book *Famlies of the Slums: An Exploration of the Structures and Treatment*, a basic resource for front-line providers in the field of mental health for decades. In 1997 Braulio Montalvo received the Distinguished Professional Contribution to Family Therapy Awared from the American Association for Marriage and Family Therapy.

Case Study: Treatment of Substance Abuse with a Family Approach

Abstract

This workshop will present two case studies that will help understanding of the problem of substance abuse in its early and later stages. Dr. Charles Fishman's crisis intervention approach, using the family's internal resources to manage behavior, will be discussed.

Case Study: Treatment of Substance Abuse with a Family Approach

Profesor: Braulio Montalvo

[Anotador: Delia Patricia González]

El Profesor Montalvo presentó un caso de familia atendido por el Dr. Fishman, terapeuta de familia, en varios segmentos de sesiones. El grupo familiar estaba constituido por la paciente identificada "joven femenina de 13 años", el padre, la madre, el padrastro, dos hermanas (mayor y menor) y una amiga de la involucrada. La joven presentaba uso de cocaína, conducta delictiva (robo de autos) y compañeros inadecuados (novio usuario de cocaína).

Profesor Montalvo indica que en terapia de familia debe mantenerse a la familia unida desde la primera intervención; evitar que se desoriente; indica la necesidad de un "grupo de rescate" compuesto por un grupo heterogéneo familiar que incluya amistades (pares). La inclusión de un "par" cercano aumenta la probabilidad de mejorar la terapia porque aportan información que la familia desconoce.

Otros aspectos que el Profesor Montalvo señala como importantes son:

- Aprovechar la crisis como "aliada" del terapeuta.
- Que el terapeuta mantenga conexión con el nexo social del paciente.
- Que ocupe su lugar al final de la familia para observar l.
- Remover en el paciente adolescente el cambio de membresía de grupo: del "malo" al grupo "bueno".
- Considerar como señal peligrosa la desvinculación del grupo "bueno": cuando no se mantiene ningún nexo.

Preguntas del Público

1. ¿Hay significado en que el terapeuta se siente al lado de la persona involucrada? (Montalvo) En este caso, nadie de la familia quiso sentarse al lado de ella, entonces el Dr. Fishman se sentó a su lado para que no se sintiera marginada.
2. Público comenta analizando la jerarquía de la familia, los roles que cada miembro asume: hermana mayor como madre; madre alejada y desvinculada emocionalmente.
3. ¿Qué recomienda hacer cuando las adolescentes no tienen red de apoyo? (Montalvo): conseguir aliados a través de las agencias, reunir miembros de la familia, conseguir pares. Terapia individual no ayuda en estos casos.
4. ¿Puede ayudar integrar un maestro en la red de apoyo? (Montalvo): Ayuda la escuela, la iglesia, los servicios de salud, además de la familia.
5. En Caguas hay un grupo de artistas que ayudan a jóvenes, les enseñan destrezas, arte, los llevan a espectáculos culturales de día y de noche. Es un buen modo de ayuda a adolescentes sin familia o con familias problemáticas. (Montalvo): Hay que tener cuidado con este tipo de intervención, puede ser contraproducente porque el joven puede repudiar a su familia porque no es "tan linda" como la gente que lo ayuda, ni tiene la familia las mismas posibilidades que estos artistas.
6. Profesor Montalvo pregunta al público que a qué conclusiones debe llegar esta terapia. (Público): Llegar a acuerdos entre la familia, buscando algún adulto que sustituya el rol de la hermana mayor que ha sido "cuidadora hostil". Buscan alguien que tenga el control ejecutiva.
7. Profesor Montalvo indica que las terapeutas de familia deben permitir la expresión de sentimientos de la familia en crisis y el despliegue de emociones; que el terapeuta debe sentirse cómo-

do mientras la emoción se manifiesta; que el terapeuta debe encausar las emociones, no controlarlos.

(El público): argumenta que es necesario controlar las emociones para que “no se salgan de proporción”, para que la familia “no se vaya de las manos”. (Profesor Montalvo): indica que la labor del terapeuta es intervenir, conectando a las personas y manejando sus emociones para resolver los conflictos, no hacer grandes discursos ni tomar la dirección de la familia, porque entonces puede asumir el control ejecutivo en vez de los padres.

8. ¿Podrá el terapeuta apoyar más al padre antes de abandonar la sesión? (Montalvo)” El terapeuta tiene que dejar al padre para que ocupe su posición jerárquica, si se queda puede op_____lo más.

9. Hubo vinculación afectiva entre madre e hija? No, eso no se logró, no terminó “tan lindo”. Se logró que la joven dejara las drogas y abandonara las “malas compañías".

Nine Assumptions for Work with Ethnic Minority Families

Braulio Montalvo
Manuel J. Gutierrez

The therapist's task of seeing a family's problem from their perspective rather than his or her own is full of possibilities for misunderstanding. Those possibilities multiply when working with minority families, because of the disruptive conditions impacting their sense of continuity and self-worth. The stresses of migration, unsuccessful relocation, uneven cultural assimilation, inadequate schools, family dismemberment, participation in unresponsive judicial and welfare systems, lack of job skills, relentless socio-economic obstacles, and frustrated opportunities often combine to shake the stability and sense of control of these families. Many feel the world around them just generally misunderstands what they are going through. When dealing even with the most stable of such families, therapists can use a set of assumptions aimed at lessening the possibilities of adding to the sense of being misunderstood. This paper offers nine such assumptions through brief case examples and stories.

1. Cultural assimilation exists unevenly within the same family.
2. Mourning and grieving are not only internal emotional processes but behaviors of social consequence.
3. Upholding continuity and lessening disparity between family members is frequently a basic goal.
4. Misunderstandings can be solved by figuring how context explains the interpretation of behaviors.
5. The family's view of the world can be inferred from how it uses or misuses its beliefs and orientation systems.
6. Culturally endorsed intrafamily patterns of coercion must be met with extra alertness on the part of the therapist.
7. Obtaining the family's consent can be a means of preventing and correcting misunderstandings.
8. The therapist's openness to guidance from the family allows access to its cultural priorities and promotes therapist's modification
9. Alertness to preconceptions, a generic tool in all therapy, is of critical importance in working with minority families.

CULTURAL ASSIMILATION IS UNEVEN

To gain appreciation and deliberate use of the strengths of different cultures, the therapist must keep in mind that a culture's influence is not evenly distributed among all family members. Expect to see earlier roots of that culture finding expression in some members and not in others. This differentiated understanding of the family is often of critical importance in the therapy of personal loss, mourning, and violence.

Jay Lappin saw a case of a grieving Hispanic woman who had a terrible tragedy. Her husband and young son stepped out of their car to fix a tire and an oncoming ear hit both of them, killing the husband and throwing the son far into some bushes. After inspecting the accident, a policeman came to the house to report on her husband's death. He had no news about her son. She asked desperately about her child, but he was unable to provide an answer. Anxious, confused and grieved, she paced the house. For unspecified reasons the policeman followed her like a shadow. Because of his presence, she could not

even change her bathrobe to go to the hospital. She felt she might be assaulted. She feared this stranger was planning to rape her. These consecutive violations could not be controlled. They were too sudden and went beyond her usual competence, driving her crazy, after a few days, with suicidal and homicidal rage. She was hospitalized.

Months went by, and her sadness continued. Nothing could snap her out of her depression. The family was trying to "take care of its own." Her younger and more outgoing sister pushed her to go out and be with other people. After sponsoring this sister to go on with her pressure tactic, the therapist shifted and urged the victim to defend herself: "What do you want? Tell your sister." "It is my life," the patient replied. "It is too soon. I feel as if he died yesterday. Going out now would be as if I was betraying him. I know I have to go out, but later. What I need is time."

The therapist helped this woman to protect her boundaries. He put her, not the relatives, in control. His emphasis on manipulating contemporary family forces was far removed from conventional grief work and its concern with the unfolding of affective stages. Those stages, after all, never occurred strictly inside a person, without an interpersonal and cultural context. The therapist had perceived quickly that the victimized woman was more old-fashioned; she needed a pace of mourning which was fitting to her roots in an earlier and slower Hispanic world not shared by her Americanized sister. His hunch was that the rhythm and pace of her grief work was being impaired by a sense of being rushed, trespassed upon once more. The trauma had already pushed her to extremes. It was essential for her not to let her sister push her too. By helping her to resist the culturally assimilated ways of her sister, the therapist enabled this woman, who had always been the slower, less outgoing sibling, to defend aggressively all her rights. The victim went on to control and modulate the pace of change to a rate that she considered within her means. The shift towards mental health accelerated when she demanded that her sister return to her care her remaining children. The sister had taken them over during the crisis, driven by the value placed by the Hispanic culture on "Our families must help their own."

Clearly, the clinician must be ready to observe the clash of cultures not only between the family and the surrounding host culture, but within the family itself.

GRIEF HAS SOCIAL CONSEQUENCES

In working with personal loss and grief related stress, the therapist who sacks to avoid misunderstanding of the culture must shift focus. She must observe not only emotions unfolding inside the surviving parsons, but their outside conflicts as they modulate the pace of grieving and shape the image that the one they have lost will have in the memory of the community. This means the therapist needs to support the surviving relatives as they form the pace of mourning and structure or "edit" the remembered image of the lost one inside and outside the family. These are essential functions, buffering the impact of disruption and restoring some sense of control by preserving elements of continuity.

Sean has died. One by one everybody in the community approaches the mother, "Poor Sean. What did he die of?'' Sobbing, she explains, "He died from the gonorrhea." People are appropriately taken aback After their shocked "Oh's" and "Ah's,'' they move on. The parade of visitors goes on late into the night, and every questioner gets the same answer. The local therapist, a doctor who had known of Sean's illness, had been watching. Afraid that he may have been misunderstanding something, he pulls the mother aside and asks. "He died of the diarrhea! Why do you keep saying he died of the gonorrhea ?'' She looks up with a twinkle in her eye, "Well, doctor, I'd rather they think of him as a sporting fellow, not the shit he had become with booze."

This mother was coping with more than her own internal sense of loss. She was actually monitoring the external regard in which outsiders held her son, helping the community to reach agreement on a certain image. Her comments were aiming to influence the son's immediate community of peers as well as the friends of the family, protecting his reputation and hers.

The family and the community hold on to their members even after death. This is evident as well in the following anecdote:

Jose, a Puerto Rican, became a widower after thirty years of marriage. Trying to overcome his sadness and loneliness, he retired to Miami. He began efforts

to come out of his emotional retreat. While walking on the boardwalk, he was impressed with the colored shirts that "gringos" wore and by their cheerful attitude. He bought a wildly colorful shirt. He put it on and felt different. Then he saw a place advertising facial silicon implants. He made an appointment and firmed up his cheeks. After the operation, the nurse suggested he should dye his hair blonde, since now he looked young. He also took an EST course and felt, not only a surge of confidence but almost arrogance. He intended to take charge of his life. As he walked along the boardwalk, a beautiful Anglo blonde winked at him. Before he knew it, he was going arm in arm with her down the boardwalk. He was amazed. He had been a good husband, a good working man. He was sure he deserved all this. At that very instant, lightning came down from heaven and struck him dead. Angrily he showed up in heaven. God's imposing image peeked through the clouds José complained, "Why me God? Why now? I was a good husband, a good man. I worked hard all my life. For the first time I am having fun and thinking of myself. Why . . . why?" God looked carefully at him and hesitatingly said, "Is that you, José? Man, I did not recognize you, you look like a gringo!"

Many cultural groups have some version of such a story. It serves as a warning to their people to stay in line, not to lose their identities forfeiting membership in their group's culture. You will pay dearly if you transform yourself too radically whether through alcoholism, like Sean, or through cultural assimilation, like José. The collective memory others have of you will be obliterated. The culture demands that its members maintain a certain integrity, and then the interesting features of your life and character are kept in mind. They live on in the minds of those who remember the past, and in the minds of those who will learn about them in the future.

UPHOLD CONTINUITY, LESSEN DISPARITY

The family is supposed to struggle against internal misunderstanding in order to protect the continuity of its social fabric. Those misunderstandings present routine problems for therapists who deal with members from family networks that are fragmented by political upheaval, wars, and forced migration.

Juan sends pictures of his family in Chicago to his relatives in Cuba. His hope is that the tie between them will be kept alive. An old neighbor comes from Cuba and Juan finds the results were not what he expected The visitor informs him that his relatives over there are angry at him. Juan cannot understand. He had tried to keep the friendship alive despite the distance. When he showed this neighbor the Christmas pictures he sent to his relatives, the man's comment was, "Look at that table . . . that turkey looks delicious!" And looking at the next picture of the man's wife and son, he could not get over the brand new refrigerator in the background. Finally Juan realized suddenly how insensitive he had been. Unwillingly he had offended his relatives. They probably thought he was trying to show off his wealth and comforts, which those in Cuba had lost forever.

Such rifts develop painful intensity between family members, because they entail much more than rivalry over goods and status. They threaten the very core of family identity and unity. Relief from that threat comes when a friend or therapist helps the cutoff participants to repair the disparity. Sometimes reparation is achieved through white lies subtly reminding family members that everyone remains the same, that we are not different from each other. "When you go back, tell them the refrigerator is not ours, it is on loan from the landlord, and the turkey was a gift from a friend, and we were wishing they would have been there with us to share it."

When the disparity is not repaired and the ties of love and duty are overstrained, the mental intactness of those with the material advantage is put at risk. Maxine Hong Kingston sees this risk as particularly high for the mother-son relationship:

Before a letter in a white envelope reached us saying that Sao Brother's mother had died, she appeared to him in America. She flew across the ocean and found her way to him. Just when he was about to fall asleep one night, he saw her and sat up with a start, definitely not dreaming. "You have turned me into a hungry ghost," she said. "You did this to me. You enjoyed yourself. You fed your wife and useless daughters, who are not even family, and you left me to starve. What you see before you is the inordinate hunger I had to suffer in my life." She opened her mouth wide, and he turned his face away not to see the depths within. "Mother," he said, "Mother, how

did you find your way across the ocean and here." "I am so cold. I followed the heat of your body like a light and fire. I was drawn to the well-fed." "Here, take this, Mother," he cried, handing her his wallet from the nightstand. "Too late," she said. "Too late." With her chasing him he ran to the kitchen. He opened the refrigerator. He shoved food at her. "Too late." Curiously enough, other people did not see her. (Kingston, 1977, p. 175)

CONTEXT EXPLAINS THE MEANING OF BEHAVIOR

Visiting the after work activities of the uprooted Chinese in the California railroad camps at the turn of the century, an outsider to the culture would have found it difficult not to grow prejudices against the *cruel* and *barbarous* Orientals. He would have seen them lift a screaming man, one of their own, and pass him over fire. To avoid misunderstanding, the outsider would have required an interpreter, an insider like M. H. Kingston. She writes in *China Men* of her people's belief in "passing fear over fire" (Kingston, 1977, p. 90)).

This phrase refers to the custom of lifting one who had been badly frightened and passing him over a fire. This experience produced a larger fear in the person suffering from a significant fear, hoping that the larger fear would inhibit the lesser one. We have no account of the casualties of this aversive training technique, but it was clearly a cultural means of last resort. It was something the culture tried on its severe anxiety and panic cases, because it had few options and no access to medical help. These people were virtually enslaved within these labor camps for making the Western railroads. Passing "fear over fire" was a compassionate act, performed among peers in the context of helping each other at the end of a long working day. In that context of helpfulness and concern, the ordinary meaning of the act of passing someone over fire was changed.

The therapist's viewpoint similarly can change by shifts in context For a long time, a colleague cherished the notion that what is wrong with most tense people is their attitude towards errors. When this therapist made a mistake, all he needed to do was go over the mistake and accept it as part of his vulnerability and his humanity. He had elevated this notion into a kind of relaxed, "that too is all right" philosophy, and was becoming very laid-back about human errors. He was trivializing the meaning of self-forgiveness in his practice, until he saw a cartoon that allowed him to look at his working context differently (see Figure 1). The caricature showed a man in a stretcher, about to be wheeled by a nurse into a surgery room. He is looking up wide-eyed at an inscription right above the operating room's door. Under the door stand two doctors in surgical masks eagerly waiting for him. The inscription

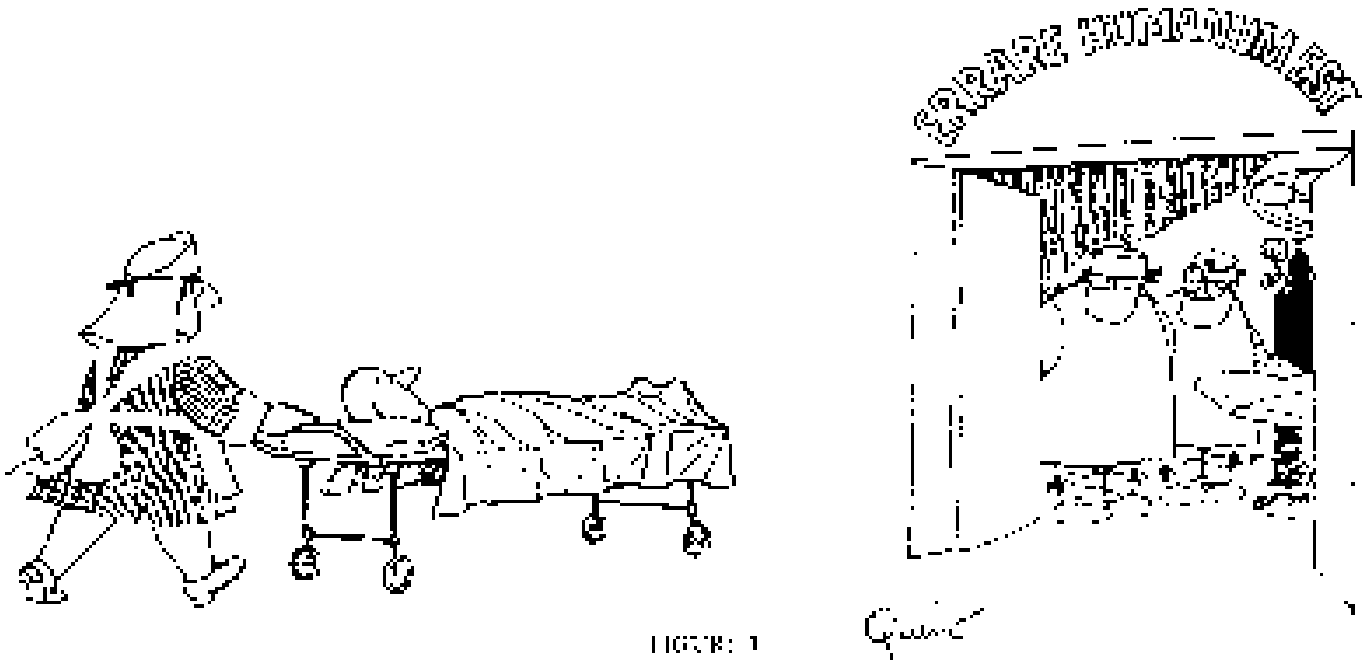

FIGURE 1

above them reads, "To err is human." Suddenly, his convenient philosophy felt far too relaxed, and the gap between the mental health professional and the patient was closed. Sharing a perception of the world from the viewpoint of the concerned patient upon whom a possible error was to be performed, the world looked different. He let go of the "that's O.K. too" philosophy, and his concept of guilt began to change. Guilt, which for him was mostly a nuisance, and nothing but an obstacle in therapy, was now reconsidered. Guilt was the nagging voice of responsibility, the standard that steers the self and prevents great blunders (Montalvo, 1985).

VIEW OF THE WORLD: USE OR MISUSE OF BELIEFS

To share a certain way of viewing the world is often the first step in inventing appropriate therapeutic interventions. Consider the grief work done in the following case.

Mrs. Rodriguez was extremely sad after the loss of her infant son. A month after the burial, she was still complaining of always seeing a little light over her child's bureau. The preoccupation with the light, which she watched until late at night, became her main engulfing relationship. Concerned about her praying, complaining, and despairing, her maid of many years offered an opinion. "Of course the little light is over his bureau. You have not gotten rid of his clothes. You must do your part." Mrs. Rodriguez proceeded to remove lovingly every little piece of clothing in that bureau, and as the light disappeared, she was filled with peace. By shedding the child's clothing, she had loosened a vital link of her attachment of the child to her, and of her to him.

This upper middle-class Puerto Rican woman shared with her lower working-class maid a quasi-mystical perception of the world. Her maid, however, maintained a more direct access to the means of coping with problems associated with that way of viewing the world. For her, the light clearly represented the soul of the child who cannot leave because the mother is not ready to let him go. The therapy she offered was classic in its simplicity. She focused on a concrete belonging, a possession that once belonged to that child, and showed the grieving woman how, by letting go of the object she could permit his soul to go on as well. Thus she gave the woman a concrete way to release her deeply held attachment.

One learns, however, that regardless of the advantages of this particular way of viewing the world, if people misuse it, trouble ensues. Misuse entails failing to do your part or wanting to manipulate hidden forces through varieties of stubborn passivity rather than shared activity.

Consider the case of Mr. and Mrs. P. They have made a modest fortune with their grocery store in New York City. Now the children are gone, and they are alone wondering what to do with their lives. "Should we sell the house?" "Would it be wise to sell the business and move back to Puerto Rico?" With those uncertainties they sink into obsessive depression and stagnation.

An increasing number of couples like this one, in the midst of a mid-life crisis, seek professional help. When the therapist sees them they are usually neglecting their business, as well as their social and sexual life, and are passively waiting for direction-sometimes even waiting for mystical or supernatural guidance. They misunderstand and desist the therapist's lack of empathy with their passivity. Therapists who look around for whatever culturally syntonic materials could lighten and support their work do better with these families. They use whatever in the culture may help those couples come closer to seeing that they have to make their own decisions, not just wait for the spirits to make them for them. To nudge them away from mystical determinism and allow a place for their own choice making in the larger providential design, popular stories are useful.

Certain stories help summarize the culture's best reality testing and elicit no-nonsense reactions from the patients using their culture's emotional and cognitive resources. Alvarez Guedes' repertoire offers this one:

One night Mrs. B. wakes up her husband, "Do you hear it?" "Hear what?" he asked. "A soft voice asking me to pay attention." Indifferent her husband goes back to sleep. Shortly afterwards she wakes him up again. "I heard it again, did you hear it this time?" By now he is curious. "No, I did not hear it. What did it say?" "It just said: 'pay attention.'" This goes on for a few nights. To her surprise, one night

the husband clearly hears the voice. "Pack up," the voice said. "Sell the store, get all your money and go back to the island." Anxiously they do as the voice said. Once back on the island they still feel adrift, lost. They do not know what to do with this new stage in their life. They listen avidly for guidance, and the voice tells them, "Go to the casino. Take all your money." So they do. After much uncertainty they approach the roulette. They hear the same voice distinctly saying, "45." Realizing this is the moment they have been waiting for, they put all their money on 45. The roulette goes around and around. It comes to a stop . . . NUMBER 44 . . . and the voice says . . . "SHIT!" (Guedes, 1983)

Through stories we can even tell ourselves that the spirits, like us, are fallible and capable of misguiding us. Guedes emphasizes that the spiritualism inherent in a culture is misused when it is summoned at the expense of the self.

ALERTNESS TO CULTURALLY ENDORSED COERCION

The human relationship to the cosmic or supernatural scheme scams to be, in most cultures, notoriously vulnerable to misuse and difficult to work with therapeutically. Such relationships are easily placed at the service of those who need to control coercively, to rob choice, from the other. The enormous credentializing and legitimizing power given to "religious conversions" by the family's culture often facilitates that negative process. It is a process of cultural endorsement that must be carefully watched since it can trap the most alert therapist into serious misunderstanding.

The mother of an adolescent girl abused by her father goes into therapy. She has lots of difficulty in mobilizing protectiveness towards the girl. Because of her rigid patriarchal outlook, she often felt the girl was to blame. To protect the girl's well-being the authorities put the father in jail, and soon after, the girl too was removed to a foster home. After a few months, the mother more or less complied with the view of the therapist. She painfully admitted that her husband was dangerous. He could do the same to her other children. She did not want him back. In the meantime, the foster home reported that the girl was beginning to act defiant and strange She was resistive and rebellious with her foster parents, breaking curfews, using tons of lipstick, and generally trying to look older, sending erotic signals to older youngsters in school.

The therapist soon discovered that sometimes the girl won thought she was her father's girlfriend. All these behavior changes emerged during a period in which the mother talked with the therapist as if she was indeed distancing from her abusive husband. However, she was actually misleading the therapist and fostering the relationship of the girl with the father. The mother had visited him and had come back to tell the girl that he had received the Lord now. He had undergone a religious conversion and was a different man. The mother wanted her daughter to reconcile with him and write to him. The girl began writing letters, and the father answered with pornographic responses attempting to reinvolve her. During this process the girl started acting psychotic.

The mother had dropped her guard and sacrificed her daughter. Herself a victim of subordination in her own tyrannical patriarchal family of origin, she was unable to resist being deceived once more by her husband's story. That story skillfully framed the man's behavior as part of a transcendent scheme. She was convinced, not just by him, but by the irresistible authenticating power that her culture grants those experiences. This authentication makes possible further coercion.

CONSENT PREVENTS AND CORRECTS MISUNDERSTANDINGS

What a therapist sees as coercive or non-coercive between a husband and wife from a different culture often leads to basic lessons for the therapist. The most basic one is on the significance of the therapist requesting permission before intervening. Such a move will tend to prevent misunderstanding.

At the end of a session with a couple, a therapist met a request from a wife. "Would you just tell him [husband] that in this country he should stop bossing me around in front of people." Apparently, she would not mind putting up with being ordered around by her husband in the tight patriarchal context of her country. Here in the States, already influenced by the liberated stance of women, she was beginning to object to such treatment. The therapist turned to the man. "I think she wants to ask you something. Can she?" Then, quickly, back to the woman, "You tell

him." The wife went ahead and expressed her request in no uncertain terms as the session ended.

Professionals from Central America, watching this therapy through a one-way mirror, were upset. For most of them, the therapist had "overstepped" the lines of the culture. They jumped on the therapist. The therapist defended himself. "By returning the question to her, I was facilitating her own revolt against the practices of her culture." They did not let him get away with this. "You were disrespectful of the culture. You pitted yourself against what these people have decided the relationship between a man and a woman should be. You invited her to fight him just by the act of allocating as much concern to her as to him all throughout the session." The therapist replied, "This woman felt it was no longer her role to accept coercion from her husband. She would have been able to put up with him had he been more considerate of her in other life areas."

To guide the therapist's understanding of the culture, the couple was consulted. The man was asked, "How did you feel about how I handled her request?" He answered, "I was glad that you asked first for my permission for her to talk against me. It is the custom for the woman to go through the man . . . She embarrassed me in front of you, just like I embarrassed her in front of her American friends. You wanted her to attack me, but you still treated me as the head of this family." The woman, too, was debriefed. She smiled, Thank you He is still doing it, but he is doing it less."

GUIDANCE FROM THE FAMILY FOR THERAPIST MODIFICATION

The importance of such efforts to let the participants guide the therapist through the culture cannot be overrated as a way of preventing misunderstanding and expanding the therapist (Montalvo & Guiterrez, 1983).

A pediatrician visiting Puerto Rico in the early 1950s was invited to attend a baby's wake. A "baquine" was going on. He saw family and relatives of the baby not crying, but drinking and laughing while the infant lay on top of the table with ice around him. He was shaken by this image which has all but disappeared from the experience of poor Black families in certain coastal areas of the island. Trying not to misunderstand these Puerto Rican families and judge them as being unfeeling to a child's death, he searched for the underlying view of the world organizing their experience. He turned for guidance to the infant's grandfather who explained "We don't cry because our tears would wet the little angel's wings. If the angel's wings get wet the soul of the baby can't fly to heaven. What's there to cry about anyway? By having an early death he didn't have to go through this valley of tears." Through the "baquine," the family was upholding a coping stance that helped to face its dismal existence, strengthening itself to deal with more hardships to come. "Though in grief, let us be happy that at least one of us was saved from pain." By seeing the family's wish to relate to the good fortune within the misfortune, the doctor not only avoided a misunderstanding of the culture but gained an appreciation of its strength by grasping its priorities.

Any misunderstanding about the priorities organizing and justifying the persons in their culture provides an opportunity to learn not only about that culture but also about our own prejudices. This revelation of prejudice can happen in therapy or outside of therapy.

Right after the first anti-AIDS TV commercials hit the streets, the following racist story emerged in New York. Five Puerto Rican addicts are in an alleyway passing their needle around getting ready to shoot up into their veins. Right in the middle of this process they arc interrupted by one who arrives late. "What are you guys doing? Don't you watch TV? The stuff gives you AIDS man." One of them looks up reassuringly "There's nothing to worry about. We're all wearing condoms."

This is an ignorant attack against the underprivileged. These Puerto Ricans are dumb. They do not understand what is going on in the world. The story laughs at Puerto Ricans instead of with them but it also manages to criticize the gap between the poor's subculture and the ruling middle-class establishment. That establishment spent large sums of money to educate the community to lessen the chances of AIDS, but failed to target the use of needles, the main source of contamination among the large populations of lower-class Blacks and Hispanics. Those first self-serving commercials emphasizing only the middle-class worry about "safe sex " have given way to more culturally encompassing materials avoiding

intercultural misunderstanding.[1]

Cultural misunderstandings happen all the time. They are caused by our "knowledge" or wrong expectations about who or what is included in a culture and what that culture means by this or that behavior. Such wrong expectations are often corrected by openness to experiences that promote modification of the therapist's prejudices.

In a shopping mall a therapist saw an ex-patient coming towards him. This woman had become a single parent through divorce, slipping as do many from a fairly comfortable working-class status into poverty. She was finally emerging from eight years of being trapped as a member of the permanent underclass and was now a computer programming student. As she approached him, he reflected on how he had helped her years ago. He would not put up with her feeling sorry for herself. He had told her that. When she complained bitterly he had confronted her pushing her to work seriously on her recovery. He was glad he did not indulge her needs for dependence. To have done so would have been a disservice to her. She looked good now.

She interrupted his thoughts curtly, "Do you remember me? Yes, I do," he answered expecting a friendlier greeting. "You know, I always wanted to tell you something. You never gave me a break, you know that? You never understood what I was going through with the kids and no job. You thought it was me, not what I was going through." "Well, I'm sorry, but maybe my lack of pity did help you. I wanted you to take charge of your life," said the therapist. She replied, "But you wanted me to do it when I couldn't, and it would have helped if you would have understood that. I'm glad I moved on and found another therapist." She turned and walked away, leaving the therapist with a disturbing vision.

Defeated, the therapist thought perhaps he had misunderstood the priority needs of this ingrate. Next, he saw one of his poor clients, a jobless man, and was surprised to hear himself commiserating more and fearing less the effects of his sympathy. He listened to the man holding himself together by externalizing, blaming the system and this time, he challenged nothing. He found himself reassessing even his campaign against those whom he thought were patronizing and condescending to the poor. Perhaps he was against those do-gooders who display compassion not just because they robbed the poor's autonomy, but because they made him feel unkind or uncaring. Overly conscious of how often throughout history people have co-opted and exploited others in the name of compassion, he had too effectively concealed his own empathy.

UNCOVERING STEREOTYPES

Catching our moments of misunderstanding remains a time-honored way of discovering preconceptions and stereotypes, a first step lo improving our interventions.

Dr. A. faced a hyperanxious Rastafarian man who appeared under enormous pressure to get across his problem. His accent made him hard to understand. To get within this man's culture and grasp his complaint, Dr. A. rushed in, "You mean pills?" What the man said he thought, must have been "pills." Some Rastafarians in the big city push pot and pills. The man shouted back, "No man I mean bills, bills!" The man was under pressure to pay bills, nor to pay for pills. The embarrassed feeling arising in this therapist, who quickly corrected himself, was no different from the one of the lawyer in the next story.

A Puerto Rican lawyer attended a meeting called by the City Hall for all the town's minorities. Koreans, Vietnamese, Blacks, and Hispanics were represented. The discussion centered on their difficulty as minorities in obtaining small business loans from the local banks. Angered by a perceived unfairness, the lawyer complained, "The city must be making it easier for banks to give loans to the most recent arrivals, the 'boat people.' Yet we Hispanics have been here forever, but cannot get loans!" The Vietnamese man jumped in, "We have our own banking system, we don't get no loans from no city." The embarrassed lawyer learned that this new minority had arrived with a well-developed tradition for sharing in banking co-ops, which evolved long ago in fishing villages of Vietnam.

A Navajo mother and her son, who had several DWI arrests, were asked, "Why does he keep doing it?" Rubbing his shirt sleeve, the mother replied, "See this? His father and friends are like that too. Thirty five degrees, and they go outside in light cotton shirts and no coats." As if on cue, the young man

started bragging about drinking from nine to four while driving his pick-up truck with friends. By following the content of their English, the therapist misunderstood this mother and son as tangential and enigmatic (following the stereotype that Indians are enigmatic). Reconsidering the sequence of the discussion, not just its content, the therapist dropped his preconception and recovered a message. To withstand excessive cold is the equivalent of withstanding excessive drinking. The mother was conveying that the males had conned themselves into believing that by binging on liquor without complaining they were being "good Indians," stoic Indians. They had twisted a wonderful ancestral value, stoicism, which helped their people bounce back from personal loss and adversity, into one more rationalization for alcohol abuse.

By establishing contrasts between our stereotypes and the real world, we get some of the most revealing lessons about a culture. Take the situation of Mercedes, a South American woman who in her seventies visited the prosperous United States for the first time. Observing in amazement everything around lower Manhattan, she turned to her daughter and whispered, "See that man there? He sells newspapers, yet look how well dressed he is!" The man, a Wall Street broker in a three piece suit, was carrying the Sunday New York Times under his arm. Therapists are not far from Mercedes when it comes to how they get into misunderstandings.

NOTE

1. To supplement interculturally encompassing materials, the development of subculture-specific products has emerged. See "Ojos Que No Ven" (Eyes That Fail to See), an educational video available from the Latino AIDS Project (415) 647-4141.

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Movilización de la familia: el trabajo con parejas de edad avanzada que mantienen una relación conflictiva*

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Cuando los integrantes de parejas de edad avanzada que mantienen una relación conflictiva tienen dificultades para cuidarse uno al otro, se reduce la capacidad de cada uno para atender los problemas de salad de su cónyuge, y esto lleva a movilizar a la familia. En este articulo se presentan una serie de preguntas para examinar cuatro pautas de movilización familiar: la mediación positiva, la imposibilidad de desenredarse, la participación intermitente y la fijación defensiva de caminos paralelos. Según la impresión clínica de los autores, estas pautas suelen estar asociadas a los problemas que presenta el control de la salud de dichas parejas.

A partir de breves estudios de casos, se describen diversos enfoques destinados a ayudara estas parejas tanto en lo relativo al control de su salad como a sus interacciones maritales conflictivas en los períodos en que declina su salud. Se delinea un procedimiento para la fijación deliberada de caminos paralelos al trabajar con parejas que exhiben acuerdos interpersonales particularmente rígidos. Basándose en el estudio de las pautas mencionadas se extraen algunas conclusiones vinculadas con la formación de los terapeutas.

Introducción

El sentimiento de continuidad posee una importancia fundamental en la edad avanzada, y autores como Atchely (2) y Becker (ó) se la han concedido merecidamente. Sin embargo, las espléndidas teorías de estos autores resultan limitadas por el hecho de que restringen ese sentimiento de continuidad a un suceso perceptual personal desvinculado de su contexto familiar y social inmediato. Estas teorías suelen impartir un matiz incidental a las actividades interpersonales a través de las cuales un cónyuge, sus contemporáneos o la familia mantienen, sustentan, restauran o disocian aún más el sentimiento de continuidad de la persona. Dicho sentimiento es considerado fundamentalmente como un producto "Psico-lógico" intrapersonal, el cual tendría apenas tenues vínculos con los amplios factores sistémico-sociales (la pareja, la familia y el contexto de pares) que contribuyen a corregirlo, extenderlo o mantener su vigencia.

Esta concepción subestima la importancia de la participación de las personas encargadas de atender o cuidar al anciano [*care givers*], así como la de los aspectos sociales de la geriatría (4). Además, relega al "trasfondo" el "suprasistema" compuesto por el cónyuge y el resto de la familia, o sea, todos aquellos que en su calidad de acompañantes se movilizan a fin de subsanar las pérdidas, aminorar sus efectos y ofrecer consuelo por ellas, y reestructurar todo el mundo del anciano para que recobre alguna semejanza con lo que fue antes del episodio de la enfermedad aguda (7). Es precisamente ese "tras fondo" coevolutivo el que pasa a primer plano cuando se quiebra la continuidad. Las personas que están en ese "trasfondo" ayudan al anciano a restaurar las

* Publicado en *Contemporary Family Therapy,* vol. 20, No. 2, junio de 1998, págs. 163-79. La traducción es de Leandro Wolfson.

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prácticas de control y mantenimiento de la salud que son esenciales para rescatar en lo posible su calidad de vida y permitir su supervivencia.

En lo que sigue examinaremos la movilización del cónyuge y la familia como factores de interés decisivo para los prestadores de servicios profesionales que deben atender en primer lugar a estas parejas (34, 36). En los estudios de casos se atenderá a las diversas actividades de movilización familiar, que incluyen los esfuerzos realizados por el cónyuge y la familia para detener la experiencia de discontinuidad del anciano, retardarla, compensarla o subsanarla, y que a veces, lamentablemente, la mantienen o incrementan.

De ordinario, el cúmulo de las conductas de control de-la salud organizan los pequeños episodios de la vida que evitan trastornos y resguardan a la larga la salud y la continuidad (12, 15, 25, 40). Observando los cambios que se producen en tales conductas, el profesional descubre las nuevas erosiones de la autonomía que se generan en cada cónyuge. Los ajustes ante este deterioro ponen de relieve la flexibilidad o inflexibilidad de los limites que separan a la pareja de los demás miembros de la familia. Esos límites interpersonales con la familia inmediata deben ser lo bastante flexibles como para permitir que los hermanos o hijos adultos intervengan y ayuden a la pareja en los períodos en que su salud decae. Gracias al reemplazo o redistribución de los cuidados, los hermanos, hijos u otros familiares de la pareja, así como sus pares extrafamiliares, pueden a me

nudo descartar o postergar la necesidad de una internación en un geriátrico u hospital. Las consecuencias, en lo que respecta a reducir el padecimiento humano de estas personas ancianas, mantener su funcionamiento y disminuir los costos de la atención de su salud, son considerables.

Resulta claro que el conocimiento de las dificultades probables que pueden enfrentar las parejas de edad avanzada con relación conflictiva en ciertos momentos de su ciclo vital (cuando suelen desencadenarse estados demenciales y otras enfermedades) es muy útil para el desarrollo de modelos de prevención, pero el fruto de tales conocimientos no es tan claro para el profesional que debe ayudar a manejar dichos problemas una vez que se presentan. El paradigma teórico dotado de valor práctico para el proveedor de servicios terapéuticos no puede derivar exclusivamente de la comprensión de la personalidad de cada cónyuge y la etapa que está atravesando la pareja en su ciclo vital, como tampoco exclusivamente de la comprensión de la evolución que han tenido la comunicación de la pareja y sus conflictos conyugales. El paradigma requiere una apreciación integral de cómo interactúan todos esos procesos con los "sucesos en materia de salud", biológicos y entrópicos, que obligan a introducir grandes cambios en toda la estructura de la familia. Como respuesta ante la reestructuración obligada de la familia que se produce a raíz de una enfermedad, pérdida de función o ambas cosas, o con posterioridad a estos acontecimientos, tienen lugar cambios en la comunicación y en la fenomenología de cada cónyuge anciano.

Para el profesional, la concepción del sistema familiar más útil para una terapia que se inclina a la reorganización estructural es la proveniente de las ideas sobre los subsistemas de Talcott Parsons (32) y no la basada en las nociones sobre el ciclo evolutivo. Parsons consideraba la pareja y la familia como subsistemas que tenían rasgos sistémicos propios pero no podían funcionar de manera independiente. Esta noción evita la actual tendencia prevaleciente en terapia familiar a tratar a la pareja, la familia o ambas como entidades casi cerradas, Permanentes y autónomas, cuyas enigmáticas comunicaciones y conflictos intrasistémicos el profesional bebería abordar para mantener intacto cada sistema (42). En la concepción de Parsons, el énfasis se desplaza de los problemas intrasistémicos de la pareja a los creados por su interdepedencia con otras personas externas a ella. La prioridad para el profesional consiste en identificar y facilitar una movilización familiar que, por su magnitud y calidad, aminore o resuelva las dificultades generadas por la quiebra del control de la salud en la pareja. El foco está puesto en influir en cualquier proceso de mantenimiento o eliminación de limites que permita lograr un nuevo equilibrio entre la pareja y quienes la rodean, con el objeto de resguardar o restaurar su salud.

Las patologías geriátricas y psiquiátricas individuales se examinan en función de las extraordinarias demandas que plantean para la reorganización del campo interpersonal.

Estas ideas han sido captadas por modelos del estrés familiar como los de Pearlin, Menaghan,

Liberman y Mullan (33). Su marco teórico atiende a "la aparición de sucesos vitales aislados que convergen con la presencia de problemas (tensiones) relativamente permanentes". Conceptos similares encontramos en la teoría de las oscilaciones de Breunlin (10), en la que se observa la interacción de los sucesos causantes de oscilaciones (v. gr., la pérdida de la audición o un accidente cerebrovascular) y los problemas o conflictos conyugales crónicos que han persistido a lo largo del tiempo.

Evaluación preliminar de la movilización familiar

Las preguntas incluidas en el Cuadro 1 como herramientas cualitativas exploratorias reflejan las ideas que acabamos de enunciar. Aunque no son aplicables a todas las parejas ancianas que enfrentan un colapso en el control de su salud, sirven para iniciar la evaluación de si dicho colapso efectivamente moviliza o no a la familia. Estas preguntas ponen de manifiesto los sesgos epistemológicos prácticos de un tipo particular de sistema de observación e intervención (3). Ayudan a verificar principalmente los elementos de interés que presenta la situación de la pareja y la familia para el profesional centrado en la reorganización de las relaciones interpersonales, o sea, lo que necesita saber para actuar con eficacia cuando la organización del control de la salud de la pareja corre peligro y exige una mayor participación familiar.

En los estudios de casos que siguen, se indica en los subtítulos el nivel, calidad y magnitud de la movilización familiar. En ausencia de datos formalmente cuantificados que pudieran sugerir lo contrario, debe partirse de la base de que estos casos son típicos y no presentan características especiales en cuanto a las pautas familiares ni en lo tocante a su manejo clínico correcto o incorrecto en el marco particular en que fueron atendidos: el de una clínica geriátrica.

Caso 1: Movilización familiar eficaz *(mediación positiva)*

Cuando el control de la salud por los cónyuges está gravemente comprometido, es fundamental que intervenga la generación más joven. No obstante, la intervención de los hijos tal vez exija el acicate y la orquestación de un hermano de uno de los cónyuges, como demuestra el siguiente caso.

La Sra. C había sido objeto de maltrato emocional por su marido durante años, y lo que la salvó, literalmente, fue la oportuna intervención de su hermana. La relación entre los esposos era tan mala que estando el Sr. C en su lecho de muerte, cuando su esposa se sentaba junto a él el Sr C desviaba la mirada. En sus últimos días, el Sr. C sólo permitió que ingresaran a su cuarto sus hijos, que habían hecho causa común con el padre y rechazado a la madre. Poco después del fallecimiento de su marido, la Sra. C se sentía culpable, totalmente desplazada y rechazada por sus hijos. Al año de quedar viuda, también murió su madre. Nunca había contado con la ayuda de su esposo para atender a su propia salud, y ahora, tras la muerte de su ma-

Cuadro 1. Preguntas básicas para la evaluación

1. En caso de convocarse a los hermanos o hijos adultos de la pareja, ¿se movilizan en forma rápida y prudente, reorganizando sus propias conductas y limites según las nuevas necesidades de aquella? ¿Pueden mediar de manera positiva entre los cónyuges? ¿Saben cuándo corresponde que sigan interviniendo y cuándo deben dar un paso atrás?

2 Si uno de los cónyuges asume la responsabilidad por el control personal de la salud del otro y se convoca a la siguiente generación, ¿genera este proceso un enredo permanente (una sobrecarga) de los hijos adultos? ¿Estos enredos crean un peligro para todos los involucrados?

3. Los problemas de control de la salud, ¿se dan en un marco de buena o mala disposición recíproca de los cónyuges a largo plazo? ¿Relata la pareja o la familia una historia de armonía conyugal o de peleas? En la terapia, ¿resuelven los miembros de la pareja negociar o esforzarse por solucionar sus conflictos, o bien se distancian y se evitan aún más uno al otro (mantenimiento de los limites)?

dre y el alejamiento de sus hijos, incluso su escaso autocontrol sufrió un colapso. Volvió a tener los mismos problemas de antes y fue necesaria una intervención quirúrgica; y luego de una complicada y difícil convalecencia se sintió efectivamente aislada. Sus hijos no venían a visitarla porque estaban peleandos entre si, y para no molestarse unos a otros resolvieron apartarse asimismo de la madre.

En el momento en que más le urgía recibir ayuda, enfrentando a la vez sus dolencias físicas y sus pérdidas psicológicas, la Sra. C se quedó sola, hasta que vino en su auxilio una hermana. Preocupada por reinstaurar el control de la salud de la Sra. C, la hermana consultó a otros médicos. Verificó, por ejemplo, si era apropiado que la Sra. C tomase Syntroid para los problemas de su tiroides, y analizó nuevas opciones para la diabetes insuficientemente controlada de la Sra. C. Gracias a la intervención de la hermana, los profesionales descubrieron que la Sra C había estado tomando medicamentos equivocados o en dosis excesivas. Estos problemas se corrigieron.

Luego la hermana actuó como "mediadora positiva" a fin de restablecer el lazo de la Sra. C con sus hijos, y a la postre logró incorporarlos a una terapia familiar. Le dijo a la Sra. C que podría invitarlos a cenar en forma separada, a fin de evitar los conflictos entre los hermanos. Habló personalmente con cada uno como tía preocupada y les subrayó la importancia de apuntalar emocionalmente a su madre. Les señaló que ésta no quería molestarlos, ni siquiera había querido crearle dificultades a su propia hermana. Les advirtió: "Lo único que tal vez desee la madre de ustedes es abandonarse, deprimirse cada vez más y morirse". Los hijos respondieron a la eficaz convocatoria de la tía reuniéndose en torno de la madre.

En las tres semanas siguientes la Sra. C aumento cinco kilos; a medida que sus hijos la visitaron para cenar juntos fue creciendo su alegría y esperanza, y estableció con ellos un vinculo positivo para reparar la relación. Más tarde se le declaró una insuficiencia renal, pero en esta ocasión contó con el creciente apoyo de sus hijos, quienes hacían todo lo posible por ir a visitarla y cuando estaban junto a ella contenían su despliegue de rivalidades. Aunque años atrás se habían puesto del lado del padre y contra ella, ahora la apoyaban procurando compensar el rechazo que le había manifestado su marido cuando estaba moribundo.

La hermana orquestó hasta el final el apoyo de la familia. La ayuda de esta hermana, sumada a los recursos espirituales de la Sra. C. (tenía el intenso sentimiento de estar bajo el amparo de su protectora y aliada, la Virgen de Guadalupe), colmó sus últimos días de vida con el cariño que le permitió irse de este mundo con dignidad.

Caso 2: Movilización peligrosa *(imposibilidad de desenredarse)*

A la cabeza de la lista de casos de parejas complicadas están aquellos en que uno de los cónyuges utiliza sus responsabilidades en el control de la salud del otro como excusa para incurrir en conductas defensivas y controladoras. Puede hacer caer a la generación más joven en la trampa de sustentar adaptaciones precarias del matrimonio de sus mayores, aumentando así de manera inconsciente el estrés o aun creando un peligro permanente.

Después de haber tenido un amorío extra-matrimonial unos años atrás, el Sr. X inició un proceso de lento deterioro. Perdió su empleo como técnico y administrador de un edificio y se volvió cada vez más maníaco, agresivo y capaz de chantajear a su esposa. Por ejemplo, en cierta oportunidad la Sra. X realizó un viaje muy postergado con el fin de visitar a una amiga que residía en un estado vecino. El marido la llamó por teléfono amenizándola con matar a la hija de ambos--quien en ese momento estaba en la casa con su bebé– si la esposa no regresaba de inmediato. La Sra. X sabia que podía llamar a su hija y decirle que se fuera de la casa con el bebé, frustrando así el chantaje emocional de su marido, pero se asustó y entró en un estado de confusión. Temerosa de que su marido se quitase la vida, se apresuró a volver para salvarlo. Este episodio pareció situar al Sr. X en una posición de extraordinario poder, reforzando su convicción de que era capaz de controlar a cualquiera mediante la intimidación.

En otra ocasión en que el Sr. X amenazó a su mujer con un cuchillo, ésto finalmente solicitó ayuda acompañada por su nuera y su madre. Por fortuna, el hijo mayor de la pareja llegó a tiempo para calmar al padre y persuadirlo de que dejara el cuchillo.

El Sr. X había manifestado durante mucho tiempo estallidos de conducta violenta y amenazadora, pero su esposa siempre lo defendía. "Bueno –decía ella–, tal vez eso sucedió por que no tomó sus medi-

camentos". La Sra. X pensaba que la culpa la tenía ella y que si hubiera cuidado mejor la salud de su esposo el incidente no habría acontecido. Afirmaba que su amor por él se había extinguido años atrás, cuando le confesó su amorío, pero se sentía atada a él y en ese momento había llegado a confiar en las maniobras de rescate de la familia, principalmente de su hijo. Los profesionales que intervinieron consideraron la posibilidad de que el Sr. X fuese un psicótico bipolar o de que su conducta estuviera impulsada por alguna otra dolencia aguda no diagnosticada. Dijeron que era urgente someterlo a evaluaciones biomédicas y psicosociales, y que debía ser traído a la terapia. Instaron a la Sra. X a no correr riesgos y a estar preparada para solicitar ayuda telefónica urgente en caso necesario.

Con el correr del tiempo, respaldada por la indebida involucración y el enredo de sus hijos adultos, esta pareja quedó encerrada en sus precarias adaptaciones. La intervención frecuente de los hijos era la única válvula de seguridad para desmantelar las recurrentes situaciones peligrosas. Según el último informe que se obtuvo, esta familia seguía igual, congelada en esa dinámica peligrosa y yendo y viniendo continuamente de un servicio psiquiátrico a una clínica geriátrica. Los problemas iatrogénicos generados por la colaboración indispensable entre los distintos organismos complicaron y anularon los esfuerzos realizados para estabilizar dicha situación.

Caso 3: Rápida movilización familiar *(participación intermitente)*

El esquema predominante en nuestra cultura en cuanto a cuál de los cónyuges debe vigilar en forma más activa las conductas vinculadas con el cuidado de la salud dictamina, en general, que lo haga la esposa y que el marido sólo intervenga más pasivamente cuando es absolutamente imprescindible. Si el marido no está preparado para asumir un papel más amplio cuando se enferma su mujer, las consecuencias pueden ser catastróficas. En el siguiente caso, la esposa había soportado la carga de la mayor actividad durante años y su marido no pudo ajustarse al cambio.

La Sra. R resumió así su situación en la primera visita que le hizo a los profesionales: "Me golpeó porque la roca que lo sostenía desapareció. Se refería a que ella era "la roca" sustentadora del matrimonio, la que siempre se habla ocupado de todo y de quien se suponía que "atendería el negocio" en todo momento. Pero ella se estaba volviendo sorda y había comenzado a presentar síntomas del mal de Parkinson. Ya no era capaz de cumplir su antiguo rol estabilizador como cuidadora principal de su marido.

El Sr. R no sabía ayudarla con eficacia en su decadencia. Por ejemplo, trataba de evitar que su mujer chocase con objetos cuando caminaba, pese a lo cual ella tropezaba por las maniobras a que la obligaba su marcha inestable. Cuando eso sucedía, él reaccionaba con ira. Por más que el Sr. R trataba desesperadamente de ayudarla, un día el problema lo superó: "reaccionó y le dio un golpe.

También el Sr. R se estaba volviendo sordo. Antes nunca había actuado con violencia, pero su mundo cambiaba velozmente; siempre había vivido en un sistema en el que no le tocaba a él dar apoyo y estar disponible. Su esposa le perdonó esa momentánea pérdida de control, pero antes le comunicó a su médico lo que pasaba. La comunicación de este incipiente problema por parte de la Sra. R. permitió que el terapeuta familiar y el asistente social movilizaran a la hija de la pareja.

El Sr. R no sólo privó a su esposa de todo apoyo emocional e instrumental sino que, sintiéndose amenazado, aceleró sin quererlo el avance de los problemas de salud de ella mostrándose crítico y agresivo. Afortunadamente cuando los profesionales recurrieron a la hija, ésta respondió de inmediato con una actitud equitativa y se involucró más que antes en la vida de sus padres. Defendió a la madre y la ayudó a que retomara su concurrencia a un natatorio cubierto, al que la Sra. X había dejado de asistir cuando comenzó con sus temblores y dificultades de locomoción. Además, la hija colaboró para que el padre pudiera concretar su deseo de volver a hacer gimnasia y tuviera más "oportunidades para salir" en lugar de quedarse en la casa todo el tiempo "vigilándola" a la esposa, como él lo dijo. No obstante, la hija no se enredó en la situación. Sabia cuándo debía intervenir y cuándo tenía que retirarse rápidamente.

La colaboración de la hija fue eficaz por dos motivos: 1) contó con el respaldo de su marido; y 2) su ayuda estuvo dirigida a una pareja, la de sus padres, que tenían suficientes "ahorros emocionales en común" o reciprocidad positiva (9). Vale decir, a través

de gran cantidad de años de una relación satisfactoria la pareja había acumulado un grado suficiente de buena voluntad recíproca como para poder, con un poco de ayuda de su hija adulta, poner freno a la violencia incipiente antes de que ésta dañara más la amistad que había entre ambos y el cariño que se tenían. Parece que no se puede sobrestimar la importancia que tiene una relación marital bastante satisfactoria y continua. Fue esto, junto con la intervención de la hija lo que protegió a esta pareja de los efectos negativos de los agudos problemas provocados por la pérdida de audición y por la enfermedad de Parkinson

Caso 4: Dificultades para la movilización familiar *(fijación defensiva de caminos paralelos)*

El Sr. H, profesor universitario, cayó en una grave depresión luego de haber sufrido una apoplejía. Insistía en que estaba "acabado", que no podía hacer nada más en la vida. Rechazaba molesto todos los esfuerzos realizados por su mujer para consolarlo y ayudarlo. Aunque seguía siendo físicamente apto se rehusaba ocuparse de su cuidado personal y no hacia nada para recobrar la salud y la autosuficiencia. Esta actitud enfurecía aún más a su esposa, que ya estaba bastante enojada con él. Ella se sentía esclavizada y él se sentía forzado por ella. La Sra. H se había convertido en un "paciente oculto" (18, 21).

Los profesionales pronto descubrieron que durante años se habían traumatizado mutuamente. Por mucho tiempo mantuvieron una relación en la que se evitaban uno al otro, pero después de la apoplejía la esposa sintió que la tensión ya era abrumadora y buscó apoyo emocional reuniéndose con su grupo de cuidadores. También se intentó trabajar conjuntamente con la pareja, con lo que se logró que la Sra. H hiciera planes infructuosos de ayudar a su marido en la redacción de un libro. El Sr. H tenía que ocuparse de su cuidado personal, pero se resistía. No era posible llevar demasiado lejos algún contrato de cambio o negociación en la pareja sin que prevaleciese el rencor mutuo. Más aún, cualquier esfuerzo deliberado por hallar posibilidades de colaboración entre ellos parecía hacerlos retroceder, generándoles angustia, sentimientos de fracaso y hasta el temor de volver a ser traumatizados. Para complicar más las cosas, la medicación antidepresiva que estaba tomando el Sr. H. no parecía ser la indicada para ayudar a resolver sus antiguos problemas maritales.

Los prestadores de servicios psicosociales cambiaron de táctica y alentaron a la mujer a que iniciara actividades que en el pasado habían aliviado las tensiones conyugales. Ella encontraba un respiro realizando excursiones y paseos, y los profesionales facilitaron que pudiera realizarlos.

Mientras se esperaba que la medicación tomada por el Sr. H hiciera efecto, se le cuestionó cordialmente su convicción de que estaba "acabado". Una consulta con su médico permitió establecer que el nivel de incapacidad que él siempre había sostenido tener no era ratificado por su desempeño cognitivo. Pese a su depresión, podía formular enunciados con claridad y expresarse con largas frases cargadas de sentido, sin manifestar tensión. En lo tocante a su raciocinio su discapacidad no era tan grave como él la sentía. Podía pensar y escribir bien, aunque más lentamente que antes. Tampoco estaba aislado: seguía suscitando la admiración de los estudiantes avanzados que acudían a él para pedirte consejos, haciéndolo sentirse importante.

La depresión del Sr. H no sólo había sido poderosamente alimentada por el episodio agudo de su apoplejía y la consecuente pérdida de funciones, sino que provenía también de una historia de enojos con su mujer (4). En el pasado había habido entre ellos hechos de violencia. En una oportunidad ella se encerró en un cuarto y él tomó un hacha decidido a echar la puerta abajo. Era fácil comprender que la Sra. H estuviera aterrada de su marido.

En esta pareja los terapeutas encontraron escasos "ahorros emocionales en común"; eran pocas las experiencias de colaboración positiva entre ellos y ya no se podían fomentar sentimientos de buena voluntad recíproca. Sus recuerdos gratificantes de su vida juntos eran escasos y no quedaban rastros constructivos de los años de buena convivencia; sólo existía la huella difusa de un sentimiento de apego (13).

Los terapeutas se propusieron disminuir la hostilidad de la pareja restableciendo su capacidad de andar por "caminos paralelos" de llevar vidas separadas. Su intención era apuntalar los limites individuales de cada cónyuge. Entretanto, a medida que se restauraban tales limites, los estimularon a que buscaran apoyo entre sus familiares u otras per-

sonas que pudieran atenderlos y ayudarlos, pero cuidando de no bloquear agresivamente ningún momento de encuentro "accidental".

En el Cuadro 2 se presenta este método de último recurso para la fijación deliberada de caminos paralelos. Se trata del procedimiento establecido por Rhyne para las parejas que se encuentran en un acuerdo interpersonal inflexible de caminos paralelos defensivos (30). El método funciona mejor si los profesionales utilizan la información inicial que les dan los cónyuges acerca los familiares que los a tienden y cuidan y sobre el nivel actual de sus tensiones (etapa 8). Esto los orientará para conducir a la pareja por el procedimiento de los caminos paralelos (etapas 1-7). Estas ocho etapas no constituyen necesariamente un proceso lineal. A fin de favorecer la colaboración en lugar de provocar resistencia, el profesional debe percibir de entrada, con la mayor exactitud posible, las posibilidades que existen o no existen para reorganizar a la familia. Son los profesionales quienes, con el consentimiento de la pareja, facilitan la redistribución de tareas entre la familia a fin de que ésta ayude a los ancianos en el control de su salud.

Cuadro 2. El procedimiento de los caminos paralelos de Rhyne

1. Desestimar que una depresión generalizada sea la causa fundamental de la conducta de uno de los cónyuges o de ambos.
2. Observar un breve ensayo de intentos fallidos de resolución de los conflictos.
3. Observar un breve ensayo de intentos fallidos de "renovación" de la amistad entre los cónyuges.
4. Observar qué sucede durante el distanciamiento o gradual alejamiento entre los cónyuges
5. Establecer si luego de desvincularse uno del otro la reacción que ambos tienen es de alivio.
6. Apoyar la mediación de los hermanos o hijos.
7. Desalentar toda reconciliación prematura, sin por ello bloquear agresivamente que de tanto en tanto mantengan un "contacto básico".
8. Atender a las necesidades emocionales de los hermanos o hijos adultos que actúan como mediadores.

Casos como los del Sr. y la Sra. H demuestran que la salud de una pareja entraña su vigilancia recíproca del cambio de estado de ánimo y de nivel de estrés del otro, en particular, así como de su ira y otras emociones.

En esta ocasión, los profesionales facilitaron que el Sr. H volviera a ponerse en contacto con sus libros y sus alumnos, y que su mujer retomase sus paseos y excursiones en comunión con la naturaleza y buscase apoyo en su grupo de acompañantes. Como en el caso anterior, la transferencia de las conductas de control de la salud de uno de los cónyuges a un miembro de la siguiente generación fue un proceso necesario y casi natural.

Intervino un hijo que se hizo cargo de la situación. Se llevó al padre con él a viajar y dejó a la madre a cargo de su casa y de su perro. Ambos sintieron un alivio. Al igual que los clínicos este hijo pensaba que la única manera de **evita**r males mayores era simplemente respetar el deseo de los cónyuges de separarse y avalar una situación en la que pudieran tener escapes intermitentes. Estos escapes parecían ofrecer a los cónyuges un sentimiento de control sobre sus conductas de distanciamiento defensivo, permitiéndoles modular hasta qué punto podían distanciarse o aproximarse al par que mantenían el sentido de continuidad de la relación que su actual grado de conflicto hacia posible (37).

La relación de esta pareja parecía agotada; les quedaban muy pocas reservas emocionales. La esposa se había retirado de una terapia de pareja pero mostró gran fidelidad a su propio camino, el del

grupo de apoyo de sus acompañantes, con el que había empezado a trabajar antes de iniciar la terapia de pareja. Retornó a ese grupo y extrajo de él una buena orientación y apoyo emocional para su salud. Se sentía una víctima de su marido y pensaba que no debía abandonarlo, ya que se había hecho acreedora a alguna reparación económica por los cuarenta años de "esclavitud" que habla pasado con él. Aunque poseía algún dinero propio, a menudo se percibía a si misma como si "no tuviera nada y estuviese en peligro porque él podría "quitárselo todo". El grupo de sus acompañantes la escuchó con todo respeto pero le indicó que aun así le quedaban otras opciones.

El terapeuta familiar y el asistente social siguieron estimulando a la pareja para que continuase por caminos separados; los alentaron a ambos para que por separado buscaran amparo visitando a sus hijos y amigos. Les sugirieron que estas visitas fuesen cada vez más prolongadas y que los numerosos momentos en que la vida de uno se superponga con la del otro fueran lo bastante breves como para impedir toda ulterior violencia y depresión. Los objetivos perseguidos eran simples: reducir el grado, frecuencia y duración de los conflictos hasta que ambos estuviesen firmemente arraigados en sus respectivos caminos.

El marido dejó al psiquiatra con el que se atendía cuando éste le inquirió amablemente acerca de la posibilidad de que tuviese una conducta suicida u homicida, y buscó un nuevo psiquiatra. Por su parte, la esposa intensificó sus lazos con el grupo de apoyo. Empezó a acicalarse más y pareció más capaz de cuidarse sola. En un momento ella dijo: "Tal vez mi marido y yo deberíamos separarnos del todo". Lo intentó, aunque a la larga él quiso que ella volviese junto a él y ella lo hizo.

En la sesión de seguimiento, la Sra. H informó que se había quebrado la cadera. En esa coyuntura, los integrantes de su grupo de apoyo pensaron que el marido le brindaría más atención y estaría más atento a las necesidades de ella, pero la preocupación principal que él manifestó fue: "?Y ahora quién va a despertarme a la mañana?" Por suerte, el grupo de acompañantes rápidamente se congregó en torno de la Sra. H brindándole en ese periodo de tensión un grado excepcional de cariño, cuidado y apoyo confiable (21, 39).

Un último recurso: el método de los caminos paralelos

Hay parejas mayores con relaciones conflictivas que parecen beneficiarse más que otras si los profesionales emplean el método de los "caminos paralelos" de Rhyne. Son aquellas a las que les viene bien el lento proceso de "alejamiento" mutuo, pero siguen vinculadas en todos los otros aspectos psicológicos y sociales. O sea, a medida que un cónyuge se va distanciando gradualmente del otro, conserva su vinculación con sus allegados, sus hijos y las actividades que tienen interés para él. La teoría de la desvinculación ha sido rebatida pero resulta útil para que el profesional siga localizado en las personas y actividades concretas con las que está vinculado cada esposo (16).

Una forma de discernir si una pareja con depresiones interrelacionadas podría verse beneficiada por el método de los caminos paralelos es observar su reacción cuando se les permite apartarse uno del otro. Este alejamiento, ¿genera principalmente alivio o intentos de volver a reconectarse? Un breve ensayo del método debería traer un claro alivio a la pareja, sin que ninguno de ellos procure volver a la relación anterior. No hay efectos paradójicos, o sea, ninguno procura oponerse a la presunta dirección que se le ha fijado a la terapia mediante una tentativa de reconciliación. En otros términos, no puede invocarse ninguna tensión terapéutica, ya que la dinámica prevaleciente no consiste en la oposición a algún presunto intento del terapeuta de separar a los esposos. Haga lo que hiciera el terapeuta, ambos permanecen firmemente decididos a seguir en su oposición mutua. Este proceso se ve reforzado si existe entre los pares e hijos adultos la tácita resolución de no intervenir. (El proceso puede dar lugar a una lucha amarga y destructiva si los hijos adultos se alían con uno u otro de sus progenitores al mismo tiempo que presionan a ambos para que vuelvan a juntarse.)

Otra manera de determinar si la pareja requiere o no la fijación deliberada de caminos paralelos es investigando su capacidad de responder a breves gestiones dirigidas a la resolución del conflicto. La clave reside en saber si ambos son capaces de dejar de lado sus propios sentimientos durante un plazo suficientemente largo como para tratar de comprender el punto de vista del otro. Si no tienen "ahorros

emocionales en común", no existirá un remanente de buena voluntad recíproca sobre el cual basar la disposición a perdonar y a trabajar de consumo frente a la adversidad común. Los esposos se han lastimado el uno al otro tan profundamente en el pasado que no son capaces de liberarse de su dolor residual (41). En tales circunstancias, debe renunciarse a todo intento de reconciliación y emprender en cambio el método de los caminos paralelos a fin de impedir que se produzcan mayores daños emocionales y de promover su estabilidad y equilibrio.

Si uno de los esposos que está en conflicto con el otro necesita cuidados biomédicos casi continuos, el trabajo que se realice no puede estar dirigido únicamente al que presta los cuidados o al bienestar del enfermo, sino que debe atender al alivio y supervivencia del grupo familiar en su conjunto. El desafío, en el caso de muchas parejas conflictivas que padecen enfermedades, es de qué manera emplear los servicios de salud domiciliarios y los grupos de apoyo para la conservación y reabastecimiento de la energía de la pareja, la protección de los recursos emocionales antes de que prevalezca la tensión entre los acompañantes y de que tanto el cónyuge como el resto de su familia lleguen a un grado extremo de ira y de "agotamiento" (43). Por ejemplo, tareas como la supervisión de los análisis de sangre en una diabetes no controlada, la administración de complicadas combinaciones de medicamentos o de inyecciones endovenosas, o los cambios de catéteres, pueden ser demasiado para cualquier pareja familia. El profesional deberá centrarse en facilitar el establecimiento de coaliciones entre recursos externos como los servicios de salud domiciliarios y los miembros de la familia más próximos a la pareja, que permitan al grupo familiar en su totalidad soportar la situación.

Conclusiones

Muchas parejas, algunas de las cuales se encuentran en un periodo de deterioro de su salud, se las ingenian para vivir en forma independiente de sus hijos adultos y, en general, parecen felices con ellas mismas y con sus hijos (28). Sin embargo, hay una submuestra de parejas de edad avanzada que mantienen una relación conflictiva entre si, no son felices en su relación conyugal ni en la relación con sus hijos, y cuyas relaciones con la familia son una fuente de disturbios y tormentos (27). Entre ellas, algunas necesitan ayuda terapéutica para abrir el sistema formado por la pareja y hallar otros sistemas protectores con los cuales conectarse. La conexión social hace que la gente se mantenga dinámica, independientemente de variables como su estado de salud, su posición socioeconómica, su hábito de fumar o de beber, su obesidad, la actividad física que realiza y aun la frecuencia con que recurre a servicios de salud (5). A fin de serles de ayuda, los terapeutas deben saber cómo se crean, disocian y reparan las redes sociales alternativas, y cómo pueden establecer super-posiciones entre ellas.

La movilización de la familia es un modo muy natural de que las parejas ancianas conflictivas puedan seguir cumpliendo con funciones de control de la salud comprometidas, pero si los hermanos o hijos adultos sólo intervienen con renuencia y a regañadientes mientras los esposos mantienen su discordia, es casi inevitable que el resultado sea desfavorable. Las notables excepciones son aquellas parejas que, pese a estar desavenidas, se las ingenian para aliarse con sus pares y otras personas que los apoyen a fin de sostener o sustituir las funciones de control de la salud que normalmente cumple la familia. Estas alianzas generan redes de pares que tienden a preservar el grado de autonomía y funcionalidad que la pareja es capaz de alcanzar frente a las fuerzas que la erosionan. Estas parejas se beneficien con cierto grado de superposición de los sistemas asistenciales. Al pertenecer a distintas redes de grupos diversos, evitan verse obligadas a confiar totalmente en la movilización de su familia inmediata y ganan entereza (35).

En este articulo se ha descrito de qué manera los terapeutas pueden favorecer la movilización familiar promoviendo la "mediación positiva" de los hermanos, hijos adultos o pares de la pareja; asistiendo a ésta para el restablecimiento de los limites en el proceso de desvinculación de sus hijos indebidamente envolucrados; apoyando a la familia para que establezca una rápida y eficaz "movilización intermitente" con el objeto de manejar las crisis de breve duración; y aplicando, como último recurso, el matado de los "caminos paralelos" si la pareja y la familia no responden a los enfoques convencionales.

En lo tocante a la formación de los terapeutas, de lo anterior pueden extraerse los siguientes corolarios:

1. Hasta los terapeutas de orientación más individual deben ocuparse de los cataclismos estructurales y las consecuentes adaptaciones provocadas por el deterioro de la salud. Estas adaptaciones implican resistirse al énfasis puesto por la cultura en la independencia y la realización personal, aceptar que el cuidado de los padres forma parte de la función natural de las generaciones, así como la realidad de la interdependencia de los sistemas (11). "Cuando impera la fragilidad, la dependencia se vuelve adecuada, y uno no tiene otra opción que confiar en la compasión de los demás; entonces se sorprende permanentemente de la fidelidad con que son capaces de actuar ciertas personas que lo acompañan" (17).

2. 2. Los terapeutas y educadores deben reexaminar sus empeños por hacer confluir los aspectos biomédicos y psicológicos del cuidado en la formación de profesionales de la salud en general, y de la salud mental en particular (26, 38). Muchos profesionales de atención directa siguen empeñándose infructuosamente en integrar su interés habitual por la farmacología de las enfermedades coexistentes, la dinámica intrapersonal y los problemas de comunicación de la pareja, con los enfoques más con textuales, estratégicos y estructurales que se centran en facilitar el reordenamiento funcional de la familia en su totalidad (8, 22, 29).

3. Los terapeutas deben dar prioridad al mejoramiento de sus propios sistemas fragmentarios y mal coordinados de atención multidisciplinaria. Estos sistemas no tienen un buen manejo de los casos que incluyan complicaciones biomédicas y psiquiátricas sumadas a familias resistentes al cambio (como el Caso 3). Movidos por diferentes ideologías, estos sistemas terminan provocando daños iatrogénicos en el paciente y agotando a los profesionales.

4. Los terapeutas deben aumentar sus conocí mientes sobre la forma en que las parejas establecen y restablecen alianzas no sólo con su familia de origen, sus hermanos hijos adultos, sino también con sus pares con el mundo de la espiritualidad (1, 19, 24) Los contactos con los pares extrafamiliares y el mundo espiritual parecen sustentar a un número aún no establecido de aparejas semi-aisladas que extraen de ellos suficiente ayuda instrumental y sentido como para seguir adelante pese al quiebre que puede haber sufrido el control de su salud.

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Primeros auxilios emocionales en un caso de abuso sexual contra una menor

Braulio Montalvo *

En este articulo se examinan procesos naturales que utilizan algunas familias cuando uno de sus miembros debe enfrentar una situación traumática. Describe los primeros auxilios que presta una abuela antes de que los profesionales en salud mental intervengan en la experiencia de trauma sexual de su nieta. El artículo pone de relieve el acierto con que obra esta abuela en su prospección e improvisación clínica y sugiere algunas posibles implicaciones para el campo de la salud mental.

Son frecuentes las ocasiones en que los abuelos tienen que hacerse cargo del cuidado y de la educación de sus nietos con motivo de la incapacidad o ausencia de los padres. Ésta es una de las formas comunes de la organización familiar en Estados Unidos, donde, conforme a Schor (7), más de una cuarta parte de los menores vive bajo la tutela de un adulto solamente. La familia ha dejado atrás su prototipo nuclear. Los padres –la segunda generación– se ven forzados a valerse de los abuelos –la primera generación– como recurso compensatorio, ya sea porque ambos padres trabajan o debido a que surgen obstáculos como consecuencia de divorcios, adicciones, enfermedades y encarcelamientos.

A menudo la educación y disciplina que reciben muchos de esos niños que provienen de familias truncadas es de carácter intermitente. Ni los abuelos ni los padres pueden mantener la constancia que se requiere. La oscilación e inestabilidad que se crea en estos casos pone en peligro la debida formación de los niños –la tercera generación–. Conjeturamos que, en el caso que vamos a estudiar, la inmadurez y la falta de discriminación de Josefina (una niña de ocho años, demasiado confiada y amistosa con todos) fueron el resultado del control inconsistente que es bastante usual en estas familias. Ella y su hermanito de tres años quedaron al cuidado de su abuela materna cuando sus padres fueron encarcelados por consumo y distribución de estupefacientes.

En este articulo, que comienza con la presentación de algunos fragmentos del relato que le hace la abuela a la pediatra en su segunda visita al consultorio, se describe lo que hizo la abuela, a manera de primeros auxilios, poco después de que un desconocido raptara a su nieta y abusara sexualmente de ella. Es necesario destacar que fue un desconocido porque las gestiones terapéuticas serían distintas si se tratara de una persona conocida o de un familiar. Estamos circunscritos a lo que la abuela dramatiza en el diálogo entre ella y su nieta a raíz de los acontecimientos degradantes. Su dramatización nos ofrece una oportunidad de escudriñar los esfuerzos espontáneos que hacen ambas partes por amortiguar el impacto de lo sucedido. Cabe aclarar que no tenemos acceso ni a la sesión inicial, en la cual se efectuó el examen físico de la niña, ni al trabajo del consejero individual a quien se le asignó el tratamiento de los aspectos emocionales del caso.

A renglón seguido, en el articulo se cuestionan ciertas creencias que preocupan a quienes trabajan con el trauma emocional.

Para concluir, se señala que lo que la abuela hace es una práctica de prospección mediante la cual se tantea el terreno para detectar el momento propicio en que la persona está propensa a dar y a recibir. Su modo de improvisar los primeros auxilios es afín con el trabajo de los profesionales en distintos campos de la medicina.

Entrevista en el consultorio

La niña está presente al comienzo de esta entrevista, pero se inquieta al oír los intercambios de la doctora con su abuela.

*Terapeuta familiar en práctica privada en Albuquerque, Nuevo México, Estados Unidos. El autor desea expresar su agradecimiento a Rosa E. de Leyba, a la doctora Denise Coleman, a Margaret Moore y al doctor Steve Cohen.

Abuela: Yo le estaba buscando ropa de bebé a su hermanito en una tienda grande del centro comercial. Pasarían unos veinte minutos cuando fui a buscarla al departamento de calzado, pero no la encontré y pensé que estaría por ahí probándose algo. Luego me dije, "No la encuentro. La busqué. Seguí buscándola por todo el almacén. Hablé con los empleados; les dije: "¡Ha sucedido algo. ¡Llamen a la policía!"

Doctora: ¿Llamó a su hijo a la casa?

Abuela: Si, en el almacén hasta me marcaron el numero de teléfono y todo eso. Me dijeron: "Quédese aquí quieta y la llamaremos en cuanto tengamos alguna información". Y así fue. Yo estaba al borde de un ataque de nervios. Me decía a mi misma: "Esto es una pesadilla, esto no puede estar pasando". Al cabo de dos horas el policía me la trajo y yo me sentí un poco más tranquila pero... seguía asustada. Le pregunté: "¿Te pasó algo?" Ella en seguida me abrazó y me dijo: "Te quiero mucho, abuela. Tenía miedo de que nunca te volverla a ver". Yo me había sentido igual que ella. Entonces me dijo: "Un hombre me llevó". Le pregunté en seguida: "¿Te tocó?" Y con un gesto me dijo que no, que nunca la tocó. Quizás creó un vacío en su mente... no lo sé.

Doctora: En la primera sesión, en la sesión pasada, lo único que ella nos dijo fue que él hizo que le tocara su pipi con el pie. ¿Le ha contado algo más?

Abuela: Esa noche hablo conmigo abiertamente. Si, hubo contacto sexual oral, por eso quiero que vuelvan a examinarla.

Doctora: ¡Claro que si! Podemos hacerle cultivos de la garganta. En el examen de la semana pasada no se encontró evidencia, ni en la vagina ni en el recto, de que hubiera habido penetración... pero eso no significa que no haya habido contacto sexual.

Abuela: Si, hubo otras cosas. ¡Él la insultó diciéndole muchas cosas! Le dijo que era una puerca y cosas así. Era un loco. Ella me mencionó muchas cosas que me abochorna tener que repetir.

Doctora: Dígamelas aunque se le haga difícil.

Comentario: Como el incidente había ocurrido hacia muy poco, la abuela decidió actuar con paciencia, no insistir en que la niña divulgara más de lo que en ese momento podía. Al cabo de un rato la doctora se dirige a Josefina, quien no se apartaba del lado de su abuela y simulaba estar leyendo pero estaba intranquila, golpeaba su libro y las interrumpía para decir que tenía que ir al baño. La doctora, consciente de que el tema la ponía nerviosa y de que iban a adentrarse en asuntos sexuales gráficos, le pide que se vaya a la sala de espera mientras ella habla con la abuela. Antes de que salga, le anticipa que dentro de un rato hablará con ella. Antes de salir del consultorio Josefina le da un abrazo a la doctora.

Doctora: Así estará mas cómoda y no le meteremos ideas en la cabeza.

Abuela: Si, es mejor que no esté aquí. Ya tuvo suficiente con esa mala experiencia. Ella me preguntaba: "Abuela, ¿soy puerca?" Lo que yo decidí fue no interrogarla y me di instrucciones de esperar hasta que ella estuviera lista para hablarme... de darle tiempo para que le diera vueltas al asunto en su mente. Ella le dijo a una amiga mía: "Ustedes no me quieren". Y... pensé: "Eso seguro que fue el sinvergüenza ése... el secuestrador"; alguien le había hecho creer eso.

Doctora: ¿Le preguntó usted si había sido él?

Abuela: No, porque yo sabía que ella estaba empezando a desembuchar y decidí dejar que siguiera. Empecé a decirle: "Te quiero mucho" y entonces ella me preguntó: "¿Tú odias a ese hombre que me llevó? Le dije: "!Claro que si!" y ella reafirmó: "Yo lo odio, abuela". Le respondí, "Tienes razón para odiarlo, pero algún día dejarás de odiarlo y no pensarás mas en él; pero ahora mismo. . . sí, lo odias... y yo también lo odio porque te quiero".

Comentario: *La vigilancia ecosistémica de la abuela es notable: captó en el acto cuando su amiga comentó que había oído a Josefina quejarse de que no la querían, pero en su afán de protegerla no se precipita, se amolda a las necesidades de la pequeña, respeta que vaya a su propio ritmo y así le permite revelar detalles cuando siente que puede hacerlo Mientras tanto, lo primordial para ella es demostrarle su amor y comunicarle, sin lugar a dudas, que ella está allí dispuesta a ayudarla y que puede contar incondicionalmente con ella. Gracias a la falta de presión, llega a hacersele más fácil a la niña expresar sus reacciones, pero a su debido tiempo. Cuando la niña ingenuamente le pregunta a la abuela si odia a ese hombre, ella le expresa contundentemente que las dos lo odian y le confirma que están aliadas en su contra. Pero su aporte no se limita a declarar su afiliación con la nieta; proyecta hacia el futuro y trata de prevenir que el odio se petrifique en la niña y se*

convierta en un rencor oxidante que la obsesione en el mañana. La abuela evita las perturbaciones dañinas del rencor. Antes de que la niña se afiance en el rencor, se apresura a plantearle oportunamente una imagen de ella convertida en una mujer libre del recuerdo cruel y de la humillación que ha vivido. La imagen que le sugiere es la de una persona que pudo despojarse del poder corrosivo del odio y del rencor. Le habla del tiempo como elemento paliativo y le esclarece la diferencia entre el "ahora"–cuando es aconsejable que ventile la rabia que siente—y el "algún día"–cuando habrá dejado atrás los sentimientos nocivos–. La forma en que se comunica con su nieta es increíblemente sutil. Jamás cae en la trampa de la negación. Ni siquiera le insinúa que la violación no sucedió; nunca reprime la realidad ni la empuja a olvidar precipitadamente, como suele hacerse en el manejo de muchos casos de esta índole. Cuando esto sucede es porque los familiares, en desaprobación de la infamia, se dejan llevar por su propia desesperación.

El mensaje escueto de esta señora es: "Eso si pasó, pero podrás olvidarlo". Simplemente, con gran naturalidad, la ayuda a enfrentarse al presente doloroso y a visualizar un futuro apacible. Con sus palabras tranquiliza a la niña y allana el camino para que termine de exponer su hiriente secreto. La abuela continúa dramatizando el diálogo con su nieta.

Abuela: "Abuela –me preguntó–, ¿no te pones furiosa si te digo algo?" No –le respondió–, nada que tú me digas harta que me sintiera así ¡Tú no tuviste la culpa de eso!

Doctora: Cuando ella se dé cuenta de que no tuvo la culpa se le hará más fácil contarnos. El culpable fue él.

Abuela: Ella me decía: "Él me hirió, abuela: hirió mis sentimientos. Él estaba jugando con su pipi".

La abuela, compungida, cierra los ojos. Por un instante interrumpe su dramatización; no cabe duda de que se a vergüenza de lo que tiene que relatar. La ahogan los sentimientos y se le atoran las palabras, pero se repone y continúa citando lo que le dijo su nieta.

Abuela: "Él me dijo que se lo besara, que se lo tocara con el pie... y que se lo chupara". Yo le pregunté si había hecho eso y ella, muy abochornada me dijo "!Aaaay, abuela...! "Yo le repliqué: "Mira, si lo hiciste fue porque le tenias miedo, tú no tuviste la culpa". Me contestó: "Si, lo hice".

Después de otra pausa para recobrar el ánimo, la abuela vuelve a imitar a la nieta.

Abuela: "¿Tú crees que soy una puerca?" Le contesté: "Ni siquiera por eso yo creo que eres puerca. Tú sigues siendo mi angelito... sigues siendo mi bebe... tú eres inocente". Ella me preguntó: "¿De quién es la culpa, abuela?", Y yo le dije: "De él, únicamente de él.

Comentario: Al confirmarle que sigue siendo buena y que ella aún la ve con buenos ojos, la abuela inválida los insultos inferidos por aquel malvado y la ayuda a que se recupere y restaure su identidad de muchachita inocente. Al ver cómo el dolor y la vergüenza abruman a la niña y le impiden revelar más detalles, ella le anticipa que la justifica al reafirmarle: "Si lo hiciste fue porque le tenias miedo". Sus palabras implican su perdón, anticipando que la niña necesita saber urgentemente que no era culpable. Cuando la nieta verbaliza la inquietante duda que plaga a la mayor parte de las víctimas, en el momento preciso en que aflora la pregunta cósmica –"¿Quién tiene la culpa?"–, la abuela se deja llevar por el curso natural de la curiosidad de la niña. Con aplomo, consciente de que tiene que conseguirá toda costa que su nieta no tenga la menor duda de su falta de culpabilidad, la abuela redistribuye la responsabilidad y le explica claramente que la culpa y la ignominia son sólo del pederasta. En su respuesta no se vislumbra ninguna duda y se cuida de no parecer que le está restando gravedad a lo sucedido.

Doctora: Usted dijo todo lo que había que decir.

Abuela: Temía decir algo que pudiera hacerla pensar que eso no es tan importante.

Doctora: Ella creía que era mala y que era ella quien tenía la culpa; usted hizo lo correcto.

Abuela: Ella empezó a describirme las partes de ese hombre y yo se lo permití. Tomó una pizarrita y me dijo: "Te lo voy a dibujar, abuela". Por fin se dibujó a si misma y me dijo: "Abuela, casi no me cabía en la boca y me dolía la boca". Hizo un dibujo en el cual los ojos de ella miraban hacia abajo. Me preguntó: "Abuela, ¿se me ven tristes los ojos?" Le dije: "Sí". Y en ese momento sentí que el corazón se me partía en pedazos.

Comentario: *Por medio del dibujo se efectuó el exorcismo del atacante, pero hay que subrayar que no fue a la abuela a quien se le ocurrió ese proceso ni quien lo guió. Fue la niña quien por su cuenta encon-*

tró que con el dibujo podía exteriorizarlo que le había sucedido. Sin esconder la intensidad de sus sentimientos agresivos, la niña le da a la abuela el dibujo que ha hecho del pederasta. Se lo entrega como si se tratara de un rito de exorcismo, como si lo expulsara de su cuerpo y de su alma y lo colocara en las manos de quien la protege incondicionalmente.

Abuela: Me dijo: "Éste es él, ésta es su barba rizada, su cara fea, y éstas son las manchas que tiene en la cara".

Doctora: ¿Ella le dio la descripción a la policía?

Abuela: Si, como le dije, la policía lo tiene todo. Ellos vinieron a la casa.

Doctora: Muy bien.

Abuela: No sé cuánto de lo que voy a contarle sea producto de su imaginación, pero ella me contó que él se lo hizo a otro niño que estaba allí antes que ella. No sé si es que ella creó al otro con su imaginación para tener compañía... un amigo con quien compartir el dolor.

Doctora: Si, para no estar sola.

Comentario: *Cabe aclarar que la policía buscó en vano a ese otro niño y que nadie se presentó en el cuartel de la policía en busca de un niño desaparecido. Todo parece indicar que la niña, para protegerse a si misma, había creado esa alucinación.*

Doctora: ¿Qué otros cambios ha notado?

Abuela: Hay veces en que está calmada; otras... combativa. Antes no se ponía tan furiosa. Quizás en su corazón ella resienta que yo la haya desatendido.

La doctora detecta en la abuela aires de inmerecida culpabilidad y opta por defenderla, posponer sus sentimientos y distraer el curso de la conversación para no alejarse de la tarea original.

Doctora: Hablemos sobre los cambios de conducta que usted ha observado en ella.

Abuela: Como le dije, está más peleona. El consejero que le asignaron en el hospital me dijo que a veces, con tal de protegerse, la víctima hace cualquier cosa por complacer al que cometió el abuso deshonesto. Le digo eso porque ayer tuve que darle una nalgada por algo que hizo y ella prorrumpió contra mi: "Yo quiero a ese hombre más que a ti". Yo estuve a punto de contestarle, "¿Si? ¡Conque ésas tenemos! Pero me contuve y me dije, "No, no. Mejor recuerda lo que sientes por ella". Por eso le respondí: "Tú puedes querer a quien tu quieras, de todos modos yo te quiero".

La abuela se da cuenta de que iba a contestarle irónicamente y se reprime. Se autodisciplina para sobreponerse a las provocaciones de su nieta.

Doctora: Su amor por ella es incondicional.

Abuela: Ella seguía diciéndome "Yo quiero a mi mamá más que a ti". Y yo le contesté inmediatamente: "Así es como debe ser; yo también quería a mi mamá más que a mi abuela, pero ya no tengo a ninguna de las dos".

Comentario: *La agilidad terapéutica de la abuela cataliza ambos ataques. Por un segundo parece temer que su nieta pueda estar desarrollando lo que le había descrito el consejero, un síndrome en el cual la víctima "hace cualquier cosa por complacer al atacante". Pronto descarta esa posibilidad y concluye que la reacción de su nieta había sido un arrebato temporal de desafío porque se había percatado de que no podía controlar a su abuela y de que no gozaba de privilegios especiales.*

Veamos en este fragmento la agudeza de las observaciones de la abuela.

Doctora: Y... ¿qué tal su apetito? ¿Tiene pesadillas?

Abuela: No, no tiene pesadillas. Duerme conmigo, me aprieta, me abraza... duerme bien.

Doctora: ¿Y... de apetito?

Abuela: Noté que cuando se disponía a comerse una mazorca de maíz la miró en forma rara y me dijo: "No me gusta". Me parece que le recordó la experiencia. No quiero que asocie la comida con esto y le dije: "A mi si me gusta". En ese instante sentí un mareo y tuve que recordarme una vez más "No soy yo la que importa; ella está primero", y conseguí seguir adelante.

Comentario: *Al oír esas palabras y al observar sus comunicaciones no verbales, la doctora nota cuánto le cuesta a esta señora poner buena cara y que a pesar de eso está dispuesta a sacrificarse*.

Doctora: Usted es muy importante para ella. El bienestar de ella depende del suyo. Tiene que cuidarse.

Abuela: Creo que si puedo hacerlo; soy como una roca... a veces. Todavía tengo que descubrir cuán fuerte es esta roca.

Comentario: *La doctora decide dar prioridad a levantarle el ánimo y la pondera por su carácter fuerte y por su competencia. Su empeño en protegerla es afortunado, porque éste es uno de los factores que contribuyen a evitar que caiga en una depresión reactiva. Pese a la llegada, hace aproximadamente*

cuarenta años, de la terapia de familia al campo del trabajo clínico con niños traumatizados, todavía se tiende a enfocar la reconstrucción intra-psiquica de la víctima mediante terapia de juego individual y muy pocas veces se recurre al apoyo de la persona que está a cargo del menor (3). Esta doctora sabe que el arma más eficaz para ayudar a un menor traumatizado es mantener la estabilidad de la persona a cargo para que ésta pueda potenciar y emplear sus recursos efectivos e imaginativos. Si se evita que la persona encargada se torne pesimista, se puede promover una actitud proactiva. Es entonces cuando el terapeuta puede proceder a ayudar a la persona a cargo del menor a concebir más oportunidades concretas para reparar los efectos del trauma emocional.

Doctora: ¿Qué podríamos hacer para que esta niña aprenda a ser mas desconfiada? ¿Como podríamos ponerle limites? ¿En qué forma podríamos hacerle entender que no puede irse tan lejos?

Abuela: Le he advertido que puede ser afectuosa... pero con gente como usted, con familiares, con sus doctores, con sus tías, pero no con desconocidos.

Doctora: En ese aspecto, ¿cómo la encuentra ahora?

Abuela: Está más alerta, pone más limites... No hemos ido a muchos lugares públicos, pero hace poco fuimos a un parque y noté que estaba más alerta. Ahora pone más atención a lo que le digo.

Doctora: Ella necesita de usted y de su fortaleza.

Abuela: Tengo que enseñarle. Me hubiese gustado que lo hiciera su mamá, pero ella anda metida en drogas. Cuando no consumía drogas ella sabía enseñarle bien, lo hacía inteligentemente, pero yo fui muy indulgente con mi hija.

Doctora: Hay que ser consistente. Uno no puede confiar en extraños. Su nieta no le teme a los extraños, pero... no me malentienda, no estoy echándole la culpa a usted.

Comentario: *Al revelar la abuela que ella no había sido lo suficientemente estricta con su propia hija, se destaca la concatenación regresiva y progresiva de las tres generaciones. Intermitentemente, cuando no estaba en drogas, la madre sabía tratar y guiar a Josefina. En cambio la abuela está convencida de que ella no fue suficientemente estricta con su propia hija y de que su debilidad recae ahora sobre su nieta. Ella se responsabiliza totalmente. No toma en consideración los factores descarrilantes del mundo exterior: el barrio plagado de toxicómanos, de vendedores de drogas y de pandillas; la escuela donde falta vigilancia pero sobra violencia; y hasta el centro comercial y otros lugares públicos adonde acuden los malhechores al acecho de víctimas.*

La doctora se encuentra en un dilema: tiene que encomiar a la abuela por su extraordinaria labor de rescate y a la vez señalarle lo que queda por hacer. Debe hacer todo esto sin crearle culpabilidad a la señora por lo que le sucede a su nieta y por la supuesta negligencia con su hija.

Abuela: Esto me ha abierto los ojos.

Doctora: ¿Cómo está enfrentando la niña lo sucedido?

Abuela: Apenas habla ahora de eso. La he distraído llevándola al circo y con otras actividades.

Doctora: Y... ¿cómo ha seguido la diabetes de usted, señora?

Abuela: Me siento bien.

Doctora: Yo la admiro.

Abuela: He aprendido mucho.

Doctora: Usted tiene que cuidarse, señora.

Abuela: Gracias por haber atendido a la nena.

Comentario: *La abuela agudiza y expande sus destrezas de protección. Cada vez que van a un centro comercial o a algún otro lugar público improvisa técnicas de aprendizaje y las pone en práctica. Anima a la niña para que se aleje de ella, pero la vigila a una distancia que le permita observar su conducta cuando un extraño se le acerca y está muy pendiente de lo que hace y cuánto tarda en volver a su lado. Ella continuó con estas prácticas reparadoras hasta que la niña aprendió a comportarse en forma más madura y superó su trastorno de apego.*

Cuestionamiento

El trabajo de la abuela nos hace cuestionar tres tendencias que influyen en el campo de la terapia, en casos de trauma emocional, especialmente con niños.

1. *Tendencia a creer que la familia siempre agrava el trauma emocional*

Por lo general, en la actualidad se considera el momento inmediatamente posterior al trauma como ámbito exclusivo de los profesionales. Se supone que los proveedores de servicios de salud mental deben intervenir lo antes posible para contrarrestar los efectos traumáticos de la situación y para descondicionar al paciente de sus miedos. El caso se remite enseguí-

da a un especialista, quien habrá de emplear procedimientos provechosos de desensibilización, tales como el de los movimientos oculares (*Eye Movement Desensitization and Reprocessing, EMDR*), la hipnosis, la terapia de juegos expresivos, las técnicas de relajación profunda y los métodos de liberación emocional (*Emotional Freedom Techniques, EFT*). Esta tendencia a profesionalizar el manejo del trauma es muy visible cuando éste es resultado de un ultraje o de catástrofes naturales, como terremotos, huracanes, inundaciones y otros casos en los cuales se recurre a equipos modernos de salud mental. Se tiende a dar por sentado que, a raíz de los acontecimientos traumáticos, las intervenciones de la familia y de las amistades sólo logran agravar la situación. Muchas veces se considera a los familiares como un estorbo desde el principio. Antes de darles la oportunidad de probar lo contrario, se los tilda de ser incapaces de ofrecer la paciencia, la ecuanimidad y el apoyo que la víctima necesita. Contrariamente a esa creencia, vemos cómo esta abuela, que sabe utilizar al máximo sus escasos recursos sociales, logra que sus esfuerzos y su creatividad sean de provecho. Aunque su hija y su yerno estaban en la cárcel en casa le quedaba un recurso: su otro hijo. No desperdicia la oportunidad de utilizar a su vecina como un recurso y la convierte en una extensión de su vigilancia ecosistémica. Fue esa amiga quien le informó que habla oído a la niña quejarse de que no la querían.

Antes de suponer que la familia truncada es siempre un detrimento para el proceso de recuperación, el terapeuta tiene que formarse el hábito de preguntarse en qué situaciones podría la familia ser un recurso preventivo y curativo de primer orden. Tiene que preguntarse en qué casos el uso de los procedimientos provechosos debe dirigirse no sólo a la víctima sino al adulto que le brinda apoyo.

2. *Tendencia a creer que la víctima siempre se convierte en un chantajista emocional*

En casos de niños traumatizados, a los terapeutas los inquieta la posibilidad de que éstos lleguen a creer que su experiencia los hace merecedores de concesiones y de consideraciones especiales. La víctima podría desarrollar una identidad diferenciada de "persona ofendida" y sentirse justificada de ser exigente, llegando a pensar que la sociedad está permanentemente en deuda con ella por los abrojos que le ha puesto en su camino. Esta tendencia se torna más pronunciada cuando se trata de un menor rodeado de adultos que no se atreven a corregirlo por temor a herirlo más. Con niños cuyos propios frenos están toda vía en proceso de formación, resalta este peligro de convertirse en extorsionadores. En el caso aquí expuesto, la niña intenta chantajear a la abuela con dejar de quererla, pero sus manipulaciones caen en saco roto. La abuela entiende intuitivamente que, pese a la horrible experiencia que su nieta ha vivido, ella tiene que cumplir con sus deberes inherentes a la patria potestad y castigarla siempre que su conducta lo ameríta. Cuando la nieta trata de controlarla amenazándola con despojarla de su cariño y con querer a quien abusó de ella, la abuela se siente intimidada pero se aferra a su responsabilidad, y es ésta la actitud que prevalece. Cuando la niña intenta sacarla de quicio diciéndole que quiere a su secuestrador y atacante más que a ella, la abuela confiesa que eso la ha herido pero no concluye que ese arrebato de su nieta signifique que el convenio de coalición con el malhechor ya se ha establecido. Este tipo de alianza es similar al síndrome de Estocolmo, en el cual el vinculo entre la víctima y su abusante puede tornarse un contrato permanente y adquirir proporciones patológicas. Según la doctora Margaret Singer (8). el síndrome lleva el nombre de esa ciudad porque en 1973 se efectuó al allí un robo bancario en el cual los ladrones tomaron como rehenes a unas personas por varios días pero, al ser rescatados, la policía comprobó con sorpresa que defendían a sus secuestradores y, en cambio, los atacaban a ellos. Quienes sufren de este síndrome confunden con amor el agradecimiento que les tienen a los malhechores porque éstos no llegaron a matarlos y por las pocas consideraciones que tuvieron con ellos: pequeñeces como permitirles fumar e ir al baño. Por otra parte, este fenómeno se presencia corrientemente en hogares donde abunda el maltrato y donde, pese a eso, la persona maltratada mantiene la alianza con su agresor a quien, a riesgo de su propia vida, perdona una y otra vez.

En la terapia con menores que han sufrido un trauma es vital prevenir, como logró hacer esta abuela, que su condición de víctima se solidifique como identidad permanente. Para esto hay que desalentar todo intento de valerse de eso para chantajear a los demás. El terapeuta debe cuidar que los padres o guardianes sepan ejercer control y no permitan que

el niño diezme su autoridad y socave su dignidad abusando de su experiencia perturbadora. Debe poner especial cuidado en que los tutores aprendan a diferenciar entre el acto de extorsión que refleja un arrebato temporal y el que indica la plasmación de la víctima como chantajista.

3. *Tendencia a creer que la víctima va a nutrir el odio perennemente*

El odio nace inmediatamente después de un trauma emocional. Las víctimas se valen de ese sentimiento como mecanismo protector, a manera de rejas que los apartan de nuevos peligros. El odio tiene su razón de ser, pero en ninguna circunstancia se debe permitir que la víctima viva por siempre encarcelada en el odio que siente. En el caso que hemos visto, el trabajo de la abuela sugiere que hay que estar pendiente de cuándo puede surgir el efímero momento de receptividad por parte de la víctima y aprovechar esa súbita apertura, antes de que vuelva a cerrarla para inculcarle que no es necesario odiar eternamente. Si se siente verdaderamente amparada por sus seres queridos, es muy posible que cuando el odio se halla aún en etapa de incubación sea el momento en que la víctima esté en buena disposición para recibir e internalizar el mensaje posthipnótico: "algún día olvidarás". En nuestro caso, la abuela da por sentado que existe un mecanismo capaz de potenciar a la larga ese mensaje reparador y facilitar una amnesia natural. En el momento preciso en que la niña muestra curiosidad por el odio, su abuela se apresura a sembrar esa semilla que servirá para aliviarle la pesada carga de llevarlo por siempre sobre las espaldas. Su gran contribución técnica estriba en su capacidad de prospección y de improvisación. Ella busca y encuentra el momento preciso para comunicarle un mensaje dual: ahora sientes odio, pero llegará el día en que hayas olvidado. Tomando en consideración el número de víctimas que al cabo de los años reportan cuán incapacitadas han quedado por el odio, el aporte del mensaje simultáneo y oportuno de la abuela es digno de investigación sistemática. Es posible que sea de valor para salvar por el resto de sus vidas a los niños que son víctimas de la silente fuerza corrosiva del odio. Se ha supuesto hasta la fecha que la única arma de valor para prevenir el sentimiento permanente de odio es el amor, el perdón y el apoyo de quienes la víctima considere sus fuentes de seguridad. La abuela especifica que, para que el odio no se apodere de la víctima, lo que cuenta no es sólo lo que se dice sino cómo y cuando se lo dice.

Al campo de la salud mental se ha concentrado más en aliviar la culpa de la víctima que en buscar la manera de impedir que su odio se fortalezca y contagie otras relaciones y situaciones. La abuela nos señala que tal vez sea imposible extirpar el odio como precursor y fomentador de la violencia, pero que sí es posible desnutrirlo activamente. El terapeuta moderno puede concentrarse más en que no se descarne la personalidad de la víctima, a fin de que pueda visualizar un futuro en el que el odio no gobierne su conducta. Encontrar la forma de transformar el odio en un sentimiento del cual uno se puede despojar es un reto para los que trabajamos en el campo de la salud mental.

Tal vez haya que equipar a los terapeutas con un sistema de "odiómetros" internos que marquen la intensidad y velocidad con que la víctima nutre y propaga su odio. Los estudios de prospección en el terreno del odio son importantes para detectar cuándo y cómo entrar para minarlo antes de que esté a punto de erupción.

Conclusiones

La prospección se usa para detectar en qué momento de una conversación podría abrirse una brecha por donde intercalar y fomentar cambios. Hay que cuidar que al intercalar las sugerencias que se improvisan no se fortalezca el problema en vez de resolverlo. La prospección y la improvisación no tienen afiliaciones ideológicas. Estos son procesos elementales que están presentes en varias gestiones destinadas a resolver o a aliviar problemas que integran factores biomédicos, culturales y de personalidad. Cuando un familiar utiliza la prospección para improvisar los primeros auxilios en casos de traumas sexuales, como lo hizo la abuela, se de-mistifica el ámbito profesional. Ella usa los mismos principios que otros han observado en aspectos psicosociales de la psiquiatría comunitaria (6) y que algunos colegas y yo hemos descrito sobre la labor psicosocial de pediatras (5) y de geriátras (2, 4).

Si se confirma que los primeros auxilios emocionales que improvisa la familia son semejantes a los que emplean los profesionales, el campo de la salud mental tiene que modificarse. Los terapeutas tienen

que identificar los procesos naturales que usan los familiares para ayudarse entre ellos, deben respaldarlos y al mismo tiempo cuidarse de cualquier tendencia a desplazar aún más la autoridad de la familia. Las nuevas formas en que se organiza la familia necesitan como nunca de un contexto socio-profesional que valúe y apuntale su caudal creativo en momentos de crisis (1). Para esto hay que aprender a coordinar alianzas entre las redes de organismos sociales cuya misión es proteger al niño y a la familia.

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Notes

Harry Aponte, MSW

Thursday, May 10, 2001
Conference Workshop

The Application of Spirituality in our Therapy

Facilitator: Diana Valle, PhD
Recorder: Gertrudis Maldonado, PhD
Presentation Language: English

Harry Aponte, MSW

(for biographical sketch, see Harry Aponte in Pre-Conference Sessions)

Abstract

La Aplicación de la Espiritualidad en Nuestra Terapia

La espiritualidad significa diferentes cosas para diferentes personas. Para poder utilizarla en la terapia, necesitamos una definición universal y un modelo práctico. Este taller atentará alcanzar estas metas, mostrando un video (en inglés) de entrevista clínica como ejemplo.

Objetivos:

1. Mostrar la relevancia de la espiritualidad para la terapia.

2. Ofrecer una definición terapeuticamente útil de la espiritualidad.

3. Desarrollar modelo para la integración de la espiritualidad en la terapia.

–Harry Aponte

[Author outline with comments by the recorder in italics]

La Espiritualidad y La Terapia

(La espiritualidad es el aspecto de la terapia más importante de nuestra época)

La Espiritualidad – Una Definición

La dimensión de la vida que provee la vida con motivo *(el porqué de la vida)*, moralidad (*normas*) y el vínculo (*defina*) con el contexto social (humano y trascendente)

Hay espiritualidad secular y religiosa

Todo el mundo tiene espiritualidad – única para cada persona (*Porqué importa hoy más que ayer – La conformidad de ayer, la individualidad de hoy*)

Los Cambios en la Sociedad y la Terapia de Hoy

La Espiritualidad Subjetiva y Relativa

Con la accesibilidad de información, el individual se determina

No hay filosofía y moralidad común para la comunidad (*se queda libre y solo*)

La Nueva Dimensión para La Terapia

(Lo que la familia y comunidad proveía, ahora le pertenece al individuo)

El terapeuta considera el cuadro espiritual del problema (*lo bueno y lo malo*)

Lo espiritual como contributor al problema (*valores – conflictos / falta*)

Lo espiritual como meta e instrumento de solución (*disciplina y/o recurso trascendente*)

Premisas para la Terapia con Dimensión Espiritual

La Voluntad Libre

Todo el mundo tiene la habilidad de tomar decisiones libres (*morales)*

La decisión libre determina el curso y la meta del cambio

El Determinismo de la Sicología

La sicología puede dar impulso irresistible

La crisis psicológica puede crear la exigencia para el cambio

(*el tratamiento depende de la decisión-compromiso*)

El Motivo para el Cambio

Porque conviene o es necesario

Porque se debe (que puede ser impulso poderoso)

(*otro nivel de motivo que supera el sentimiento, obsesión...*

La Filosofía de un Terapeuta

(*Cada terapeuta con su propia espiritualidad*)

Principios Espirituales

Voluntad Libre – donde hay libertad hay moralidad

Amor – El motivo fundamental de la vida

Propósito y Significado – Todo en la vida tiene significado

(*la debilidad, la perdida –haya esperanza)*

Perspectiva de la Vida

Lucha Temática – cada persona con su lucha de la vida

El Problema de Hoy – el desafío de la lucha temática

La Resolución – es la puerta por la cual se crece y cambia

(*Adolescente abusa drogas y alcohol. Vive para complacer. –*

Cuando choca al auto del padre, atenta suicidio)

La Terapia con la Dimensión Espiritua

Establecer el Problema Específico (*e.g. deprimido y dependiente*)

Ponerse de Acuerdo de la Plataforma de Valores (*madurar es enfrentar la vida)*

Identificar la Decisión Clave (*alcohol, droga, mujer...)*

Conectar con los Recursos para la Solución (incluso espirituales) (*compromiso con la vida*)

Determinar la Contribución del Terapeuta (*enfrentar, desafiar, soportar*)

La Espiritualidad del Terapeuta

(*No se pueda con espiritualidad del cliente sin estar consciente de la espiritualidad de uno*)

Conocerse – su sicología, su familia, su espiritualidad

Identificar su lucha temática

Comprender su viaje de vida con respecto al tema (*sendero personal*)

Comprometerse a la lucha con sus fracasos y triunfos

Desarrollar una perspectiva

Alcanzar la distancia de la compresión

Poner esa comprensión en un cuadro espiritual (*No solo vivir su espiritualidad)*

Crear forma de utilizar esta auto-comprensión

Para sentir empatía para el otro

Para poder comunicar y relacionarse con el otro

Para aplicar su espiritualidad (filosofía y moralidad e idea de abrirse a la ayuda de otros) a la experiencia del otro

[Notes from the workshop]

The Significance of Spirituality in Today's Therapy

Es un enfoque eco-cultural que combina la terapia de familia con el aspecto espiritual.

Establece una relación entre el terapeuta y las familias con quienes se trabaja. Hace énfasis en trabajar con el "yo" del terapeuta.

" El tema de la espiritualidad es nuevo para los terapeutas. Cuando comencé causaba mucho temor...uno no sabe como lo van a recibir. Hoy día es el tema más importante en los EUA. Sin embargo, sigue siendo un tema difícil; salen los aspectos de uno y se reacciona con las personas tratadas. Por esa razón, es necesario que nos acostumbremos a hablar de la espiritualidad. Es algo muy único en cada persona.

En esta época se plantea la aceptación de la diversidad, excepto cuando se toca del tema de la religión. Hay unos temas sensitivos, entonces se opta "porque no importa la espiritualidad" y esto no es real. Hace 50 ó 60 años habían más acuerdos en relación a los valores. Se daban por sentado. Se trataba de arreglárselos para que se pudiera bregar con la vida.

(ejemplo) – El problema es que es afeminado... Hoy en día los personas se cambian de sexo. Ahora pueden haber diversidades de opiniones en los profesionales.

Ejemplo: Los novios de 14 años se quedan juntos los fines de semana.

* Si no estamos de acuerdo en los valores entonces como se determina lo que es patológico. El peligro principal es que nosotros como terapeutas no nos damos cuenta que trabajamos en base a ciertos valores; entonces no puede darse cuenta del trabajo que hace. Se afecta la ética" Tenemos que tomar responsabilidad de los valores que comunicamos".

Hoy en día:

La sociedad ha cambiado. Hay información para todo el mundo. El que tiene la información toma su decisión individualmente. El padre hoy día no tiene ese control sobre sus hijos. La mujer no depende del marido ni los hijos de los padres. No hay el compromiso de antes.

"La persona de hoy está más solo a que la de ayer; con la libertad viene la soledad y con esta la ansiedad."

La soledad, con estrés y ansiedad, puede conllevar a la adición. El terapista tiene que averiguar cuales son los valores, como piensa el cliente.

Ejemplos de mi práctica:

#1. El hombre infiel

#2. La niña de 16 años activa sexualmente con joven de 21 años de edad.

El desafío es poder hablar del tema de manera que aplique a todo el mundo, no importa de donde venga: (Tres puntos en común)

1. Toda espiritualidad ofrece una filosofía, una perspectiva ante la vida.

2. Toda espiritualidad ofrece normas y moralidad

3. Toda espiritualidad ofrece contexto social y relación con otros (comunidad)

Filosofía, perspectiva: Ante el dolor –no se debería sufrir. Ante el sufrimiento se crece.

Ejemplo: Hombre casado cuya esposa tenía un tumor en el cerebro que no podía tener vida sexual y cambiaba su cuerpo (compromiso vs. El no querer sufrir)

Ejemplo: La niña de 16 años de edad embarazada que quiere tener el bebé y los padres no.

La gente está viniendo a pedir consejos en cuanto a la moralidad.

Estamos viviendo en una sociedad que no sabe lo que moralmente quiere. "La espiritualidad provee moral".

Hay quien dice pues yo lo hago a mi manera, entonces lo hago solo, sin el apoyo de una comunidad religiosa. Entiende que esto es parte de la comunidad.

Ejemplo: El comerciante que en todos los viajes se encuentra con prostitutas y usa cocaína. Se estaba "adictando" a esas prácticas. El hombre aceptó que no tenía religión. Su religión era el dinero; vivía para hacer dinero. Se sentía vacío.

Nos encontramos en una sociedad en la cual esto es más común.

El terapeuta debe identificar que es lo que quiere la persona. Debe radicarse en la terapia, no en la religión. Luego se averigua cuál es el cuadro espiritual; cuales son los valores de la persona. "A mi manera de pensar no se puede trabajar con los valores sin considerar que la persona no tiene voluntad propia."

Hay que tener en cuenta que no se considere al adicto sin voluntad propia. En su opinión todo el mundo tiene libertad de su voluntad. Le reconoce voluntad para tomar decisiones.

"Cada persona tiene libertad para decidir como vivir su vida".

¿Qué control tiene esta persona sobre su problema?

Todo el mundo tiene su espiritualidad, filosofía y perspectiva ante la vida. No se puede vivir solo.

Hay personas que no tienen religión; el hecho de buscar su camino les cambia la vida. Para unosacar lo espiritual de la persona, pregunta sobre los recursos de su vida.

La parte más complicada es que cada uno tiene su propia espiritualidad y considera que es lo mejor.

*En nuestra formación como profesionales se debe integrar la parte espiritual; siempre se nos exige trabajar lo nuestro para poder bregar con el otro (los conflictos propios, la familia nuestra y la espiritualidad personal...)

¿Cuál es mi relación con mi religión?

¿Cómo utilizo mi fotografía de la vida y/o comunidad espiritual?

De esta manera se está pendiente de esa espiritualidad en la vida de uno.

Preguntas:

1. (Una profesora de Mayagüez –Quiere integrar el aspecto espiritual en el curriculum y pregunta como enfocarlo:

(Aponte) "En mi experiencia lo que conviene más es utilizar el vocabulario del cliente.." Se puede

enfocar en lo práctico para ver su filosofía. Se puede tener una discusión de esto sin utilizar las palabras religiosas....

2. Consejera de Teen Challenge: Me he encontrado con el dilema de que los jóvenes se enfocan en el satanismo; es un grupo muy organizado, ¿de qué forma podría trabajar con ellos?

   (Aponte) Si uno tiene la posibilidad de trabajar con la familia, puede identificar si el conflicto está entre el joven y sus padres. Esto crearía la discusión que se hace pertinente; es importante conectar al joven con sus padres. En realidad todo el mundo necesita una creencia o una moralidad. Por la necesidad los jóvenes han creado su propia religión. Hay que ver otra posibilidad y no sola atacar lo que es diferente a uno. Nos ponemos a descubrir donde hay probabilidad de cambio. (*Harry Aponte trajo un ejemplo dondo no pudo bregar con una familia donde madre e hija practicaban el satanismo.)

3. H.González: ¿Existe una crisis entre los terapeutas para bregar con estos conflictos?

   (Aponte) Trajo ejemplos de divisiones entre profesionales por "issues" tales como el aborto. "El problema mío es que tenemos que llegar a un punto donde todos en una asociación sostengan los mismos valores"... Inclusive que la asociación permita que se dialogue sobre nuestras diferencias.

4. Decano de Medicina: Trae la inquietud de cómo integrarlo al currículo. A él le parece muy difícil. Ejemplo con el aborto. ¿Cómo enseñar sobre la espiritualidad a los estudiantes de medicina?

   (Aponte) Es difícil exponer nuestros propios valores. Por otro lado, debemos tener el valor de decir donde estamos ubicados en nuestros valores. Es importante establecerle a los estudiantes que sus valores van a influenciar su práctica.

–"Break" El grupo quiere ver el vídeo–

5. Una persona (pastor) pregunta cómo enfocamos la espiritualidad si el "issue" se encuentra en todas partes.

   (Aponte) "Nada se puede hacer sino se puede hablar; lo que hacemos entonces es evitarlo para no tener conflicto"... El padre solo no puede hacer mucho sin el apoyo de la comunidad. Trae un ejemplo de cómo se están manejando los "issues" en E.U.A.

   ¿Comó vamos a trabajar el perdón con el amor de la familia?

[Vídeo de la Universidad de Maryland sobre el tema del perdón.]

1. En la sesión de preguntas sobre el vídeo"

   Parece que la familia había olvidado que estaban unidas por amor y que esto se manifestaba en todas sus inquietudes.

2. Descubieron durante el proceso la mucho que se amaban.

Audiencia:

(Pastor) entiende que según la película, los aspectos espirituales no se pueden negar.

¿Cuál era la participación, aunque pasiva, de los niños?

La discusión de los padres implicaba su seguridad y a conclusiones entre ambos el que su pareja no fuese perfecta y aun así se amaron.

Notes

Hortensia Amaro, PhD
Rita Nieves RN, MPH

Friday, May 11, 2001
Conference Workshops

HIV Prevention Interventions Designed for Populations of Latino Women:

General Community Sample and Women In Substance Abuse Treatment

Facilitator: María Alvarez, PhD
Omar Pérez del Pilar, PhDc
Language of Presentation: English

Sponsored by RCMI / Universidad del Caribe

Hortensia Amaro, PhD
Rita L. Nieves, RN, MPH

(For biographical sketches, please see Pre Conference section "Dilemmas in Substance Abuse Treatment)

Abstract

HIV Prevention Interventions Designed for Populations of Latino Women: General Community Sample and Women In Substance Abuse Treatment Workshop Abstract

While HIV infection among Latina women continues to rise, the existing HIV prevention literature offers few evidence-based models for prevention with Latina women. This workshop presents two distinct models of HIV prevention: one tested in a community-based population of Latina women in steady sexual relationships and another designed for women with a history of addiction and trauma from physical and/or sexual abuse. The workshop will present these two distinct intervention models and discuss study methods and findings on condom use and sexual risk using data from 3-month and 12-month follow-up of women in the community intervention and preliminary data from the study of women with a history of addiction and trauma.

Objectives:

1. Participants will learn about gender specific theoretical models that can be used to guide HIV prevention programs with women.
2. Participants will learn about the relationship of history of abuse and trauma and HIV risk and implications for HIV prevention with women.
3. Participants will be introduced to two HIV prevention interventions currently in the field: one for Latina women in committed relationships and another for women with a history of trauma.

For information on the material presented at the workshops, please contact Hortensia Amaro at:

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[Misc Notes from the Workshop]

Workshop Objective:

1. To describe the process involved in the development and implementation of a residential treatment program for Latino mothers and their children
2. To review and discuss outcome
3. To describe lessons learned in the development

There is a great gap between those dependent on drugs and available treatment.
"Entre Familia" Program

En 1995, 1,900 Latin women needed substance abuse treatment and approximately 200 were receiving it. Programs with adequate language and acculturation did not exist. The majority of Latin women do not receive treatment because treatment appropriate to their needs is not available (bilingual/bicultural).

Under Boston Public Health CSAT/SPMHSA it was achieved. We had 8 months to get the program going with all that implied; it opened in May of 1996.

Entre Familia =

- Promotes recovery from substance abuse and addiction for Latin mothers and their children and to improve the quality of their lives.
- Provides a place for treatment in which children can be with their mothers.

Philosophy

- "Family-focus" is critical for long-term recovery
- An atmosphere of culturally appropriate treatment
- Process of "skills and strengths"
- Continuous training of employees – solid scientific evidence

Goal

Development and implement appropriate programs

Considerations

- "cognitive behavior."
- relational model of women's development
- family systems theory (not isolated)
- training oneself and with the staff; living the principles we advocate.

Program Description
Capacity = began with 15 women and their children. Also serve 23 women and equal number of children.

Q: How handled at staff level?
A: Needed the help of consultants and training to wrestle with the dynamic of teamwork.

Stages of Treatment

Progression in treatment is based on achievement of behaviorally based goals divided into 4 or 5 stages of treatment that progressively focus efforts on skills needed for community living.

Groups for substance abuse, relapse prevention, trauma recovery, self-esteem, spirituality, job preparation, and life skills. Includes a group that helps women to struggle for better support policies.

Mental Health Services

-In-house child assessment, child therapy, mother-child intervention and referrals

-Collaboration with other health provider (inter-agency collaboration)

-Comprehensive Case Management

development of psychosocial histories and family needs

development of goals

Family Reunification

evaluation of custody status
joint meetings with child protection agencies
child visitation support

Q: Why mothers and children together?
A. Was separate and had to move to family intervention to improve the intervention. (social reality of family integration as system).

Q: How are children treated?
A: The same way

Q: Are the women different kinds of Latins? What language is used in therapy?
A: The women are all kinds (born in their countries, not born in their countries) We use the language that they respond to best.

Q: How does the program work with HMO?
A: Services are free; ask for 30% of their income for those who can't be charged. Receive federal monies for the program. The state gives a part for the whole family – $51 per day to cover family expenses. It is understood that many services are needed but the government only gives money for certain ones, although they recognize the importance of these other components. The problem in what science identifies as necessary for treatment effectiveness versus what the government is willing to support. Other obstacles are the requirements placed by the agencies accrediting the programs.

Staff: Experiences with teamwork.

One very tall white man began work and was rapidly seen as the best professional, the team/clients reacting to stereotypes. This demonstrated the impact of personnel in the treatment environment.

What issues must be looked at vis a vis the staff?

(Group): Intensive interviews. They must be clear about the program's mission. The staff be integrated.

(Presenter): Invest in the development of staff to be able to have unified interventions, especially in important areas of mental health and trauma. Burnout is a problem. It is important to help the staff handle their exposure to such difficult problems.

Advantages and disadvantages of children in a treatment facility

(Group): Advantages: Develop parenting skills; children benefit from parents' understanding. Disadvantages: replication of roles?

(Presenter): Women may concentrate more on their children than on treatment. Children can generate painful memories (and in other mothers without their children seeing these children). The idea of family reunification provides an increase in motivation and retention of treatment. One woman who overcame addiction said that when she used drugs she abused her children; it is important to recognize that.

Guide for reunification of mother and child

- Professional, integrated help for the mother (child-rearing workshops, treatment individually and in groups)
- Explore family histories
- Evaluate frequency of visits and indirect supervision

(Presenter): The goal must be to facilitate the process when it is a good idea for everyone, both for the mother and the child. It is based on the individual in this family relationship. It is important, for example to teach the mother that she cannot recover her children, relate to them in a different way without abandoning her treatment??

(Group): The process of definition of the particular family is also important. What has been the effect of the custodial decision and of the relationship of the participant with the team?

(Presenter): All the process goes together.

Strategies

-Treatment plan that takes care of the needs of the client
-Follow-up

Participation of Client

(Group): gives criteria of participation; community meetings
(Presenter): Resident's Council; asking for services; round tables; establish "godparents" –"sponsors"

Notes

Mary K. Shilton, JD
Carmen Peña, PhD
Nedda Echevarría-Juarbe, MS

Friday, May 11, 2001
Conference Workshop

Incarcerated Mothers: Maintaining the Family Bond

Facilitator: Ramonita Echevarría, RN
Recorder: José Meléndez, MHS
Presentation Language: Spanish/English

Biographical Sketches

Mary K. Shilton, JD

Mary is an advocate for improved family support programs, correctional systems, and interagency problem solving. Since 1971, Mary has been involved in adult and juvenile corrections, criminal justice planning and law related work at the local, regional and national levels. Most recently, she has served as the Washington, DC representative for the International Community Corrections Association (ICCA). She also served in the Bureau of State and Local Affairs in the Office of National Drug Control Policy, and as Deputy Director of the National Association of Criminal Justice Planners. Mary is a former cochair of the Corrections, Sentencing and Guidelines Committee of the American Bar Association and is a member of the Board of Directors of the National Committee for Community Corrections. As a member of the ACA Legislative Committee, and Substance Abuse Committee, Mary has worked with ACA's Community Corrections and Legal Committees to develop several new ABA policies which attend to diversity and disparity in the justice system. Mary has a Masters in Interdisciplinary Studies, Youth and Corrections from the University of Oregon and a JD from Hastings College of Law, University of California.

Carmen Peña Rivera, PhD

Dr. Peña received her doctoral degree in Clinical Psychology with a sub-specialization in Forensic Psychology. She works in the Correctional Administration System of Puerto Rico as the Executive Director of the Bureau of Evaluation and Assessment. During her professional life, one of her major accomplishments has been the development of innovative treatment and rehabilitation programs of inmates convicted of violent crimes, in 1990, she designed a landmark body of work conceptualized as the Learning to Live Without Violence Program that was established with a federal grant, receiving funds in the amount of three million dollars from the Bureau of Justice Assistance of the United States government. This program has been implemented in four correctional institutions as well as two community-based programs. The Learning to Live Without Violence Program has reached different penal populations, including the adult female and male offender, as well the young adult offender who has been convicted for violent crimes and has a substance abuse problem Dr. Peña also developed the first treatment program in Puerto Rico for incarcerated sex offenders. In 1993, she began to develop residential community-based programs, such as the Intermediate Home for Women, an alternative treatment approach for female inmates who are either pregnant or have children under the age of three.

During the last two years, she has created two other Residential Treatment Centers for male inmates with substance abuse problems, one in Humacao and the other in San Juan, which is in the process of opening. A more recent accomplishment of Dr. Peña has been the establishment of the Living in the Community Without Violence Program that offers psycho-educational services to domestic violence and sex offenders who are competing their sentences in the community. Dr. Peña has further contributed to the field of psychology by conducting a variety of investigations, including the Normalization of the Minnesota Multi-phasic Personality Inventory-2 (MMP1-2), in conjunction with the University of Minnesota, utilizing the corrections population. Dr. Peña has worked in the correctional setting since 1984 as a full-time Psychologist and as Adjunct Professor at the Correctional Officers Academy. She has also been an Advisor on mental health issues for the correctional system and participated in the Multi-Agency Negotiation Inmates Mental Health Plans and in the Inmates Classification Plan Task Force. She also serves as a consultant on the board of several universities and government agencies.

Nedda Echevarría-Juarbe, MS

Obtuvo su grado de maestría en Sicología Clínica del Centro Caribeño de Estudios Postgraduados en San Juan, Puerto Rico, y estudios conducentes al grado doctoral del mismo centro docente. Inicia su ca-

rrera profesional de sicóloga como coordinadora clínica en el Programa de Evaluación y Tratamiento para Niños con Deficiencias en el Desarrollo en el Recinto de Ciencias Médicas de la Universidad de Puerto Rico. Posee vasta experiencia en el desarrollo y dirección de programas de estudios continuados. Dirigió el Programa de Educación Continuada del Centro Caribeño de Estudios Postgraduados, desarrolló y dirigió el programe de la Asociación de Psicólogos de Puerto Rico. Por los últimos ocho anos ha trabajado para el Negociado de Evaluación y Asesoramiento. Ha colaborado estrechamente con la Dra. Carmen Peña en el desarrollo e implantación de los programas de tratamiento, así como en proyectos de investigación. Coordinó el Programa "Aprendiendo a Vivir sin Violencia" y la normalización del Inventario Multifásico de la Personalidad (MMPI-2) con la población penal. Desarrolló el proyecto de traducción, adaptación y validación del Inventario de Nivel de Servicio (LSI-R) al español, instrumento que mide riesgo y necesidad de la población penal, que facilitará su clasificación y determinación de efectividad del tratamiento. En la actualidad se desempeña como Sub-Directora del Negociado de Evaluación y Asesoramiento y supervisa los Proyectos Federales Convivencia sin Violencia en Comunidad, que ofrece servicios a clientes convictos por *Ley 54* de Violencia Doméstica y Ofensores Sexuales y los Centros de Tratamiento Residencial para convictos con problemas adictivos y conducta criminal. Fue miembro del Task Force para el desarrollo del Modelo Integral de Rehabilitación designado por la Lcda. Nydia Cotto Vives, Secretaria del Departamento de Corrección y Rehabilitación y del Proyecto VOITIS (Violent Offender Incarceration and Truth in Sentencing Program) desarrollando las guías para las pruebas de drogas, sanciones y tratamiento de la población correccional en Puerto Rico. Es miembro activo de varias organizaciones profesionales como: American Correctional Association, Asociación de Psicólogos de Puerto Rico, American Probation and Parole Association e International Community Corrections Association. Es miembro de la Comisión Certificadora de Consejeros en Sustancias Psicoactivas y supervisora en el Programa de Maestría en Consejería en Adicción de la Universidad Central del Caribe.

Incarcerated Mothers: Maintaining the Family Bond

Abstract

This workshop will discuss what can be done to maintain the bond between incarcerated mothers and their families. A growing number of women are incarcerated each year and most of these women have at least two children. Their children are up to seven times more likely to be arrested than those of persons who are not under correctional supervision. Research from mother-child prison and community corrections programs indicates that recidivism of women and the delinquency of their children can be substantially decreased by maintaining and supporting family ties.

We will examine the legal, social service, and medical challenges in maintaining the family bond for women who are under criminal justice supervision. It will present and overview of statistics and research that have caused child welfare and other professionals to reexamine the impact of incarceration on offender's young children The workshop will explore the dimensions of multi-systemic approaches to unite families– approaches that bring together health care, psycho-social and criminal justice professionals to rethink how services are provided. Participants will consider how child-focused approaches are integrated with other models and what stakeholders participate in this process. Distinctive models, such as prison visitation, prison nursery, residential mother child programs, day reporting and child development programs, drug treatment and drug court programs will be among some of the models explored by our discussion. Participants will discuss recommendations about what should be done in the future to build more effective child focused programs.

Commonwealth of Puerto Rico Corrections Administration
Bureau of Evaluation and Assessment

Incarcerated Mothers Workshop

CAUSAS DE LA CRIMINALIDAD EN LA MUJER

1. Dependencia - Es una característica que se desarrolla cuando la persona aprenda a depender de otros para llenar sus necesidades

a. Identidad femenina - se desarrolla a través del apago y conexión emocional que la mujer tiene con las personas significativas en su vida.

b. Invierte mucho tiempo y energía en sus relaciones interpersonales, en los roles de madre, esposa e hija.

c. Pérdida de una relación significa una amenaza.

d. Amenaza de pérdida produce una crisis en la mujer
-aprende a vivir sin la relación
-reemplaza esta relación con otra
-hace todo lo que sea necesario para mantener la relación
Cualquier tratamiento para mujeres tiene que atender problemas de las relaciones destructivas e inadecuadas en esta clientela.

e. Relaciones Interpersonales
-prostitución (mantener pareja)
-vida criminal (seguir pareja)
-uso de drogas (complacer pareja)

El uso de drogas en la mujer resulta ser más estigmatizante que en el hombre.

2. MAYOR RESPONSABILIDAD DE LOS HI]OS

a. Embarazo en la adolescencia

b. No terminar escuela

c. Vive de Bienestar

d. Pobres alternativas de cuidado para los niños

e. Estructura social inadecuada para madres/ hijos

3. ABUSO SEXUAL, FÍSICO-EMOCIONAL
-Usualmente comienza en la familia

a. Derrota el espíritu de independencia

b. Crea un sentido de impotencia

c. Mentalidad de víctima

d. Aprende que otras personas tienen control sobre ella

e. Confusión en establecer límites

FACTORES PSICOSOCIALES

Hay otros factores que juegan un papel crítico en la vida de la mujer.

1. Viene de una familia disfuncional que tiene múltiples problemas.
2. Ha experimentado una pérdida como el divorcio de los padres o una muerte temprana de uno de los padres.
3. Tiene familiares que son alcohólicos o usuarios de drogas.

4. Ha experimentado violencia doméstica en: sus relaciones conyugales.
5. No tiene un sistema de apoyo fuerte dentro de su ambiente familiar.
6. Comenzó a hacer uso de drogas o alcohol a una edad temprana
7. No tiene sus roles sociales bien definidos.
8. Su cónyuge tiene problemas de drogas y/o alcoholismo.

Todas estas experiencias comienzan un proceso de victimización que va creando un sentido de dependencia e impotencia en la mujer, lo cual la puede llevar hcia el camino de la criminalidad.

Los programas para mujeres deben incluir por lo tanto el desarrollo de destrezas sociales, fortalecimiento del sentido de valía propia y mayor seguridad en posibilidades y decisiones. Tiene que estar encaminado a incrementar su poder para valerse por si misma y salir del círculo que algunos estudiosos llaman la faminización de la pobreza.

SALUD MENTAL DE LA MUJER

Por todas las situaciones negativas que experimenta la mujer ofensora, el estado de salud mental de ella puede verse afectado adversamente, reflejándose en las siguientes condiciones y/o situaciones:

1 Depresión
2 Baja auto-estima
3 Nivel altode estrés psicológico
4 Intentos suicidas y otras conductas destructivas
5 Relaciones interpersonales conflictivas
6. Personalidad dependiente
7. Pobre imagen corporal
8. Adicciones a droga/alcohol, compras, cafeína, nicotina, sexo, apuestas
9. Relaciones de madre-hijo inadecuadas
10. Mentalidad de víctima

PROFILE OF THE FEMALE OFFENDER

Average age 31 or less	–
Marital status –single	66.12
Academic level between 8th and 10th grade	54.74
Unemployed at time of offense	98.37
Without an occupation or job skill	49.00
Urban dweller	87.00
Sentence less than two years	69.95
Have one or more children	76.00
Convicted for the first time	90.58
Drug abuse	69.42
Alcohol use	100

PROFILE

OFFENSES	
-Controlled Substance	20.05
-Robbery	39.30
-Murder	7.05

PROBLEMAS RELACIONADOS CON SEPARACIÓN DE MADRE-HIJO

Aunque la madre confinada tiene la responsabilidad mayor de sus hijos y su crianza, las necesidades de ambos se ignoran cuando ella se encarcela.

1. En Puerto Rico casi 80% de la ofensoras tienen hijos.
2. La ofensora embarazada usualmente no tiene buen cuidado pre/post natal, lo cual puede impedir un desarrollo óptimo para el bebé.

   Al nacer el bebé la situación de encarcelamiento interfiere con el proceso de apego entre madre-hijo.
3. Los hijos mayores sufren de un sinnúmero de problemas:

a. Estigmatización social
b. Trauma emocional
c. Problemas de aprendizaje
d. Problemas de conducta
e. Se etiquetan como delincuentes
f. Entran al sistema correccional con más frecuencia que otros niños

Intermediate Home for Women Program

Commonwealth of Puerto Rico
Administration of Correction
BUREAU OF EVALUATION AND ASSESSMENT

Innovations Award 1997 Nominee
Intermediate Home for Women
a Residential Treatment Alternative
for Female Offenders and their
Children 0 to 3 years

PRINCIPLES

1. We believe that people can change and we can serve as an instrument of change.
2. We believe in promoting and maintaining a positive, safe and secure environment.
3. We are responsible for maintaining a respectful relationship with the community and providing the necessary control to insure security

MISSION

- The Intermediate Home for Women: assures an effective supervision of the residents in a safe and secure environment; promotes a sense of responsibility and the ability to become useful and productive citizens.

VISION

The intermediate home for Women will demonstrate excellence in each phase of operations to inspire confidence in our ability to develop and enrich a system that:
Guarantees that each person will be treated with dignity and respect
Helps break the cycle of dysfunction experienced by female offenders and their children.
Promotes and Improves the parenting skills and preserves the family unit.
Reduces the possibility of relapse and recidivism
Develops a sense of belonging for our personnel in an environment of mutual confidence, support, honesty and respect for individual differences

ELIGIBILITY CRITERIA

- Minimum Custody
- One and a half to two years to complete minimum
- Good physical and mental condition
- Be pregnant or have one child under the age of three.
- Have problems with substance abuse
- Have motivation towards treatment

PROGRAM SERVICES

1. Housing Facilities
2. Food Services
3. Counseling/ Orientation
4. Medical
5. Psychological
6. Social
7. Religious
8. Educational/Vocational
9. Recreational/Sports
10. Security
11. Transportation
12. Coordination with Public/Private Agencies
13. Child Care

PROGRAM PERSONNEL

- Executive Director
- Program Coordinator
- Psychologists
- Social Worker
- Social Officers
- Sergeant/ Correctional Officers
- Nurse/Doctor
- Secretary
- Accounting Officer
- Administrative Assistant
- Health Education Teacher
- Home Economicsss Teacher

COMMUNITY SERVICES

- Dispensaries/Hospitals
- Department of the Family
- Vocational Rehabilitation
- Pro Bono Legal Aid
- Private Organizations
- Foster Grandparents Program
- Volunteers of diverse religious sects
- Department of Education
- W.I.C..-Nutritional Program
- Narcotics Anonymous
- Civic Support Groups

TREATMENT

INITIAL PHASE - 1 MONTH (LEVEL 1)

- Structured Interviews
- Psychological Evaluations
- Drug Testing
- Institutional Plan of Intervention
- Work Duties

TREATMENT

INTERMEDIATE PHASE – 6-8 MONTHS (LEVELS II AND III)

- Group and Individual Therapy
- Pro Social Life and Parenting Skills
- Relapse Prevention
- Academic Classes (GED)
- Home Economics and Health Classes
- Family Intervention
- Narcotics Anonymous
- Child Care/Evaluation
- Trimester Evaluation

TREATMENT

- Return to Vocational Rehabilitation
- Pre-release Plan
- Referral to Parole Board
- Electronic Supervision
- Extended Furlough
- Community and Home Investigation

TREATMENT
AFTERCARE PHASE

- Random Drug Testing
- Self-help Group (AA, NA)
- Individual Counseling
- Employment/Education
- Strengthen Family and Community Ties

POSITIVE WORK ENVIRONMENT

- Appropriate selection of Correctional Officers
- Continued Education for Staff
- Representation of Security on treatment staff
- Weekly treatment staff meeting
- Immediate follow-up
- Live by principle of Vision

Women in Educational and Occupational Activities

GED	10
College	1
Technical School	4
Vocational	7
Employed	5

Un Mundo Más Seguro

OFRECIENDO SEGURIDAD, PROPICIANDO REHABILITACIÓN

DEPTARTAMENTO
DE CORRECIÓN
Y REHABILITACIÓN

HOGAR INTERMEDIO PARA MUJERES

"Una alternativa de tratamiento para Mujeres convictas embarazadas o con hijos menores de tres años"

DESCRIPCION:

El Hogar Intermedio Para Mujeres es un proyecto innovador de servicios bio-sicosociales a mujeres confinadas, entre ellas embarazadas o con hijos menores de tres anos, que no cuentan con recursos familiares para su cuidado. Los niños residirán con ellas en el Hogar.

PROPOSITO:

El programa pretende capacitar a las participantes para que desarrollen mejores destrezas de vida, que le permitan realizar un ajuste adecuado a su ambiente social y familiar. Que en el desempeño de su rol de madre, garantice a su hijo una mejor calidad de vida.

SERVICIOS:

Los servicios ofrecidos están estructurados conforme a las necesidades indicadas de las residentes y de sus hijos.

1. albergue
2. alimentación
3. consejería
4. médicos
5. sicológicos
6. sociales
7. terapia adicción y alcoholismo
8. religiosos
9. educativos
10. recreativos
11. seguridad
12. transportación
13. coordinación con agencias públicas y privadas
14. pruebas anti-drogas

CRITERIOS DE SELECCIÓN:

Puede beneficiarse de los servicios del Hogar toda mujer que no ofrezca riesgo para la comunidad y que cumpla con los siguientes requisitos:

1. Que le falte 1 a 2 años para cumplir el mínimo de la sentencia.
2. Su condición física y mental le permita valerse por si misma y asumir responsabilidades por su cuidado y el de su hijo.
3. Puede estar embarazada o tener hijos menores de tres años.
4. Confrontar problemas de adicción y alcoholismo.

TRATAMIENTO

El tratamiento ofrecido consta de tres fases, las cuales se subdividen en seis niveles.

1. Fase Inicial - I mes

a. Primer Nivel

Comprende el primer nivel de tratamiento. La residente pasa por un proceso de cernimiento y evaluación para identificar sus necesidades físicas, sociales, emocionales y vocacionales. Se diseño un plan de intervención basado en las necesidades identificadas por el equipo interdisciplinario y la residente. En esta etapa se ofrece apoyo para el cuidado de su hijo. Se limita la salida del Hogar.

2. Fase Intermedia - 6 - 8 meses (comprende los niveles II y III)

b. Segundo Nivel

Se le ofrece servicios médicos, de orientación, consejería y capacitación tales como: cuidado prenatal, cuidado del niño, manejo del hogar, confección de alientos, aprendiendo a vivir sin violencia, auto estima, relaciones interpersonales, principios y valores, prevención de recaída, preparación académica, vocacional y ocupacional.

c. Tercer Nivel

Además de lo permitido en el segundo nivel, se le conceden pases de dos horas para ir de compras, ir al cine, a la iglesia o realizar cualquier otra actividad permitida por el Hogar.

3. Fase de Reingreso a la Comunidad (comprende los Niveles IV, V, VI) 3 - 5 meses

a. Cuarto Nivel

Se prepara a la residente para su reingreso a la comunidad. Se enfatiza en la ubicación vocacional u ocupacional.

b. Quinto Nivel

Comienza la estructuración del plan de salida. Se le permite estar fuera del Hogar hasta cuatro horas diarias para realizar actividades de estudio, trabajo o cualquier otra que interese y esté permitida el Hogar

c. Sexto Nivel

Se le permiten visitas a su hogar con el niño. Una

de las visitas es de 24 horas, las otras de 48 horas. El técnico social del Hogar corrobora los pases. Se ofrece terapia de adicción y alcoholismo en las tres fases. Al ser aceptada en supervisión electrónica o libertad bajo palabra se da de alta al Hogar Intermedio Para Mujeres.

Se le da seguimiento hasta que extinga su sentencia. De presentarse alguna situación de emergencia, luego de finalizada la sentencia y que requiera la ayuda del Hogar, se le ofrecerá el servicio.

TRATAMIENTO NIÑOS:

1. Cernimiento psicológico
2. Evaluación y seguimiento pediátrico
3. Programa de estimulación temprana
4. Intervención familiar (Psicosocial)
5. Cuidado pre-natal
6. Plan de acción para parto
7. Taller escuela para padres y madres
8. Coordinación de servicios multidisciplinarios
9. Jardín infantil

STAFF

1. Técnicos Sociopenales
2. Sicólogos
3. Trabajador Social
4. Médico- Pediatra
5. Enfermería
6. Educadora en Salud
7. Maestra Economía Doméstica
8. Oficiales Correccionales

Coordinación de Servicios

Se coordinan servicios con agencias públicas y privadas de la comunidad tales como:

1. Departamento de Salud
2. Municipio de San Juan
3. Servicios Sociales
4. Vivienda
5. Departamento de Educación
6. Programa Supervisión Electrónica
7. Junta de Libertad Bajo Palabra
8. Grupos de Apoyo para Adictos
9. Organizaciones Religiosas

UBICACIÓN:

Avenida Ponce de León #806
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Iolie K. Walbridge, MA

Friday, May 11, 2001
Conference Workshops

Treating Families in Crisis

Facilitator: Milagros Colón, PhD
Recorder: Victor Madera
Language of Presentation: English

Iolie K. Walbridge, MA

Biographical Sketch

Iolie K. Walbridge, MA, is a licensed psychologist and family therapist with 25 years of clinical outpatient and inpatient experience working with children, adolescents, families and couples. Ms. Walbridge is a faculty member of the Family Therapy Training Center of the Philadelphia Child Guidance Center.

PHILADELPHIA CHILD & FAMILY THERAPY TRAINING CENTER, INC.

Our mission is to promote the delivery of strength-based, context-sensitive developmentally informed mental health training which builds on and supports the emotionally sustaining relationships of children, adolescents, adults and their families.

The Philadelphia Child and Family Therapy Training Center, Inc. became a corporation in July, 1999, as an outgrowth of the Family Therapy Training Center founded by Salvador Minuchin, M.D. in 1975. Our Center's focus is to offer training and research in couple and family therapy and developmentally based approaches to child, adolescent and adult behavioral health issues. Most of the Center's senior faculty worked with Dr. Minuchin at the old Philadelphia Child Guidance Clinic as the concepts of Structural Family Therapy were being defined and promulgated during the 1970's and have trained thousands of mental health and other human service professionals in the practice of family therapy, examining ecologically the home, school, and community environments for those elements of strength which can be mobilized to create positive, sustained change.

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Brief Workshop Notes

Families in constant crisis

Characteristics:

- emptiness,
- despair,
- lack of correction
- caring doesn't show

Excitement covers despair: roller coaster

Live in state of denial/ rage and need controls

Behavior:

- Don't keep appointments
- Beep continually (no sense of time)
- Distractions driving home base sessions
- Take even more load of responsibility

- Move frequently
- Adolescent behavior

Contact with church is positive

Crises interviewing

- Something needs to change
- Let them feel anxiety so they want change
- It is easier to deal with overt crises
- Covert – secretive because of shame and confusion – don't know what to do.
- Recurrent crises: eg. Alcoholism
- Temporary crises:

Crises are not about what happened but about perceptions and feelings of what they think happened.

When in crises – either too self-centered or too sacrificial is not good

- Identification of the crisis
- Definition of the crisis
- Characteristics of the crisis and of the family

Coalition not goal –alliance trans-generational, leaving one of the parts of the couple out. Has to be dissolved before anything can be done.
Negligence – probably because of burn out (they don't observe) a lot of blame goes on and that's not good
Guilt –is good in small doses, but no in large doses.

Notes

Braulio Montalvo

Friday, May 11, 2001

Conference Workshops

Family Violence and the Development of Offspring from Infant to Adolescent

Facilitator: Evadne McCleary, RN, MNS, MHS
Recorder: Areliz Quiñones, MHS
Language of Presentation: English / Spanish

Braulio Montalvo

For biographical sketch, please see conference workshop "Case Study: Treatment of Substance Abuse with a Family Approach"

Family Violence and the Development of Offspring from Infant to Adolescent

Abstract

This workshop is a continuation of the studies presented by Braulio Montalvo in "Case Study: Treatment of Substance Abuse with a Family Approach."

Workshop Notes

El taller comenzó a las 2:45 con un total de 30 participantes. Braulio Montalvo comenzó explicarlo que este taller era continuación de taller de ayer. Preguntó si puede bregar inmediatamente con casos de familias "sistemas" en crisis. Braulio comentó que todas las familias dan el consentimiento para ser grabadas. Sino quieren no se graba. Se presentó un video.

*VÍDEO: Clínica para personas que tienen problemas matrimoniales (es voluntario)

1. (Braulio) planteó la duda de cómo se puede trabajar con una familia que sufre de violencia.
2. (Observación) Hubo participación activa de los participantes
3. El alcoholismo era un problema al cual la dama recurría para calmar tensiones.
4. "Harm Reduction" es una técnica que se utiliza para trabajar con alcohólicos.
5. (Pte.): ¿Los niños que ven el maltrato, hay que removerlos del hogar?
6. (Braulio) contestó que no necesariamente. Hay que probar el daño inminente antes de remover niños. Desmembrar la familia debe ser una decisión delicada.
7. (Pte.): dijo que tenía una familia con padre alcohólico, 4 hijos y el papá abusaba de la mamá. La mamá dejó a papá, los niños le echaban la culpa a la mamá de haber abandonado a papá.
8. Lo más recalatrante es la pareja que trata de volver aún con la violencia. Es como un acordeón –abre y cierra– donde los niños pequeños sufren mucho.
9. Terapeuta debe convencerlos de la separación. Que la familia comprenda que necesitan ayuda. No se debe "arrancar" niños, la familia debe "darlos" si.
10. (Pte,): dijo que ella hubiera removido al niño.
11. (Braulio): dijo que la tarea del terapeuta no era "arrancar" a los niños. Ver otras alternativas.
12. (Braulio): dijo que la separación debe ser lo menos dolorosa posible.
13. El terapeuta atiende a los miembros de la familia por separado y luego en grupo.
14. Parada de confrontación – preguntarle a los miembros de la familia lo que quieren hacer. Que ellos dejan cuáles son sus opciones. Que ellos puedan elegir que harán con la familia.

15. El pasado ayuda al terapeuta a “predecir” el futuro. El terapeuta debe ver el contexto en donde está la familia.
16. Los terapeutas no deben ser arbitrarios en sus recomendaciones.
17. La gente puede ver la opción correcta, pero no tomar acción debido a la patología de los miembros de la familia.
18. El terapeuta debe promover el proceso de toma de decisión.
19. (Pte): ¿Preguntó ¿Quién era el cliente, Montalvo dejó que todos, el niño, la madre, los hermanos.
20. (Pte.): ¿Se debe compartir los casos así con el supervisor? Montalvo dejó que se debía consultar.
21. (Pte.): Luego del divorcio el niño dice que tiene paz y prefiere ver a su padre de vez en cuando.
22. (Braulio): dijo que la remoción es selectiva (por clase social y etnicidad).
23. (Braulio): dijo que hoy día te obligan a reportar los casos.
24. El terapeuta debe determinar cómo proceder en el caso de separación.
25. (Pte): dijo que los hermanos no imaginan que las cosas sean difíciles ahora; antes sus vidas eran diferentes.
26. (Pte): ¿El terapeuta eligió hacer la intervención por separado y no en grupo? Parecía ensayado.
27. (Braulio) dijo que al hacerlo con la familia completa no hay producto. Debe haber esfuerzo enfocado. No le da la oportunidad a cada miembro a expresarse. De forma empírica es más efectivo uno a uno. Esto implica cambio de composición de la familia. Esto se llama “coreografía”.
28. Si los valores han sido traspasados, la opción es divorcio.

VIDEO –jóvenes Con problemas de adicción y con niños en el hospital de Nuevo México.

1. Una pareja joven tiene un bebé prematuro y los terapeutas enfocan la importancia del cuidado del niño. Se e a los padres para que fomenten la salud del niño.
2. El papá agarra al bebé y esto hace que el papá no abandone la familia.
3. La terapeuta le indica al papá donde debe darle masaje al bebé. Esto hace que el padre se siente competente.
4. (Participante): la inclusión del padre es muy importante.
5. (Participante): ¿Se hace esto hasta con los padres que no son adictos?
6. (Braulio): dijo que sí. El estado anímico del bebe se ve afectado por el masaje. Esta es una forma de romper la cadena de la adicción.
7. (Pte.): ¿Estos estudios se han hecho con niños de padres adictos?
8. Braulio dijo que no; que se ha hecho con direrentes poblaciones.
9. El taller finalizó a las 5:00 p.m.

Notes

Jesús Lebron, MSW

Friday, May 11, 2001
Conference Workshops

Alternative Families & Substance Abuse Working with At-Risk Children & Adolescents of Lesbian, Gay, Bisexual & Transgender Parents

Facilitator: Edna Quiñones, PhD
Recorder: Carmen A. Marrero, MPH
Presentation Language: English

Jesús Lebron, MSW

Biographical Sketch

Jesús Lebron, MSW, has been involved in lesbian and ay grassroots organizing in New York City for over ten years. He has served as a board member of the Gay, Lesbian, Bisexual Advisory Board of the Office of the Manhattan Borough, of which he was President in 1996, and was an officer with Gay and Lesbian Americans. Mr. Lebron was the founder of Marriage Equality, an organization seeking to secure civil marriage rights for same-sex couples. He works as the training and outreach coordinator at Center Kids, the Family Program of the Lesbian and Gay Community Services Center in New York City.

Alternative Families & Substance Abuse: Working with At-Risk Children & Adolescents of Lesbian, Gay, Bisexual & Transgender Parents

Abstract

There exists no data suggesting that children of lesbian, gay bisexual and transgender (LGBT) parents are different in any aspect of social, psychological and sexual development from children of heterosexual or non-trsns-gener parents. Fears concerning the influence of sexual orientation of parents on the children, the development of "improper" sex-role behaviors or sexual conflicts, the risks of child sexual abuse and the concerns regarding risks to psychological health, self-esteem and social relationships resulting from stigmatization and peer conflict have not been substantiated. Providers must be cognizant of the challenges facing the LGBT population with regards to discrimination and oppression. Prevention-oriented education and support for LBT families must engage both youth and parents in long-term

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[Brochure Text]

CENTER KIDS
EL PROGRAMA FAMILIAR DEL CENTRO

Es el programa familiar del Centro de Servicios de la Comunidad Lesbiana y Gay

Fundado en 1988 Center Kids, el programa familiar del Centro, ha evolucionado de ser un grupo diseminado compuesto por una docena de familias a ser el líder nacional sobre temas legales, educativos, médicos y de derechos civiles de los padres y familias lesbianas, gays, bisexuales y transgéneros. Center Kids produce paquetes de información sobre planificación familiar para hogares gays y lesbianos, también el centro publica un periódico bimensual, *Family Talk,* con un calendario completo de los eventos de Center Kids. **Para mayor información o para hacerse miembro de Center Kids, por favor contactarse a Terry Boggis al (212)620-7310.**

TU MAMI PUEDE SER Abuela - **La paternidad o maternidad es una posibilidad para las lesbianas, hombres gays, bisexuales y personas de experiencia transgénera.**

Mientras que hombres gays y lesbianas siempre han tenido la posibilidad de ser padres o madres de niños procreados en pasadas uniones heterosexuales, la ultima década ha sido testigo de una explosión de familias encabezadas por parejas del mismo sexo quienes han elegido ser padres juntos.

Center Kids, el programa familiar del Centro, comenzó en 1988 con unas pocas familias lesbianas y gays que buscaban oportunidades de socialización para ellos y para sus niños. El programa creció rápidamente hasta convertirse en el más grande y en el principal grupo regional de la nación, sirviendo actualmente a 2,700 familias. Este actúa como modelo para una docena de programas satélites en el área de los 3 estados ["tri-state area"]; y se ha convertido en el líder nacional del frente legal, educativo, médico y de derechos civiles en los temas de familia, paternidad y maternidad de las lesbianas, gays, bisexuales y transgéneros (LGBT).

El apoyo a las familias LGBT continua siendo el foco de la misión de Center Kids. **Aquellos que estén contemplando la paternidad o maternidad pueden escoger uno de los siguientes:**

- Hombres
- Solteros
- Adopción
- Alternativas de inseminación, maternidad substitutiva y otras opciones biológicas de maternidad o paternidad.
- Mujeres
- Parejas

Los grupos en funcionamiento están provistos para:

- Padres y Madres
- Papás donantes
- Familias formadas a través de adopción
- Hijos mayores de padres gay
- Familias con niños de pasadas relaciones

Center Kids patrocina foros y paneles durante el año sobre temas tales como:

- Custodia
- Definición de nuestras familias
- Preocupaciones legales de las familias alternativas
- Escuelas seguras
- Temas sobre el desarrollo del niño en familias alternativas
- Planificación financiera para hogares no tradicionales

Center Kids apoya activamente los temas familiares de nuestra comunidad, tales como:

- Derechos de las lesbianas y gays al matrimonio
- Derechos otorgados por la sociedad doméstica
- Leyes progresistas de adopción
- Derechos reproductivos para las lesbianas, gays, bisexuales y personas transgenéros

- Una definición más amplia de la familia
- Inclusión en el curriculo escolar y confianza en la seguridad escolar para jóvenes y niños lesbianas, gays, bisexuales y transgéneros provenientes de hogares LGBT

NOSOTROS SOMOS FAMILIAS

Center Kids provee a los niños criados en hogares LBGT con oportunidades sociales tales como bailes, viajes de campamento, narración de cuentos, meriendas en el campo y fiestas en los feriados Una parte muy importante de la misión del programa es la de construir e integrar la comunidad de niños provenientes de familias alternativas. Los niños en Center Kids tienen la oportunidad de hacer amistad con otros niños que tienen padres del mismo sexo, mientras que los padres tienen la ocasión de conocerse y socializar por apoyo. *Family Talk,* el periódico de Center Kids, difunde un calendario de eventos relacionados con la Familia e información de cientos de hogares LGBT cada dos meses, dirección de servicios sociales y consejería e información de temas sobre familias no tradicionales. Para mayor información o para hacerse miembro de Center Kids y recibir nuestro periódico bimensual, por favor contactarse con Terry Boggis, Directora de Center Kids, al Centro (212) 620-7310.

CENTER KIDS

Parenthood is a real/ possibility for lesbians, gay men, bisexuals and people of transgender experience.

Founded in 1988, Center Kids, the Center's family program, has evolved from a loose networking group of a dozen families to a national leader on the legal, educational, medical, and civil rights issues of lesbian, gay, bisexuals, and transgender parents and families Center Kids produces gay and lesbian family planning information kits. and publishes a quarterly

newsletter Family Talk. with a complete calendar of Center Kids events. For more information or to become a member of Center Kids, please contact us at (212) 620-7310 or e-mail:centerkids@gaycenter.org

Supporting LGBT families and those considering or planning for parenthood continues to be the focus of Center Kids' mission. We provide **support groups** on/for:

- LGBT parenting
- LGBT people considering parenthood
- Alternative insemination, surrogacy, and other options for biological parenthood
- Pregnant Lesbians
- Kids of lgbt parents

Center Kids sponsors **forums and panels** throughout the year on topics such as:

- Adoption and foster care
- Child development issues in alternative families Custody and visitation
- Financial planning for non-traditional households
- Seeking legal recognition for our families
- LGBT issues in schools

Center Kids **advocates** for our **communities' family issues,** such as:

- Civil marriage, civil unions and domestic partnerships for same-sex couples
- Progressive adoption laws
- Reproductive rights
- An expanded definition of family Justice for economically disadvantaged lesbian, gay, bisexual, and transgender families
- Inclusive school curricula and school safety assurances for our children

WE ARE FAMILIES!

Center Kids provides children raised in LGBT homes with social opportunities such as picnics and holiday parties–a central part of the program's mission of community-building and networking for children from alternative families. Children in Center Kids have opportunities to befriend others with LGBT parents, while their parents have a chance to meet and socialize for support. Center Kids has a new LGBT parenting education program. In development, the program will be a series of informational and interactive parenting solutions workshops, designed to strengthen and support our families, particularly families of color. From preparing ourselves and our children for transitions in the LGBT family cycle to coping with the difficult challenges brought by HIV/AIDS, the program offers a safe, welcoming space for lgbt parents to network and support each other and to discuss and help address the challenges of parenting. Center Kids volunteer

LGBT Family Sensitivity Schools Outreach Program offers our families and their supporters the opportunity to work within schools throughout NYC in helping foster a climate of understanding and inclusivity in the educational lives of our children.

Family Talk, the Center Kids newsletter, disseminates a calendar of family-related events and information to thousands of LGBT households.

Center Kids fields dozens of calls each week from people seeking legal assistance. medical information, social service and counseling referrals, and information on non-traditional family issues.

Center Kids' Family Talk List Serve is an online community of LGBT parents and people considering parenthood and family formation who share a common interest in lgbt parenting and other family issues. Designed to facilitate e-mail-based dialogue, the list serve provides many different uses**:**

- be notified in advance of Center Kids support group meetings and events
- exchange ideas and discuss issues
- learn lbgt family policy in the news and political arena
- network with other lgbt parents and people considering parenthood

For more information, or to become a member of Center Kids and receive the monthly newsletter or to get on our list serve, contact Terry Boggis, Center Kids Director, or Jesus Lebron. Training and Outreach Coordinator. **at 212-620-7310** or e-mail us at **centerkids@gaycenter.orq**

THE FAMILY PRIDE COALITION

Founded in 1979 as Gay and Lesbian Parents Coalition International (GLPCI), the Family Pride Coalition is a national non-profit with a mission to advance the well-being of lesbian, gay, bisexual and transgender parents and their families through mutual support, community collaboration, and public understanding.

We offer individuals, families and parenting groups technical assistance, information, support, referrals, and resources. Local parenting groups may become a member of our coalition at no fee. Individual and families are invited to join our membership to support the work we do to strengthen our families. For more information, call (619) 2960199 or email program@familypride.org

Starting A Local LGBT Parenting Group

While there are many local lesbian, gay, bisexual and transgender parenting groups around the country and around the world, there are more parents and families in need of support than there are organized groups. If you did not find a group in your neighborhood, consider starting one! Each group is unique, defined by environment, community, and family need. Some groups have hundreds of families that participate in conferences, some publish newsletters, some are a small number of families that meet for monthly potlucks. Groups can be social, educational, political or a combination of these. Family Pride is available to assist the start up of a group in your area We provide free individual consultations to determine resources and needs. We can help you find parents, recruit volunteers and organize a "kick off" activity. We mail free information and resources to all groups once a month and we have a parenting group listserv for any group or family.

If you are interested in starting a parenting group in your community, here are some questions to think about. Contact our office to set up a telephone consultation to assist you getting your "feet wet" in the world of LGBT parenting group leadership.

Questions for New Groups:

Where will parents come from? Who will parents be? Lesbian, gay, bisexual, transgender? Moms only? Dads only? Formerly marred? What will be the focus of the group? Social? Advocacy? Education? Parents? Kids? Who will help put this together?

TO START A LOCAL GROUP CONTACT:

Suzette Southfox, Program Director
Prograrn@FamilyPride.org
http://www.familypride.org
PO Box 34337, San Diego. CA 92163
(6 1 9) 296-0 1 99

OUR FAMILY VALUES:
LOVE RESPECT PRIDE
COMMITMENT

Dr. Robert Schwebel

Friday, May 11, 2001

Conference Workshops

New Ways of Working with the Substance Abuse Problems of Adolescents

Facilitator: Gertrudis Maldonado, PhD
Recorder: Manuel Solis, MHS, TS
Language of Presentation: English

Sponsored by: Ramsey Youth Services

ROBERT SCHWEBEL, Ph.D.

Biographical Sketch

Dr. Robert Schwebel is a clinical psychologist specializing in relationships, marriage, children and families. He is the author of The Seven Challenges Approach, a book presenting an approach for treating adolescent substance abuse which is used around the United States in schools, outpatient treatment, group homes, residential treatment, in-home counseling services and in juvenile corrections.

November 1999, Newmarket Press published Dr. Schwebel's latest book, *How to Help Your Kids Choose to Be Tobacco-Free*. A media trip followed, which included stops in Los Angeles, New York, Washington, D.C., and finally Atlanta for CNN interviews. A column about the book appeared in the October 4, 1999 issue of *Newsweek*. A story was written about it in USA Weekend, October 29-31, 1999. *The New York Times Features Syndicate* excerpted parts of the book for sales around the country. The paperback edition of the book, just released, is titled *Keep your Kids Tobacco-Free*.

It was a busy writing year. The February 2000 issue of the AMA publication *Adolescent Medicine: State of the Arts Review* has an article, "Adolescent Substance Abuse" that Dr. Schwebel co-authored with Dr. George Comerci, former president of the American Academy of Pediatrics. The May/June 2000 issue of Counselor Magazine has Dr. Schwebel's article, "Child and Adolescent Tobacco Use." Another article, "Drug Courts and Substance Abuse" will appear in this publication in 2001. A forthcoming issue of Youth and Society will have an article co-authored by Dr. Schwebel on "State of the Art Substance Abuse Treatment."

Through a grant from the Center for Mental Health Services, Dr. Schwebel completed a 27-page booklet, *Helping Your Children Navigate Their Teenage Years: A Guide for Parents*, for the White House Council on Youth Violence. President Clinton released this document at a press conference in January, 2001.

Also this year, Dr. Schwebel revised *The Seven Challenges* book (3rd edition) and the nine Seven Challenges Journals (2nd edition), which are now translated and available in Spanish.

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Abstract

New Ways of Working With Adolescent Substance Abusers

The workshop presents an overview/critique of traditional approaches to adolescent substance abuse treatment and the use of powerful and effective interventions. The following topics will also be presented: adolescent development and substance abuse: promoting healthy development with developmentally appropriate interventions; new definitions of success; new ways to think about drug treatment, and working with families.

[Workshop Outline from Robert Schwebel, Ph.D.]

1. The mad rush for abstinence: Overview/critique of traditional approaches to adolescent substance abuse treatment

2. Youth response to the mad rush for abstinence: Fakers, fighters and followers
   Fakers: Telling adults what they want to hear: "I'm going to quit"
   Fighters: Resisting adults
   Followers: Trying to quit without adequate preparation

3. New ways to think about drug treatment. Slowing the rush. Start where kids "are," not where we want them to be. Social and cultural understanding of personal context. What are powerful and effective interventions?

4. Adolescent Development and Substance Abuse: Promoting healthy development with developmentally appropriate interventions

5. Stages of Change and Substance Abuse
   Prochaska, DiClemente and Norcross on stages of change
   Patient-treatment matching

6. New definitions of success: Redefining treatment goals
   Progress along a continuum
   Treatment goals that are short of immediate, long-term abstinence
   Accountability and false accountability

7 A different type of relationship: an alternative to harsh confrontation
   Redefining the counselor role
   Communicating a new role to youth: undoing expectations
   Being problem-solving partners with adolescents
   Respectful power: Different types of power and influence

8. An educational/ consciousness-raising process
   Managing ambivalence
   Allow discussion of "benefits" of drug-use
      Validation of motivation
      Holistic: Identify co-occurring problems
   New ways of working with denial
   The rebuttal cycle: rolling with resistance
   Reducing defensiveness and opposition
   Respectful and loving confrontation
   Techniques for promoting self-motivated change
      Discussing harm from drug use

9. Working with the family

10 Stages of treatment
   Create climate of change

Increase motivation
Clarifying and making the decision to quit, and to make lifestyle changes
Relapse prevention; including 12-steps as an intervention

11. **The Seven Challenges**: An example of a model program: culturally sensitive, developmentally appropriate, and matching treatment to stage of change: The Seven Challenges challenge ourselves to make wise decisions about alcohol and other drugs.
    1 We decided to open up and talk honestly about ourselves and about alcohol and other drugs.
    2 We looked at what we liked about alcohol and other drugs, and why we were using them.
    3 We looked at our use of alcohol and other drugs to see if it had caused harm, or could cause harm.
    4 We looked at our responsibility and the responsibility of others for our problems.
    5 We thought about where we seemed to- be headed, where we wanted to go, and what we wanted to accomplish.
    6 We made thoughtful decisions about our lives and about our use of alcohol and other drugs.
    7 We followed through on our decisions about our lives and our drug use. If we saw problems, we went back to earlier challenges and mastered them.

These challenges are based on the thoughts and experiences of a culturally diverse group of young people who either recovered from drug problems or prevented themselves from having serious problems with drugs.

Included are excerpts from: *Saying No Is Not Enough*: *Helping Your Kids Make Wise Decisions About Alcohol, Tobacco and Other Drugs,* by Robert Schwebel (Newmarket Press). These pages present positive ways to open a discussion and gather information from adolescents about their drug use.

1. **Introduction to The Seven Challenges**
2. **Executive Summary of Seven Challenges Evaluation** by the University of Arizona
3. **Key Points of New Ways of Working with the Substance Abuse Problems of Adolescents**

(These are excerpts from The Seven Challenges book)

Also Included in the materials for this section are seven articles from *A.O.D.: The Alcohol and Other Drugs Review*, written by Robert Schwebel.

(1) **How People Change.** re: stages of change in overcoming addiction.

(2) **Underlying Psychiatric Problems of Drug Abusers**. re: Longitudinal study of abstainers, experimenters and frequent users of drugs; characteristics of abusers.

(3) **Revisiting Denial and Resistance**. re: The pitfalls of harshly confronting drug abusing clients.

(4) **Motivational Interviewing**. re: Finesse methods of increasing motivation to change.

(5) **Drug Seeking Lifestyle**. Re: behavioral patterns that define the lifestyles of drug abusing people.

(6) **Relapse Prevention**. re: How to help once a decision to be drug-free has been made.

(7) **AOD Abuse**: A Defect in Character or a Social Problem.

Introduction to The Seven Challenges Program

The Seven Challenges Program is rooted in the latest research literature regarding adolescent substance abuse. The approach addresses the underlying psychological problems that typically accompany drug abuse, the stages of change in overcoming drug problems, the preparation required for individuals to effect lasting change in their lives, the life-skill deficiencies that must be corrected so that individuals can meet their needs without drugs, and the skills and values needed to avoid relapse.

The program is aligned with the important research findings of psychologists Prochaska and DiClemente about the stages of change in overcoming addictions. Patient-treatment matching is a high priority. Instead of a one-size-fits-all approach, the Seven Challenges Program is individualized with a careful matching of client stage of change and level of involvement with substances to the appropriate intervention. This matching has special importance with an adolescent population in which most clients do not enter treatment voluntarily and often will not honestly admit to a problem. Often they will make "phony" commitments to change and go through weeks or months of "faking it" by giving adults "what they want to hear." Sadly it is a common practice in adolescent substance abuse treatment to accept insincere commitments to change and to proceed with teaching abstinence to young people – often skilled at the art of deception – without getting an honest and internally motivated commitment to such change. The Seven Challenges Program is specifically designed to create a climate of honest disclosure and to help young people make real progress through the stages of change.

The Seven Challenges are as follows:

1. We decided to open up and talk honestly about ourselves and about alcohol and other drugs.
2. We looked at why we were using alcohol and other drugs.
3. We looked at our use of alcohol or other drugs to see if it has caused harm or could cause harm.
4. We looked at the relationship between our drug use and other problems in our lives.
5. We thought about where we seemed to be headed, where we wanted to go and what we wanted to accomplish.
6. We made thoughtful decisions about our lives and about our use of alcohol and other drugs.
7. We followed through on our decisions about our lives and our drug use. If we saw problems, we went back to earlier challenges and mastered them.

These challenges, which were developed with the participation of a culturally diverse group of youth, match what we know about adolescent development. Adolescents are charged with forming their own independent identities: Rather than telling them what to do and generating either "phony" compliance or rebellion, we need to help them arrive at their own wise decisions. The Seven Challenges engages young people in actively thinking about drug/alcohol use and its direct effect on their lives. Working through the program helps them understand what needs they are meeting by using drugs, what harm they are causing, and what it entails to give up a drug using lifestyle. This is a decision-making program. Once youth decide to change and make a commitment to change, the program prepares them for success. The Program is also holistic, helping young people understand what new life skills must be learned and positive values attained in order to have a fulfilling and healthy life without drugs. Co-occurring problems must be addressed. Lifestyle action groups are provided for youth who are ready to succeed in making changes both in their drug habits and lifestyle.

EXECUTIVE SUMMARY
PROVIDENCE: SEVEN CHALLENGES
April 1999

Providence's Seven Challenges program is a substance abuse treatment program for adolescents ages 12 to 18 years. The Seven Challenges curriculum is based on the Stages of Change Theory, which assumes that people enter treatment at different stages in the change process. Effective treatment must take into account the stage of the client; whether the client is not yet contemplating change, contemplating change, in the process of making change or trying to maintain positive behavior change. Given Providence's commitment to providing quality services and to the evaluation of Seven Challenges treatment effectiveness, Providence has collaborated with the University of Arizona (U of A) to conduct an outcome evaluation.

Since January, 1998 adolescents in the Seven Challenges are assessed at treatment entry (baseline) and at three months after treatment exit (follow-up) by U of A personnel. Using the Problem Oriented Screening Instrument for Teenagers (POSIT), the adolescents are assessed on their substance use, physical health, mental health, family relationships, peer relationships, educational status, vocational status, social skills, recreation, and aggression. A comparison of baseline and follow-up data with regard to these domains indicates positive changes:

- positive changes were evidenced for all of the 10 domains, and
- positive changes in the substance use and the aggressive domains reached statistical significance (substance use $p = .03$; aggressive $p = .01$).

In addition to the POSIT, data was collected on criminal involvement, HIV/AIDS knowledge, relationships and communication, level of honesty, and stage of change. On average outcome data with regard to these domains also showed positive results:

- criminal behavior decreased
- HIV/AIDS knowledge increased
- relationship and communication with family members and adults improved level of honesty heightened, and
- the stage for change increased from "almost ready to make changes or have made small changes" to being "firmly committed to not using drugs for more than two months".

KEY POINTS of New Ways of Working with the Substance Abuse Problems of Adolescents

1. Slow the rush for a commitment to abstinence.
2. Undo the expectation that you are working with only one purpose: to make them quit using drugs
3. Think about stages of change
4. Redefine success in smaller chunks - as moving through the stages.
5. Validate reasons why people use drugs
6. Differentiate use/abuse/dependence
7. Approach the harm from drug use very slowly and gently - don't get argumentative; don't build a case; avoid the rebuttal cycle
8. Roll with resistance
9. Clarify ambivalence
10. Don't try to control behavior
11. Elicit concerns
12. Raise doubts
13. Use loving confrontation
14. Identify underlying issues and build optimism about positive ways of coping with problems and life's stress
15. Postpone a discussion of drug decision-making
16. Clarify the meaning of a decision to quit using drugs
17. Nurture a future orientation
18. Help with lifestyle choices
19. Help with drug decisions
20. Plan for success

Dr. Robert Schwebel

A.O.D.

The Alcohol & Other Drugs Review

From Theory to Practice

Vol. 2, No. 1 Spring 1993

HOW PEOPLE CHANGE:

APPLICATIONS FOR TEENS WITH AOD PROBLEMS

When parents or school authorities bring teenagers for help with drug problems, they expect that the practitioner will encourage and teach abstinence. They assume that teens are ready to quit when they enter treatment. Practitioners often respond to these expectations by launching an aggressive abstinence program. Although some succeed in their efforts, many do not Often, teens compliantly agree with practitioners while confined in residential or hospital treatment, only to resume alcohol and other drug (AOD) use upon their release.

Practitioners who work with adolescents make a serious mistake when they ASSUME that teens referred for AOD treatment are ready for abstinence. Many of the referred teens have never even contemplated quitting.

In a recent research study, Prochaska, DiClemente and Norcross examined the process by which people overcome addictive behaviors, either on their own or with the help of professionals. According to their findings, people who successfully break addictions inevitably pass through five stages, three of which precede taking action. The researchers warned:

"The vast majority of addicted people are not in the action stage"

Stages of Change

Precontemplation: In this stage, AOD using Individuals have no intention to change. They are unaware or under-aware of their problems, and if in counseling, it is only because they have been coerced. They may wish to change, but don't intend to.

Contemplation: In this stage, they are thought about overcoming them. However they are not yet committed to action. Contemplators struggle with positive evaluations of the addictive behavior and the amount of energy effort, and loss it will cost to overcome it "1 think I should do something," they say. "Maybe I will."

Preparation: This stage combines intention and preliminary behavioral change. People are said to be in this stage if they have unsuccessfully taken action in the past year and now intend to take strong action within a month. They may have recently reduced their AOD use, but not yet established and attained a criterion for effective action, such as abstaining from cigarette smoking.

Action: This is the stage in which individuals modify their behavior, experiences, or environment in order to overcome their problems. The action stage is said to begin when an individual has successfully altered the addictive behavior for a period of one day to six months. Success means reaching a particular criterion, such as abstinence. This stage involves behavioral changes and a considerable commitment of time and energy.

Maintenance: This is the stage in which people work to prevent relapse and consolidate gains made during the action stage. It is not a static period, rather a continuation of the struggle.

Once it was understood that people passed through various stages in overcoming addiction, it became evident that different clinical interventions are more appropriate at different stages.

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Stage Appropriate Clinical Interventions

The earlier stages are more oriented toward INSIGHT, the after ones, toward behavioral ACTION. For example, consider the appropriate interventions during the contemplation stage and the action stage.

People in the contemplation stage are often receptive to consciousness raising techniques such as observation, confrontation, and interpretation. They are likely to benefit from role-playing and psychodrama techniques, and from reading educational material During this stage, they increasingly express feelings about their problems. As this occurs, they are more likely to reexamine personal values. Contemplators also are increasingly willing to evaluate the effect of their behavior on the people closest to them.

During the action stage, people often rely on what the researchers call "self-liberation." They commit themselves to act in a strong way, and then follow through with will power. Behavioral techniques such as stimulus control and counterconditioning are especially helpful during this stage. Stimulus control means restructuring the environment, avoiding stimuli that elicit the addicted behavior. For example, it could mean staying away from AOD using friends, removing AODs from one's home, and avoiding the sight or smell of AODs. Counterconditioning means substituting alternative behaviors for AOD use, such as assertive action, new types of "self talk," and relaxation exercises. Because the action stage is a stressful time, individuals increasingly need support and understanding from helping relationships.

Assessing the Stage of Change

This research on overcoming addiction shows the importance of assessing a client's stage of change: AU drug abusing or drug dependent people should not be treated as if they were the same. Individuals will be at different stages of the change process and need different interventions.

An understanding of the stages of change should guide clinical practice. Failure to understand them can result in serious errors. One error is that practitioners might encourage overt action, such as abstinence, without providing the requisite insight and preparation. As the researchers explained: "Overt action without insight is likely to lead to temporary change" (p. 1111).

Another possible problem from failing to understand the stages is that therapists may attempt to help clients _____basis of awareness alone without using techniques designed to modify behavior. This is likely to result in failure and a defeatist attitude in the client.

Understanding the stage of change has important applications for dealing with relapse. Most people are nor successful in their first attempt to modify addictions. Relapse is the rule rather than the exception. During relapse, individuals regress to an earlier stage Some feel like failures and regress to the precontemplation stage. Others only regress to the contemplation or preparation stages ... to consider plans for future actions while learning from their recent efforts. However most do not revolve endlessly in circles and do not regress all the way back to precontemplation. By helping clients understand the stages of change, therapists can help them learn from their mistakes, fortify them against feeling like failures, and prevent them from slipping back to the earliest stages of change.

Promises

Third party payers, parents, and school officials want abstinence, and want it now. Reacting to the pressures of these expectations, practitioners often act as if adolescents in treatment are ready for this change. They browbeat teenagers who agree to quit using AODs, and accept instruction about how to quit, without thinking it through for themselves. Because they do not get stage appropriate help, most of them fail and feel like failures.

Therapists must have the courage not to promise the impossible and to stick with what is appropriate in each case.

SOURCE: Prochaska, J.O., DiClemente, C.C., Norcross, J.C. (l992). In search of how people change. *American Psychologist,* 47, 1102-1114.

CLINICAL APPLICATION

A fifteen year old boy AT desert Hills Hospital talks openly about the way AODs have been a serious part of his problems.

"what do you want to do about it?" the psychologist asks.

"I want to quit," the boys says.

"You know in this program, you don't have to say that you want to quit. Just say what you really think and feel."

"Well, I do and I don't want to quit."

"Fine then, let's talk about the reasons you want to keep using and the reasons you want to quit."

It is important that the practitioner realize that this teenager is in the contemplation, not action, stage. Given a chance to think it through for himself, he can be helped to make the right decisions.

Underlying Psychiatric Problems of Drug Abusers.

Re Longitudinal Study: Use and Abuse

Personality? Parenting? How do they relate to drug abuse?

Jonathan Shedler and Jack Block from the University of California, Berkeley, recently reported a long term developmental study of individuals over the course of 30 years giving insight into the personality factors and parenting styles that correlate with drug abuse by teenagers. The researchers pointed out that _____ studies of drug use lump together all children who use drugs and compare them to abstainers. BO____ this they failed to differentiate between those who might be called experimenters and those who are clearly in a category of abuse. The Shedler and Block paper differentiated drug abstainers, drug experimenters and drug abusers.

Subjects recruited

Subjects were recruited into the study from a nursery school at age 3. They were assessed on a wide range psychological measures at ages 3, 5, 7, 11, 14, and 18.

Abstainers were defined as subjects who had never tried marijuana or any other drugs.

Experimenters were defined as subjects who had used marijuana "once or twice," "a few times," or "once a month" and who had tried *no more* than one drug other than marijuana.

Frequent users were defined as subjects who reported using marijuana once a week or more and had tried at least one drug other than marijuana. The drug experimenters were used as a frame of reference for comparison purposes because they constituted the largest group and reflected the pattern of drug most typical for adolescents in the nation as a whole.

From Drug Use to Drug Abuse

What leads some teenagers to become heavy drug users, while others experiment and seem to escape without harm? In the past researchers only compared alcohol and other drug users to non-users and failed to make important distinctions about level of use, In the January, 1950 edition of the APA *Monitor,* staff reporter Tina Adler discussed a technical review conference sponsored by the National Institute on Drug Abuse titled "The Transition from Drug Use to Abuse/Dependence."

One point of view is that drug abuse is simply a linear extension of drug use, and drug abuse prevention requires preventing any drug use whatsoever, perhaps following the "Just Say No" approach.

A second perspective is called the "clinical model." Although drugs and social factors are influential, according to the clinical model, characteristics of the individual strongly determine the person's vulnerability to drug abuse. These people would have problems even if they were not exposed to drugs. The clinical perspective calls for a greater variety of interventions that are more individualized, both to prevent and treat drug abuse.

In the same January 1990 issue of the APA *Monitor,* Tina Adler discussed the findings of Robert Pandino, a psychologist at Rutgers University. He found that those most at risk for problems with alcohol or drugs have strong and lasting negative feelings. They use drugs to try to handle these feelings. Also, they are easily aroused. This means that they are reactive and impulsive They have a strong tendency to be affected by their environment and to react to it.

People with high negative affect feel that bad things are happening to them. They tend to be distressed, upset, nervous and tense. They dwell on the negative.

The treatment and prevention implications are interesting. For one thing, Pandino suggests that it is much more important to look at individuals' problems and underlying conditions, such as whether they suffer from negative affect, than to bombard them with drug information. The resources invested in a global effort to educate about the dangers of drugs could be used to reduce whatever is making people unhappy in the first place. Teaching mood management could be a key in both prevention and treatment of drug abuse and drug dependency.

Troubled, alienated adolescent

The emerging picture of a frequent user is one of a troubled adolescent who is alienated from others, unhappy, impulsive, and emotionally withdrawn. He expresses maladjustment through undercontrolled, overtly an _____.

The antecedents of these troubles were found to exist as early as age 7, predating the drug use. Relationships at home –especially with mothers – seemed to be connected with frequent drug

use. There were few differences between the fathers of experimenters and frequent users. However, the mothers of the frequent users were "...perceived as relatively cold, unresponsive, and underprotective." Although they gave little encouragement, they pressured their children to perform well.

Different kinds of people

The results show that drug experimenter, and frequent users are very different kinds of people from a psychological point of view. The meaning of their drug use is quite different. Although Shedler and Block were clear that they do not necessarily condone the behavior, the drug use of drug experimenters represents developmentally understandable experimentation. However for the frequent users, drug use is a manifestation of a general pattern of maladjustrnent, a pattern that predates adolescence and predates the initiation of drug use.

Current theories emphasize the role of peers in encouraging drug use. The importance of peers in encouraging experimentation cannot be denied. But peers are an inadequate explanation for *frequent* drug use. That use appears to be motivated by deeper psychological causes.

'Just say no'

Current social policy assumes that peer influence leads to experimentation which in turns leads to abuse. Thus we have "just say no" to discourage experimentation. Shedler and Block argue that given the developmental tasks of adolescence, efforts to eliminate drug experimentation are likely to be costly and meet with limited success.

The authors state that current efforts at controlling drug use by drug -education that stresses resisting peer pressure is flawed. They say that such efforts do not give adequate recognition to the deeper problem of drug abuse and its psychological underpinnings: "the psychological triad of alienation, impulsivity, and distress." Individuals with these particular personality characteristics are the ones who really need help to avoid potentially catastrophic results in their lives.

Empathic parenting

"Given current understandings of personality development, it would seem that the psychological triad of alienation, impulsivity, and distress would be better addressed through efforts aimed at encouraging sensitive and empathic parenting, at building childhood self-esteem, at fostering sound interpersonal relationships, and at promoting involvement and commitment to meaningful goals. Such interventions may not have the popular appeal of programs that appear to tackle the drug problem *directly,* but may have greater individual and societal payoff in the end."

SOURCE: Shedler, J. and Block, J., (1990). "Adolescent Drug Use and Psychological Health: A Longitudinal Inquiry." American *Psychologist,* Vol. *45, No. 5,* 612-630

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The Alcohol & Other Drugs Review

From Theory to Practice

Vol. 2, No. 4

Revisiting Denial and Resistance

Why do the majority of people with substance abuse problems not seek treatment? Why do so many people drop out of treatment?

Clinicians typically attribute these failures to denial and patient resistance to change. And the proposed solution (which often fails) has generally been harsh confrontation of the client and his or her perceived state of denial.

In a recent article, Frederick Rotgers (1994) discussed new thinking about the change process in addiction. He noted that many substance dependent people stop or reduce their drug use *without* any formal intervention. Many others would like to seek professional assistance, but do not. He reported that a recent study on the barriers to treatment found that *35-60%* of substance abusers cited the following reasons for not seeking help: inability to share problems, the stigma of being labeled an "addict," embarrassment about one's problems, and negative attitudes toward available treatment. Only 24% of alcohol abusers and 20% of drug abusers stated they did not seek treatment because they did not have a problem. Thus, the vast majority did not deny having a problem.

In considering the treatment failure of those who started in treatment but terminated prematurely, Rotgers refers to the work of Prochaska, DiCiemente and their colleagues on the stages of change (discussed in Vol 2. No l of the AOD Review). These researchers found that people with addictive behavior pass through three stages before they are ready to take decisive action to change their behavior: pre-contemplation, contemplation and preparation.

People at different stages of change require different treatment approaches. In this context, treatment failure is often the result of mismatches between therapists' approach and the clients' stage of change. People in the first three stages of change are not ready for taking action. They are not fully aware of their problem or only beginning to recognize it. These clients need help in gaining awareness and insight. However, most programs start by requiring action, usually one particular action: abstinence. Clients feel that they have failed if they cannot agree to this requirement.

Adolescents who are often coerced into treatment by school, family or the juvenile justice system are likely to be quite ambivalent about changing their behavior. Generally they are in the precontemplation, contemplation, or preparation stages ...not ready to take action to change their drug using behavior. When they don't immediately take the decisive action prescribed by a practitioner, they are told that they are in denial. Often they react against this characterization by resisting or leaving treatment.

HARSH CONFRONTATION FOR LACK OF MOTIVATION

Traditional thinking about lack of motivation for change in addictions has placed the burden on the patients.

Rotgers wrote: "Addictions are probably the only disorders in which clinicians demand that clients change to some degree before they enter treatment by expressing appropriate *motivation* to change, eliminating *denial,* and making a commitment to the sacrifices required by treatment. Traditionally the most frequent method of inducing these changes in patient motivation has been an approach in which the patient is forcefully confronted with evidence of his/her addiction, and left no alternative but to enter treatment or experience dire consequences." (p 2).

However, using the stages of change model, a different view of

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motivation is proposed. As you will see in the following article, it has been suggested that the confrontational approach can create or exacerbate resistance and denial. Motivational interviewing is a promising new alternative for facilitating behavior change by matching the stage of change with the appropriate treatment.

SOURCE: Rotgers, F (1994). Motivating substance dependent patients for change: new thinking and techniques, *Carrier Foundation Medical Educational Letter, #186,* March.

Motivational Interviewing

Why do people get stuck, persisting in patterns of behavior that clearly harm them and the people around them? Why do they pursue short term gratification at the expense of long term harm? Even when they know they are harming themselves, why do they vow to change, but keep on relapsing?

In Motivational Interviewing, William Miller and Stephen Rollnick (1991) attempt to answer these questions, stressing that people can be trapped by ambivalence.

AMBIVALENCE

Ambivalence means having coexisting but conflicting feelings about something. Simultaneously, or in rapid succession, people go back and forth between different feelings. For example, they want to use drugs, but don't want to use them. They want to change, but don't want to. They feel two different ways.

A see-saw is a good metaphor for drug use. In psychological parlance, it is an approach-avoidance conflict, with perceived benefits from drug use and perceived costs. From this perspective, ambivalence about drug use makes sense. People swing back and forth on both sides of the ambivalence in sometimes confusing and frustrating ways.

Miller and Rollnick explain that people who do not immediately commit to abstinence are not necessarily in denial. It may not be that they are resistant or lack motivation. Typically the problem is that they are ambivalent, and caught in an approach-avoidance conflict.

FIVE GENERAL PRINCIPLES

Miller and Rollnick list five principles behind motivational Interviewing

(1) – EXPRESS EMPATHY.

Empathic warmth and reflective listening could be called "acceptance." Paradoxically, it has been shown that accepting people as they are is an important component in motivating change. This approach contrasts with non-acceptance – "You're not okay; you have to change"- which seems to keep people stuck. Within this framework, AMBIVALENCE IS SEEN AS NORMAL AND RELUCTANCE TO CHANGE IS EXPECTED.

(2) DEVELOP DISCREPANCY.

Motivation for change occurs when people see a discrepancy between their present behavior and important personal goals. Developing discrepancy means to make use of this discrepancy, increase it, and amplify it until it overrides attachment to the problem behavior.

(3) AVOID ARGUMENTATION.

In simplest terms, arguing is counterproductive. It breeds defensiveness. Therapists too often fight clients rather than motivating them to change.

(4) ROLL WITH RESISTANCE.

Clients start with their present perceptions. Skillful counselors can reframe the thinking to create a momentum toward change. Reluctance and ambivalence are not opposed. Rather clients are offered new perspectives and invited to consider new information.

(5) SUPPORT SELF- EFFICACY.

Self-efficacy is a person's belief in his or her ability to carry out and succeed with a specific task. It is not enough to persuade someone they have a problem. People need a sense that they can do something about it. This is promoted by stressing personal responsibility (rather than "I will change you"). It is bolstered by offering, hope and by presenting options.

CONFRONTATION CREATES RESISTANCE AND DENIAL

Miller and Rollnick suggest that the traditional confrontational style used on drug abusing individuals can actually create or exacerbate resistance and denial.

Counselors tend to misinterpret client ambivalence as a personality problem. They see the unwillingness to immediately commit to abstinence as a faulty judgment or mental state and a sign of poor motivation. They conclude that clients need to be educated and persuaded. So they begin to stress the adverse consequences of drug use.

This represents one side of the conflict from which the client suffers. The client then voices the other side of the conflict: reasons to keep using drugs. Therapists interpret this client response as resistance, and will escalate the conflict and by arguing even more intensely about the need to change behavior The client counters with stronger reasons why the behavior is attractive and

acceptable. In this confrontation-denial trap, the counselor takes responsibility for the pro-change side of the conflict and the client is left to defend the status quo. The results are the opposite of what was intended.

Miller and Rollnick also suggest that harsh confrontation can promote the status quo by creating psychological reactance, which is the pattern of emotions and behavior that occurs when an individual feels that his or her personal freedom is being reduced or threatened. When people are told that they must, should or cannot do something (such as using drugs), they are likely to argue and assert their personal freedom. This reaction may be particularly strong when they are told not to do something about which they are ambivalent. The authors cite a study that demonstrated that high levels of confrontation actually increase client resistance in treatment.

MOTIVATING CHANGE

In their book, Miller and Rollnick say that the therapist should not blame a client for his or her unwillingness to commit to abstinence. It is not a fault of a client. Rather it is a stage of change. The role of a therapist is to motivate progress.

"As a therapist, you are not a passive observer of your clients' motivational states. You are an important determinant of your clients' motivation. 'Lack of motivation' is a challenge for your therapeutic skills, not a fault for which to blame your clients." (p.35).

Motivational interviewing is designed to help clients reach a decision and build a commitment to change. It offers both a framework and positive techniques for dealing with the ambivalence that entraps people in self-destructive behavior.

SELF-MOTIVATIONAL STATEMENTS

One of the methods suitable for use in motivational interviewing is to help clients develop a balance sheet, with the pluses and minuses for drug use. This is a way to clarify the ambivalence and consider the possibility of change.

One of the keys to success is to get the clients, themselves, to present the arguments for change. Counselors try to elicit self-motivational statements. Two categories of these statements are problem recognition (such as "I guess maybe there is a problem. I never realized I was drinking this much. Maybe I have been taking foolish risks") and expressions of concern ("I'm really worried about this. I feel pretty hopeless").

These modest statements in the contemplation of change represent progress. This progress is consistent with what we know about how people change their drug abusing patterns. Small gains are far more beneficial than what is attained in harsh confrontational battles that either increase resistance or lead to false promises of abstinence.

Increasing motivation is usually the first step in treating AOD abuse.

SOURCE:

Miller, W.R. and Rollnick, St. (1991). *Motivational Interviewing: Preparing people to change addictive behavior.* NY: The Guilford Press.

CLINICAL APPLICATION

In working with teenagers, there is enormous pressure for adults to stress the dangers of drug abuse and to push for immediate abstinence. Motivational interviewing offers a different methodology, consistent with what we know about how people change.

Thus when adolescents start discussing all the wonderful benefits they derive from drug use, it may be wise to let them continue, and to even validate this side of their ambivalence: "It sounds like you really love drugs."

Avoiding an unnecessary confrontation, the client can be disarmed with a simple question, as in this case involving a fourteen year old boy, Kevin, at Desert Hills Center. He was talking about how much he loved the wide variety of drugs he abused:

"Is there a downside" I asked. "Is there anything that concerns you?"

(Long pause.)

"Yes, I guess so. I have to steal from my mother to pay for my drugs. (Pause.) That's the only thing that bothers me."

"Tell me about that."

"Well, sometimes I steal $20, or even more."

"And it adds up?"

"Yes, I've stolen from her a lot."

"That feels bad, huh."

"It does," Kevin said. "I don't want to steal from my mother."

"She's good to you," I said, "and you want a trusting relationship."

"Yeah, and life is hard for her."

"How do you feel about that?"

"Bad, because it's my problem not hers.

"What's your problem?" I asked.

"That I need to buy drugs so much, and it costs so much, that I have to steal to pay for them "

"Yeah, you need to steal from your mother to pay for drugs. That has to weighed against the pleasure you get from using drugs."

This exchange is not a quick cure. But you can see motivational interviewing at work. Kevin has given voice to a self-motivational concern about the down side of his drug use (that he steals from his mother). The problem was further elaborated: He uses drugs so much that he feels he needs to steal. Discrepancy has been increased between his desire to have a trusting relationship with his mother and the fact that he steals from her to pay for his drugs. This is a good beginning for the process of change.

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The Alcohol & Other Drugs Review

From Theory to Practice

Vol. 2, No. 2 Summer 1993

Drug Seeking Lifestyle

A fourteen-year-old boy had been privately flirting with the idea of giving up his drug use. He was well aware of the harm he had experienced from drugs, and the risks and dangers. He knew he was on the brink of a problem with the juvenile court.

One night at a friend's house one of the girls lit up a joint, took a hit, and passed it to him. After a split second of thought, he decided to smoke. He took a hit, and passed it on. This then led to a night of "partying," and eventually his arrest.

I met the boy a few days later in residential treatment at Desert Hills. I asked him what he had been thinking before he smoked that night. The boy reflected briefly and then said: "I just thought: fuck it."

This cognition, one often reported by teens, is a form of "cutoff," a thinking style in which individuals who are aware of the self-destructive nature of their alcohol or other drug (AOD) use can rapidly suppress this knowledge in order to keep using. "Cutoff" is one of the eight thinking styles — along with four behavioral patterns— that are considered part of the "lifestyle approach," new way to conceptualize the drug-seeking behavior of people who abuse AODs. The term "lifestyle approach" means that the abusive use of drugs is best understood, and ultimately modified, by fully ad dressing an array of lifestyle factors in addition to the drug-taking behavior.

BEHAVIORS THAT DEFINE THE B DRUG LIFESTYLE

Glenn Walters (1993) delineated four behavioral patterns that define the lifestyles of drug abusing people:

IRRESPONSIBILITY AND PSEUDO-RESPONSIBILITY

Drug abusers typically fail to meet their obligations and commitments to family members, friends, employers or schools, and others to whom they are accountable. Their irresponsibility is sometimes covered by a veneer of responsibility, lacking in depth and commitment.

STRESS/COPING IMBALANCE

AOD abuse is less a problem of self-indulgence and hedonism than a failure to learn lo deal effectively with stress. Drug abusers "find themselves locked in an escalating pattern of social and environmental pressure, followed by drug ingestion for relief, followed by even greater social and environmental distress and conflict" (p.140). This way of life denies people an opportunity to learn more effective coping strategies. It further alienates them from social support networks and contributes to increasing amounts of pressure and stress.

INTERPERSONAL TRIVIALITY

The lifestyle of drug abusers diverts them from purposeful interpersonal relationships. It moves them toward the company of other drug users with whom the major commonality is the use of AODs. Drugs soon become the substitute for meaningful human interaction.

SOCIAL RULE BREAKING OR BENDING

In order to engage in the lifestyle activities associated with drug use, drug abusers violate the norms and rules of society. Sometimes they bend norms and rules, sometimes they break them.

THE THINKING PATTERNS OF LIFESTYLE DRUG ABUSERS

In the lifestyle approach to drug abuse, certain conditions (genetic and environmental) are seen as influencing a person's chances of becoming harmfully involved) with AODs. Within the context of these conditions, individuals make choices about their behavior When they those to use AODs, they support and justify their decisions by constructing a system of beliefs or cognitions. Six of the eight thinking patterns of the drug lifestyle–

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the ones most relevant to adolescents– are described below (Walters, 1993):

Mollification

As a means of justifying their past and current activities, AOD abusers blame their troubles on others instead of accenting responsibility. This leads them to conclude: if only the world would change, their life would markedly improve.

Cutoff

This thinking pattern allows drug abusers to eliminate concerns about the negative impact of their AOD use. Their need for AODs to cope with the stress and frustration of life drives them to suppress any thoughts about the consequences of their use.

Entitlement

Drug abusers are very creative in formulating excuses for their behavior, and conjuring up reasons why they are entitled to continue using AODs. They tell themselves they deserve a "break," or they were hassled by parents or teachers, or they deserve a reward for a short period of abstinence.

Power Orientation

AOD abusers often feel inadequate, weak and lacking in self-efficacy. AODs enable them to feel more positive about themselves for brief periods of time by giving them the power to change their feelings. AODs also open the door for arrogant, manipulative, and sometimes violent behavior.

Super Optimism

This is optimism to an extreme. AOD abusers believe they can continue to use AOD s at high levels without becoming dependent, and that they can continue breaking and bending rules without consequences.

Discontinuity

This refers to a lack of consistency or congruence in drug abusers' thinking and behavior over time. They typically lose sight of many of their goals in favor of drug use and a drug lifestyle. When individuals become AOD dependent, their major goal becomes seeking drugs.

PRACTICAL IMPLICATIONS

By delineating behavioral patterns and thinking styles, the lifestyle approach provides a framework for skill-training and corrective cognitive interventions in treatment. It suggests a way of healing AOD abuse that promotes personal responsibility, choice, and self-discipline. Corrective cognitive interventions can help individuals see the contradictions and problems with their thinking. Life skills training can increase their self-efficacy. For example, friendship skills can help counter interpersonal triviality; problem-solving skills and emotion-management skills can help counter stress-coping imbalance; and goal-setting skills can help counter discontinuity.

The lifestyle approach has the potential to help individuals replace a shortsighted and destructive lifestyle with one that is satisfying, fulfilling and free from AOD abuse.

SOURCE:

Walters, G.D. (1992). Drug-seeking behavior disease or lifestyle? *Professional Psychology*, 23, 2, 139-145.

CLINICAL APPLICATION

Let's continue with the example of the fourteen year old boy who said he was thinking "fuck it" just before he proceeded to smoke marijuana.

"What did you mean by fuck it?" I asked him

"Just...I give up. I'm not going to try to stop myself. I don't want to miss the fun."

"Why were you trying to stop yourself?"

I was getting into lots of trouble, and didn't want any more more of it."

"But, somehow, the simple thought "fuck it" let you forget about the dangers and go ahead and do drugs?"

"Yeah."

"How do you feel about it now?" I asked.

"I really wish I had turned down the weed."

"Well, let's see what you can learn from this for the future; Sounds like if you really decide to quit using drugs, you're going to need to think about risky situations where you will be tempted. That's when you have to watch out for the voice that says "fuck it." Because really what it means is to forget about the harm and danger to yourself, and to think only about the good stuff. And when you forget the harm and danger, you go ahead and use drugs."

"I guess you're right."

"You know, there's a name for that type of thinking, when you say 'fuck it.' It's called 'cutoff.' What it means is you cut off all your thinking about the dangers of your drug use.

"If you want to make a decision to quit using AODs, we can talk about what you can say to yourself next time you start to think 'fuck it.' You don't have to get caught in this trap again."

Dr. Robert Schwebel

A.O.D.

The Alcohol & Other Drugs Review

From Theory to Practice

Vol. 2, No. 1 Spring 1993

Relapse Prevention

I have found that many teenagers in treatment who have chosen to be clean and sober do not like the term "relapse prevention." They complain that those of us who use the term are "just doubting adults" who think they will fail.

So I have reduced my use of the term at Desert Hills. But we cannot avoid the concept. Relapse is the norm, not the exception, with alcohol and other drugs (AODs). In adult studies, it has been found that 90% of alcoholics are likely to relapse over the four year period following treatment. Similar rates have been found after treatment for other drugs as well. Therefore, reducing relapse and responding to it appropriately are important treatment issues.

It is a fine line to navigate: believing in our adolescent clients' ability to stick to their decisions, yet preparing them for temptation and risk situations.

Research has begun to focus on the factors influencing relapse, resulting in treatment strategies that can reduce the probability and severity of relapses.

LAPSE AND RELAPSE

From the clinical point of view, relapse prevention is quite different from the earlier phase of treatment when a drug free decision is initiated. Relapse means a failure to maintain behavior change, not a failure to initiate it.

An important distinction has been made between lapse, which represents a single incident of AOD use, and relapse which signifies a return to previous high levels of abuse. Relapse prevention is designed both to (1) reduce the incidents of lapse and (2) to influence the reaction to lapse, thereby reducing the occurrence and severity of relapses.

WHEN DOES RELAPSE OCCUR

Lapses and relapses generally occur in response to high risk situations such as these: (1) while experiencing interpersonal stress, especially situations that lead to frustration and anger; (2) while experiencing social pressure: (3) while negative affective states prevail, such as depression and boredom; (4) in the presence of alcohol or other drug stimuli (the substances themselves or something associated with them); and (5) at celebrations.

AOD abusers have learned faulty –or failed to learn protective – cognitive and behavioral responses to high risk situations. So for example, when depressed in a high risk situation) an individual might tend to follow a familiar pattern which evolved as a conditioned response to a depressed mood. The person thinks of alcohol as a way to cope with the negative feelings, and has positive expectancies: "Drinking will relax me and make me happier." This conditioned pattern is even more difficult to resist when alcohol is present, or when attending or even anticipating a party. The alcohol serves as a stimulus cue, leading the individual to feel an urge to drink that could be described as craving.

PREPARING FOR SUCCESSFUL TREATMENT

With teenagers, rather than using the technical term "relapse prevention," I talk about preparing for success. This means having the ability to anticipate difficult situations, the skills for coping with them, and the necessary confidence to use these skills during challenging times.

Monti et al. (1988) have talked about two ways to reduce the risk of relapse. One is to make clients expect negative consequences with AOD use and to help them fully understand the impact of these consequences. For example, consequences can be made to feel more immediate by involving family members in treatment, and by encouraging friendship with drug-free peers.

A.O.D
Alcohol & Other
Drug Review

A quarterly Review of literature in the child and adolescent AOD field
by Robert Schewel, Ph.D.

Editor William Fearneyhough
Sponsored by:
Desert Hills Center for Youth & Families
Tuscon Arizona

Monti and his colleagues also talk about building positive expectancies in the absence of AOD use. In other words, people can produce the same positive outcomes that drugs would produce, except without using drugs. This is achieved by teaching life skills, social skills, and emotional coping skills, and by increasing a client's sense of self-efficacy. Individuals in treatment can learn to solve problems or even to relax and calm themselves when depressed. They can also find new ways to change their feelings without drugs, such as through aerobic exercise.

In their research, Monti et al. found that alcoholics, compared to others, did not have less social skills in general situations. However, their anxiety level was higher and their social skills were deficient in drinking situations. The researchers found that drinking rates can be reduced by providing behavioral training in social skills relevant to situations in which alcohol would be available.

Another important factor in relapse prevention is self-efficacy. People can learn skills, but still not feel competent. They must believe in their abilities –that is, have self-efficacy – so that they can use these skills in high risk situations.

THREE BASIC GOALS

Relapse prevention is an important part of treatment for AOD abuse. Alan Marlatt (Marlatt and Gordon, 1985), the originator of the concept of relapse prevention, suggests three basic goals: (1) modify lifestyle to enhance the ability to cope with stress and high risk situations; (2) identify and respond appropriately to internal and external cues that serve as relapse warning signals; and (3) implement self-control strategies to reduce the risk of relapse in any situation.

SOURCES

Marlatt, G.A., and Gordon, I.R. (eds.) (1985). *Relapse Prevention: Maintenance Strategies in the Treatment of Addictive Behaviors*. New York: Guilford Press.

Monti, P.M., Rohsenow, D.J., Abrams, D.B., and Binkoff, J.A. (1988). Social learning approaches to relapse: selected illustrations and implications. *Learning Factors in Substance Abuse*, NIDA Research Monograph 84. DHS Pub. No. (ADM)88-1576 Washington, D.C., 141-161.

Relapse and craving (1989). *Alcohol Alert*. National Institute on Alcohol Abuse and Alcoholism, No. 6, PH 277, October.

CLINICAL APPLICATION

The Super Situation

Adolescents complain when adults raise the issue of how difficult it is to remain abstinent after a history of abusing AODs. Then, they often make sweeping statements about how they have made up their minds and intend to be drug free from this moment forward (in fact, some argue they will not need any additional help: thanks anyway).

I like to playfully engage some of these adolescents in an exercise about the "super situation." I will ask their peers to describe the "perfect situation" for drug use, making it especially relevant and attractive to the individual who has said that he will quit. Here's the super situation presented to Mark, age 15, at Desert Hills.

"Okay Mar, you're at a party at Tom's house (best friend). All of the people you use to smoke-up with are in the room. Your girlfriend Crystal is there, right next to you. You smell the weed. You see it. Everyone is really having fun. You feel you're missing out. Crystal takes a big hit of the weed and hands you this humongous water bong. The smell drifts to your nose. You think how good it would feel to be high. What do you do?"

If Mark says "I pass," we keep pushing him.

Maybe we would say that Crystal looks disappointed. Or we would say his friends started discussing the high quality of this weed. We keep pushing until he sees how tempting it will be.

This exercise almost always gets people in touch with the relapse prevention work that lies ahead.

CLINICAL APPLICATION

RELAPSE PREVENTION PLAN

Because it is so hard to remain drug-free, adolescents in treatment benefit from a relapse prevention plan. This begins by helping individuals develop a list of their own high risk situations and putting them in a "plan for success." The plan might be to avoid certain situations (e.g., drug oriented parties). Some situations may be unavoidable (e.g., offers of drugs at school). A contingency plan can be made for dealing with each situation. Part of the plan is to anticipate the cognitive messages that the individuals will face in various risk situations such as, "Go ahead, it'll be fun. Just one hit_____ developed to each of these thoughts. Also, behavioral strategies can be picked, and even rehearsed, for various high risk situations (such as refusing drug offers, walking away from a high risk situation, using a drug free friend for support for abstinence, etc.) And, contingencies can also be made for lapses: What to do to avoid progressing from lapse to relapse.

AOD Abuse: A Defect In Character Or A Social Problem?

Many professionals have been troubled over the years ears by the simplistic slogan: Just Say No.

In all fairness this slogan made two important points. (1) that adults need to be clear in their message that children should not use AODs, and (2) that peer influence is a factor that contributes to AOD use.

Although "saying no" may help some individuals resist peer pressure, it can never be a stand-alone prevention strategy of significance because it does not address the basic underlying problem, which is: Why are so many peers (i.e., children) using drugs in the first place? Where did it all begin? What is the root of the problem?

The inability to resist peer pressure is certainly one factor that puts young people at risk for AOD abuse, as does a variety of other risk factors which also have been delineated. But again the question could be raised: Why do we find all these deficits in social skills? We need to ask: What about families? What is wrong in families? Are children getting enough time and positive attention in families? And then, taking it a step further: What are the stresses and stressors in family life? How are we supporting families? What is the impact of poverty, racism, and other social factors on families and children? And, what about schools and other social institutions? How have they fallen short? What sort of support have we given these institutions?

BLAMING THE INDIVIDUAL

In a recent article, Keith Humphreys and Julian Rapaport (1993) talked about the dominance of the personal defect (or individual deficiency) model for explaining AOD abuse. They note a strong tendency to attribute AOD abuse to the failure of individuals (for example, the failure to resist peer pressure). Environmental factors such as unjust social conditions and oppressive family life are overlooked or given little attention.

They point out that the PSYCHLIT database between January 1981 and March 1992 has 170 references to "drug addiction and personality" and only three to "drug addiction and poverty." There are only 72 total references that relate substance abuse to the following topics: socioeconomic status, environment, disadvantaged, cultural deprivation, ghettos, poverty areas, social issues, social environment, and lower income level.

In explaining other ways to look at AOD Problems –besides personal defects —the authors wrote:

"Urban drug dealing and use could be seen as the result of a lack of worthwhile employment and recreational opportunities. We might also study the effects of the millions of dollars that cigarette and alcohol companies spend on minority-targeted advertising" (p.898).

These authors were writing from the research perspective and urged certain changes in research direction. From the practitioners point of view, these findings reinforce the importance of balancing an understanding of the contribution of internal factors to AOD abuse with environmental, social causes.

PUTTING PROBLEMS IN PERSPECTIVE

The most sophisticated prevention efforts these days do not use a single strategy (such as "saying no"). Rather they are comprehensive and stress community changes that must coincide with individual changes. Job programs and alternative recreational programs have proven important in preventing drug abuse. Keeping in mind the importance of the social causes of problems, we need to be careful about using labels such as "high risk youth." Perhaps we would be better off thinking in terms of teaching resiliency skills to youth from high risk environments.

In interviewing children with AOD problems, it is easy to unwittingly imply a personal defects model, by stressing functional problems (in school, with the family, etc. and life skill-deficits. Knowing of this tendency, it is important to be vigilant in finding and reinforcing strengths in the individuals we serve. It is also important to help children understand ways in which they have been denied opportunities, even the love and support that they deserve and require. Often young people have to transcend awful social environments in order to escape the abusive use of AODs.

SOURCE:

Humphreys, K. & Rappaport, J. (1993). From the community mental health movement to the war on drugs. *American Psychologist*, 48, 8, 892-901.

CLINICAL APPLICATION

AN ANGER AND ALCOHOL PROBLEM

In clinical work, it is important to incorporate an understanding of both personal and social factors in problems. Below is an example of an effort to balance individual responsibility with the kind of broader social perspective that validates the individual.

A teen in group counseling who physically attacked his adopted father after drinking alcohol is feeling bad about himself, about his anger, and about his drinking problem.

As he feels safe in the group, he starts to talk about the incident of violence, and calls his father "a jerk."

A peer in the group says: "It's your own fault. Don't blame your father. You're the one who drank too much and started hitting him."

What should the counselor say at this point?

With a strictly internal defects model, the counselor might well agree with the peer.

However, with a broader perspective and an understanding of the boy's background, the counselor could say the following, over the course of several sessions:

"Look, we know some of the things that have happened to you in your life that have made you so angry. You've been terribly hurt over the years. You were never taught positive ways to cope with your anger, and not many people were interested in what you felt. So you started to drink to deal with the pain of your hurt and anger, and for other reasons. Finally your problem exploded in this hurtful way.

"I know you feel bad about what you did. You told me. I know you're still angry at your father. You know you must not physically attack him – it's not right. It also won't help to beat yourself up about what happened. Let's see what you can learn from this experience.

"Certainly you must learn to manage your anger in different ways. We can help you learn that skill. And if you keep drinking, you're likely to get in more trouble. Now is the time to make some changes about drinking. And we have to get your father in here to work on his part of it."

This type of exchange would be a beginning of a balanced understanding of the problem. At least it informs the boy that responsibility for his problem must be shared by himself and others. Perhaps as treatment continued, he and his parents might learn that certain social pressures or deprivations, such as inadequate income or work stress, might also have contributed to their family conflict.

SAYING NO IS NOT ENOUGH

HELPING YOUR KIDS MAKE WISE DECISIONS ABOUT ALCOHOL, TOBACCO, AND OTHER DRUGS
A GUIDE FOR PARENTS OF CHILDREN AGES 3 THROUGH 19

By ROBERT SCHWEBEL, PhD

Following are excerpts from the book that present positive ways to open a discussion and gather information from adolescents about their drug use.

STARTING DIALOGUES WITH TEENS ON DRUGS

Too Much, Too Soon

Once dialogue commences children vary in their readiness to openly disclose personal details. With so much information needed for a good assessment, you will be eager to get the facts. In your eagerness, you can act too pushy or overbearing. Sometimes the result is an onslaught of questions, one after the other called "pumping for information":

-When was the first time?
-Who were you with?
-Who got the drugs?
-What was it like?
-When else did you use drugs?
-Where are you getting the drugs?
-Which of your friends use drugs?

All these questions will be of interest, but asking them one after another will probably create resistance. Remember, the discussion is just beginning. If you try to find out everything right away, you may find yourself locked in a power struggle. You'll be trying to extract information and your child will be trying to withhold it. Think of this initial discussion as the beginning of a long-term process requiring patience.

Defense Mechanisms

If your teenagers do have a problem with drugs, several forces work against their recognizing it: feelings of invincibility, the defense mechanism of denial, the defense mechanism of externalization, and erroneous information. In a dialogue, in order to reach an understanding, you may have to reckon with any or all of these forces.

Teenage children typically have false feelings of invincibility that extends to many types of behavior: "Nothing can happen to me. I won't get pregnant from unprotected sex. I won't get AIDS. I won't get hooked on drugs. I know what I'm doing."

With the defense mechanism of denial, drug users say: "Drugs aren't a problem. They don't affect me. I can stop whenever I want to." (Sometimes this is true. Sometimes it's a denial of reality.)

Still another characteristic defense of teenagers is externalization. They blame everyone and everything except themselves for their drug use, and they take no personal responsibility for their own behavior: "I only use drugs because school is so bad and this city is so boring." It's as if drugs have been imposed on them by outside forces. If the world would change for the better, their drug use would cease of its own accord.

Erroneous information about drugs and their effects is another factor preventing teenagers from accurately assessing their drug use. Teenagers may, for example, assert that there are no dangers in smoking marijuana. They may also have mistaken notions of what a drug problem looks like. In their mind, the only real alcoholics are the guys lying in the street drunk. They don't recognize subtler forms of addiction.

Another misconception is about tile "norm." Many teenagers enormously overestimate the number of their peers using drugs, and therefore see their own use as "normal."

Because of all these factors, you may find that your child is unaware of the extent of his drug use, his motivation for drug use, and the consequences and risks of his actions. You may find that he is contradicting himself. He may be misleading you, himself, or both of you.

Rebuttal Cycle

With all these many obstacles to an objective assessment of the problem, many parents feel the urge to make an aggressive challenge, either by asking accusatory questions or by rebutting what their chil-

dren say. Unfortunately, this causes the discussion to degenerate into a no-win argument, with your children getting defensive. It goes something like this:

"You said there weren't any drugs at the party, but now you're telling me that Joan was there. You've told me that Joan uses drugs. You're contradicting yourself. You're lying."

The message here is: "I don't trust you. We're in a competition. I'm gonna try to prove you wrong."

The rebuttal cycle is a serious pitfall. Parents get hooked into it when they are too eager to disprove their children's point of view. They tear down what their children say instead of helping to broaden and expand their thinking.

Children will answer a rebuttal with a counter-rebuttal of their own. When engaged in the rebuttal cycle, no one listens seriously to anyone else:

Child. "There's nothing wrong with pot."

Parent: "But it's illegal."

Child: "Driving over the speed limit is illegal and you do that."

Parent: "I'm a grown-up and you're a child. I have some prerogatives that you don't have. I don't want you breaking any laws."

Child: "Oh, a double standard. Anyway, all the kids in school use drugs."

Parent: "I doubt if Jane and her friends use drugs."

Child: "Yeah, but they're nerds."

In this "discussion" (really an argument), the parent has some serious concerns about his child's seeming disregard for the law and what appears to be an inaccurate assessment of the extent of drug use among peers. But by falling into the rebuttal cycle, the parent fails to get any serious attention. As you will see later in this chapter, there are better ways to communicate without trying to "win" in a contest for dominance.

POSITIVE WAYS TO GET MORE INFORMATION

In making an assessment, you want more information but don't want your child to feel that he's on trial or under investigation. You're not trying to catch wrongdoing.

Open-Ended Questions

One underused strategy for gathering information without cross-examining is to invite openness and self-disclosure by asking open-ended questions. These are the questions that allow people to answer on their own terms, in contrast with closed questions that allow only limited possible responses.

To illustrate, consider the difference between these approaches in gathering information from a child who has smoked marijuana.

Closed questions: "Did you enjoy it?" (yes or no) "Who gave you the drugs?" (name the person) "Will you ever do it again?" (yes or no).

The open-ended approach goes like this: "How did it feel? What was it like? What are your thoughts about smoking in the future?"

These open-ended questions encourage the child to think and to talk. With the open-ended approach, you could even say:

"You know that I'm very curious about what's happening with you and drugs, but I don't want to start bombarding you with questions. Could you tell me what's going on?"

Don't give up if you get an "Oh, nothing" response. Encourage further discussion:

"What do you mean by 'Oh, nothing'? I'd like to know more."

Or you can ask a few closed questions– such as "Where were you? Who were you with?" –before switching to open-ended ones.

Lighten Up

During this early part of the dialogue, as you are gathering information, you should be developing sensitivity about the amount of questioning that is appropriate with your own child and when you need to lighten up or back off. Remember, nobody likes to be put through the Spanish Inquisition, especially teenagers, who are forming their independent identities.

If at any point your child indicates he can't talk or feels too pressured, show that you're not going to be pushy. Sometimes it helps to say something encouraging, such as: "I know it's hard for you to talk. But I think it's important. Please hang in here with me."

As it becomes clear to your child that you're not going to send in the cavalry, as he feels more comfortable about opening up, he'll gradually disclose information. Later you can ask more detailed and specific questions. Your child will answer if he feels safe.

Some teenagers will protest: "You're asking a lot of questions. I thought we were going to have a discussion. I wish you wouldn't pry."

You can remind them of the purpose of the discussion:

"Let me explain why I'm asking these questions. I want to help you think through what's happening with drugs. It's my responsibility as a parent to help you learn to make wise choices. That's why I'm asking But if it feels like a lot of questions too soon, I'm willing to back off. We can talk again later."

"But," your child protests, "why are you so uptight?"

It's an important question. If you are uptight, you won't be helping matters. In that case, your child lies given you important criticism If you're not uptight, only concerned, make that clear to your child.

If your child still feels stuck about talking further, ask about the guarantees he needs to feel safe. (Refer back to the previous chapter for how to do this.)

If for some reason your consistent and patient effort to maintain a dialogue hasn't been successful, you can suggest alternatives. Again, it's important to insist on discussion: .

"These are tough times for kids. Everyone is entitled to support, to someone to talk with. If you can't talk with me, I'm willing to set up an appointment with a professional [or a clergyman]. But I can't look away from this. I'm disappointed we're stuck, but maybe a psychologist can help us get going together. Or maybe you would want to talk with him or her alone. One way or the other, I want you to have the support you deserve."

Columbo Style

When drug abusers are asked about their drug use, some of them lie by omission –not by giving false information but by withholding important details. To a lesser extent, even people, who dabble in drugs sometimes distort the truth.

"Okay, I confess," Michael tells his father. "I'm gonna come clean with you. I drank alcohol."

He also has smoked pot and tried cocaine but doesn't offer this information.

Because of distortions like these, to get an accurate assessment of the situation, you need to ask specific questions about which drugs have been used, how much of them, and how often. This is a delicate process. You don't want to start cross-examining. Yet you want to be informed. The tone of these questions should be supportive, not confrontational. I think of the television character Columbo. You sort of scratch your head and ask some questions to get a few more details. Instead of saying to your child, "I don't believe that you've told me everything," or "Stop lying," you communicate interest and support.

Ask direct questions, but be intuitive about how rapidly to proceed. Start with, "Have you tried any other drugs?"

"I told you once before I smoked pot."

"Anything else?"

"Just because I smoked pot doesn't mean I've used any other drugs."

"I know that, but I'd like to know if you've used anything else.

What about cocaine? Have you tried it?"

"Well, yeah, I tried it once."

"Is that all?"

"No, actually a few times."

"How many times?"

"Three."

"Is that all?"

"Yes."

"You sure?" "Yes." "How about crack?"

And the questioning would continue with other drugs.

In therapy with seriously addicted clients you quickly learn about the importance of this type of questioning. I remember a college student telling me he had had only one vodka all week.

A tumbler?

No way. It was a bottle.

Thought-Provoking Questions

As information unfolds you will begin to have thoughts you want to share with your children. You may want to challenge misinformation or provide a different perspective about something that was said.

Before you offer your perspective, consider taking the approach of asking thought-provoking questions. This means asking a child if he has ever considered the flip side, the opposite, of what he is saying.

I was talking with a sixteen-year-old girl who was smoking pot and drinking alcohol on a regular basis. Her drug use was clearly creating problems for her in school and at home, yet she was boldly pro-

claiming the merits of drugs. She focused on how great she felt when she was high. I sort of rained on her parade by changing the focus with a couple of thought-provoking questions: "Is there another side to this? Do you ever worry about your drug use?"

Taken aback, she admitted she had worried, then added: "But I don't dwell on it."

"It's unpleasant to think about, isn't it?" I asked.

"Yeah," she said.

"But not thinking about it doesn't make it go away, does it?"

"No, I guess I need to deal with it," she said.

And I agreed.

Because thought-provoking questions are so effective, I'd listed a few that I frequently use in talking with teenagers:

Is there another side to this?

-Do you worry about your drug use?

-Do you feel your drug use may be out of control?

-Have you thought about the potential dangers?

-Do you see any risks?

-Do you have any concerns?

Thought-provoking questions are also a good opening for you to express your own thoughts and feelings. For example, I asked Jane, age sixteen, if she was worried about her drinking. She said no. Then I said: "I guess you're not worried about how much alcohol you're drinking, but when you tell me you have been drunk several times in the last couple of months, it concerns me."

This is a way to keep the discussion personal rather than abstract, to state your concerns rather than to get argumentative.

Directed Questioning and Labeling

You want to understand your child's drug use and to help him understand it. Certain questions not only help you gather information, but also broaden his thinking about drug use. These are directed questions, so named because they increase awareness by pursuing a direct line of reasoning. As your child answers directed questions, certain information and patterns of behavior become apparent. You can ask your child if he notices the patterns, or you can point them out yourself.

Many times children do not know why they are using drugs. They may not have thought about it. Their own reasons may be hidden from themselves. Directed questioning is particularly helpful in uncovering motivation.

"Okay," I said in a counseling session, "you don't know why you use drugs. Let's take a look at when you use them and see if together we can figure out why."

"I just do drugs when I feel like it. No special reason."

"Well then, let's look at when you've been feeling like it. When was the last time?"

"Saturday night."

"Where were you? What were you doing?"

"I was at Ken's house. We were bored."

"So, at least one time when you used drugs, you were feeling bored."

"Yeah, so what?"

"Well, I don't know, let's keep looking at this. Maybe we'll find a pattern."

"And maybe not."

"That's possible. Let's see."

"Okay."

"When was the next to last time you used drugs?"

"It was the weekend before. I had nothing to do."

"Kind of bored then, too?"

"I guess so."

"What do you think? Maybe one reason you use drugs is because you get bored and want something fun to do."

This dialogue shows a pattern of drug use for fun or to avoid boredom.

Similar questioning of the same child uncovered other reasons for drug use at other times.

With directed questioning about motivation, it's important to search for root causes and not to stop with vague generalizations.

Betty told her parents that she used drugs "to feel good." At first they thought she meant she was using them for a "trip," to alter her consciousness, but as they asked more questions, it became clear that she was smoking pot to self-medicate against depression. She was having problems in school and didn't know how to cope with them, so she used drugs to escape the pain. That's what she meant by "to feel good."

As children explain the context of their drug use, you can identify the underlying motivation:

"I wanted to see what cocaine was like. I wanted to try it."

(experimentation)

"At parties, everyone does drugs." (peer pressure, conformity)

"When you guys (Mom and Dad) fight, I get high." (to cope, to kill pain)

"I drink on dates." (for fun and possibly to deal with stress)

"I take downers before exams." (to deal with stress)

Sometimes the motivation is subtle. A boy who says he smokes pot because he "likes it" may appear to be enjoying the sensation of being high. Butt another question revealed a different motivation:

"What is it you like best about it?"

"I can brag to my friends. I'm the only kid in my class who has smoked pot."

Besides revealing important information about patterns of drug use, directed questions. Are also useful in uncovering contradictions in thinking. This is a special type of directed questioning, called the feed-it-back approach.

The Feed-It-Back Approach

As information begins to unfold, you will probably see gaps in your child's knowledge base and contradictions in his reasoning that you want to discuss. For example your child might say he has not been harmed by drugs when it appears that there is evidence to the contrary.

The feed-it-back approach is a way to gradually help children see the contradictions in their own thinking. It helps them overcome denial mechanisms and other obstacles that could interfere with objectivity Through careful questioning about feelings and experiences, hard facts are brought into the open. Parents "feed back" what they hear through simple comments about the hard facts.

Swiss psychologist Jean Piaget once said that every time you teach a child something, you deprive him the opportunity of figuring it out for himself. This maxim has special relevance when the child is a young teenager who is determined to take charge of his own life, determined to reach his own conclusions.

The feed-it-back approach is an excellent teaching method to help children see all the facts clearly and arrive at their own conclusions. With skillful and tactful questioning, you can help them gain valuable knowledge about themselves with a minimal amount of explaining.

Even with this non-threatening approach most children will not immediately acknowledge contradictions in their thinking. The feedback approach is not a quick solution. It is an educational method for the long haul, a way to plant some seeds of wisdom, to begin to gradually crack the defenses. Often you have to discuss the same material several times until the child can clearly see the facts.

The feed-it-back approach is best illustrated by actual transcripts. Below are examples of using the method to explore the assertion that "drug use hasn't affected me;" to explore the assertion that "I could stop at any time;" and to determine whether a person is dependent on drugs. As you read the dialogue, remember that the tone of voice of the parent is always warm and supportive, not confrontational.

The feed-it-back approach is here applied to the question: "How have drugs affected you?"

PARENT: "How has smoking pot affected you?"

CHILD: "It makes me feel good."

PARENT: "I know it does, but I want to know more. How has it affected your life in other ways?"

CHILD: "I feel good more often."

PARENT: "Have there been any negative effects?"

CHILD: "No."

PARENT: "Well, let's look at this together. When did you start smoking marijuana?"

CHILD: "About a year ago."

PARENT: "What were your grades back then?"

CHILD: "A's and B's."

PARENT: "What are they now?"

CHILD: "C's and D's."

PARENT: "It sounds like the drugs may be having an effect in school. What do you think?"

CHILD: "Yeah, they make me feel better when I go to school."

PARENT: "I know that. But it sounds like maybe your schoolwork has suffered and the drugs are part of the problem. Maybe I'm wrong. Do you have any other ideas about why your grades have fallen?"

CHILD: "No, not really. I hate school."

PARENT: "I'm sorry school feels so bad to you. I'd like to talk with you about that, to see if we could figure out some solutions. But maybe drugs are part of it. It sounds as if they could be. Anyway, why don't we drop it for now."

CHILD: "Okay. Fine with me."

The facts speak for themselves The child has revealed a potential problem. The parent isn't avoiding the problem, but maneuvering to reduce defensiveness. If the parent tries to hammer it home; he will only meet resistance. It is a wise move to back off. Soon another discussion of the same issue can bring these thoughts back to the attention of the child.

The feed-it-back approach is here applied to the question: "Could you stop using drugs it you wanted to?"

MOTHER: "Sounds like you use drugs whenever you feel bad. I wonder if you're becoming dependent on them."

CHILD: "I can stop whenever I want to."

MOTHER; "Have you ever tried?"

CHILD: "Yeah."

MOTHER: "Tell me, what happened?"

CHILD: "I didn't smoke for a couple of weeks"

MOTHER: "How was it?"

CHILD: "Fine, no problem."

MOTHER: "Good. Then what happened?"

CHILD: "My teachers started hassling me at school."

MOTHER: "Then what? Did you smoke again?"

CHILD: "Yeah, because my teachers were hassling me."

MOTHER: "Well, I m pleased you could stop for a couple of weeks. But I'm concerned that you started again when you were feeling bad. I guess it helps kill the pain."

CHILD: "Well, my teachers were hassling me."

MOTHER: "I believe you. But, you know, I'm not sure the solution is to get high. And I'm concerned that you smoke pot when the going gets rough. Are there any other times you stopped using drugs?"

CHILD: "Yeah, there was another time."

MOTHER: "When was that?"

CHILD: "Uh, about six months ago."

MOTHER: "How long did you stop?"

CHILD: "About a month."

MOTHER: "What happened?"

CHILD: "Well I started again when you and Dad were fighting about the divorce stuff. It was really depressing.

MOTHER: 'I know, those were tough times for all of us. I m sorry it was so hard for you. But you know, I seem to be hearing two things here. One is that you must be concerned about your drug use, because use you've attempted to stop it, at least twice. The other thing is that you can stay off drugs as long as nothing is really bothering you. But when the going gets rough, you start using them again. Drugs kill the pain. You know, there's an alternative.

CHILD: "What's that?"

MOTHER: "To figure things out, to deal with problems without getting high, and even to learn to prevent problems."

CHILD: "I know. You've told me that before."

MOTHER: "I guess it's a thought to keep in mind."

CHILD: "Maybe you're right."

MOTHER: "Will you think about it?"

CHILD: "Yes, I will."

The parent has planted some seeds of wisdom. Again, in this example it's wise to back off and allow the child to think about what was said.

The feed-it-back approach can also be applied to the issue of whether a person is dependent on drugs. As you will see, this issue is related to the one discussed above– a person's ability to discontinue drug use.

CHILD: "It's not a problem. I'm not dependent."

PARENT: "But you say you smoke pot when things bother you at home or in school."

CHILD: "Yeah."

PARENT: "Does this solve your problems?"

CHILD: "Well I feel a whole lot better."

PARENT: "I know that drugs help you feel better, but I'm concerned that they just help you escape from difficult situations. Do you know what I mean?"

CHILD: "I need to escape. I *have* to live at home. I'm still a kid. I have to go to school. I'm too young to drop out."

PARENT: "But there is an alternative."

CHILD: "What's that?

PARENT: "We could talk things out at home. If you're upset, I'd like us to deal with the problem so you don't feel bad. I don't want home to feel so bad that you need drugs to escape from feeling rotten."

CHILD: "What about school?"

PARENT: "Look, I'll be honest. I didn't exactly love school either. No one does. But there are ways to make it feel better. I'm concerned that you're getting into a habit of running away from things."

CHILD: "But I like drugs. They don't harm me."

PARENT: "I don't deny you like them. I don't deny

they lessen the pain. But I don't think they're a long-term solution. We all face lots of things in life that are unpleasant. If we take drugs to deal with them, we'll have some serious problems."

CHILD: "Well, I don't take drugs *every* time I feel bad."

PARENT: "I'm glad to hear that. But I still think the number of times you do take drugs is worth thinking about, isn't it?"

CHILD "Yeah, I guess so."

In this dialogue the parent almost lapsed into lecture by discussing the long-term risks, but the comments were relatively brief, so this still can qualify as the feed-it-back approach.

THE SEVEN CHALLENGES

Challenging ourselves to make wise decisions about alcohol and other drugs

Robert Schwebel Ph.D.

Challenge One: We decided to open up and talk honestly about ourselves and about alcohol and other drugs.

Taking An Honest Look at Ourselves

We pushed people away when they told us we had problems or told us what to do. We pushed them away when they wanted to talk about alcohol and other drugs. We were defensive. Many of us were tired of people talking AT us. We said: "Only I can make the decisions; you can't make me do anything; it's my business. If I want to drink or do drugs...I can."

This is true: It was our decision. But we had to be smart about it.

If we wanted to take care of ourselves, if we wanted to control our own lives, then we had to begin by challenging ourselves to take a close look at what we were doing.

Challenge One. We decided to open up and talk honestly about ourselves and about alcohol and other drugs.

Lying To Ourselves

We knew that many people who had drug problems denied the truth. They said their drug use wasn't a problem, or was no big deal, or that they didn't care. They refused to look at themselves. They were stuck. We didn't want to do that. We wanted to search for the honest truth. We had to force ourselves to take a closer look at our lives. Did we see problems? Did we have any doubts? Did we have any concerns? If not, why were we convinced that everything was OK? What was our evidence? How strong was the evidence?

We had to ask if we were making excuses for ourselves. For example:

- Did we keep saying that things would get better in the future, but nothing was changing?
- Were there problems that we tried to ignore or overlook?
- Had we thought carefully about how we were doing at home, at school, with friends, and on jobs?
- Had we been in trouble?
- Were we possibly headed toward trouble?
- Were we satisfied with ourselves and the direction of our lives?
- Were we preparing ourselves for the future?

These were tough questions. But we were determined to take a close look at ourselves.

Challenge Two: We looked at what we liked about alcohol and other drugs, and why we were you using them.

How To Dig Deeper

Most people don't say, "I feel depressed, I'm going to get high."
They don't say: "I'm feeling lonely. I'm going to drink beer."
They don't say: "I feel uncomfortable when I'm straight and my friends are getting high. So, I'll get high with them."

If they said these things, it would be a lot easier to know exactly why they were using alcohol and other drugs. But, they don't, and it can be difficult to know exactly what leads to their choices.
When people asked us why we used drugs, we usually gave simple answers: "because I feel like it," or "because it's fun," or "because I want to kick back with my friends."
Sometimes we wanted to change the topic. Sometimes we tried to skip over this discussion by saying: 'It's no problem. I'm not addicted. I can stop whenever I want. I only use when I feel like it."
But the question remained. Why did we feel like drinking and doing drugs? What did we like? What made it fun?
Digging deeper was a big challenge because we were looking for the hidden reasons for our use. To find them, we had to look at all the situations in which we were using drugs. Who were we with? What were we feeling before we used? What were we thinking before we used? What were we feeling after we used? What happened when we used?
By asking these questions, some of us easily discovered hidden reasons for using drugs. Others had to think hard to pin down our reasons.
Some of us found one main reason why we usually got high. Others found a variety of them. For some of us, it was hard to admit our reasons for using.

Challenge Two: We looked at what we liked about alcohol and other drugs, and why we were you using them

Reality Has Its Own Rules

Many of us didn't like our own reality. So we did drugs to get away from it. We wanted to escape reality. We liked the feeling of being high better than how we felt straight.
We said we got high or drunk to "make our problems go away." Of course the problems didn't go away. We just forgot them.
Drugs were a "security blanket." They took care of us when we felt bad. They made us feel good. They gave us the power to change our feelings. We could depend on them when we had nothing else that worked for us.
If drugs were so wonderful, then why didn't everybody get high all the time? The catch is this: there's no free lunch; no one rides for free. Problems don't go away when you get high. They're still there...only worse.
One of the things we found out the hard way is that reality has its own rules. You can never completely escape it. When you are young, escaping reality means getting suspended from school, poor grades, getting in trouble with parents or other adults who take care of you, tighter restrictions and closer supervision, losing privileges, stealing or compromising your beliefs to pay for drugs, getting arrested and going to "juvey," getting caught in a web of lies, and a variety of other consequences.
We knew what we like about drugs. We came to see why we used drugs as much as we did. Now we needed to consider the consequences. We had to look at the down side of our drug use so we could make wise decisions about what we were doing.

Challenge Three: We looked at our use of alcohol and other drugs to see if it had caused harm or could cause harm.

If I'm Not Craving Drugs. I'm Fine

Many of us had believed the myth: "As long as I don't crave drugs, I'm OK. If I'm not addicted, I'm fine." We thought that drug use had to be at a high level for a long period of time to be a problem.
We called it a drug problem when someone's life centered around drugs; when a person was willing to do anything and give up everything for drugs; when someone was stealing cars or selling possessions to pay for drugs. But we were naive about drug abuse.

As we talked among ourselves we found that even isolated episodes of alcohol or drug use could cause problems. For example: drinking or drugging and driving; or doing drugs and getting into fights or getting arrested; or doing crazy, stupid and dangerous stuff.
Many of us went to excess at different times. We would play "quarters" with alcohol. We would get trashed. We would black out and pass out. We would try to be the most "wasted." We would try to outsmoke or out-drink everyone else, or smoke more bongs, or do more lines. Some of us built our reputation on what we were doing.
We didn't realize that drug abuse could cause serious problems. It could affect us in school, with friends, or with our families. Drugs could become a substitute for learning to deal with life and reality. Drugs could lead to our arrest.
We began to realize that drug abuse can occur long before craving or addiction becomes an issue.

Challenge Three: We looked at our use of alcohol and other drugs to see if it had caused harm or could cause harm.

What We Did Not Do

Sometimes harm is best understood by what did not happen that should have happened. All the time we were doing alcohol and other drugs, there were things we should have been doing, such as: going to school and preparing for a career; learning to feel comfortable with male and female friends (without being buzzed or high); learning to solve problems; learning to cope with stress; learning to cope with pain, anger and other strong feelings; learning to have fun and excitement in our lives (without drugs); and figuring out what we believed in, and where we wanted to go in life.
While we were using drugs, many of us did not learn things we should have been learning. We stopped growing up in certain important ways. This type of harm is the most difficult harm to see because it sneaks up on you in the future. We kept saying: "Drugs haven't caused me any problems." Some of us only discovered the harm years later when we had the body of young adults and the mind of a young teenager. Some of us were lucky enough to see this potential harm and do something about it before the damage was serious.
We discovered that we were relying on drugs more than we cared to admit. We could see we might be heading toward trouble because drugs were the only way, or the main way, to cope with life. Drugs were becoming too important to us. We had to learn to meet our needs without relying on them.

Challenge Four: We looked at our responsibility and the responsibility of others for our problems.

We Blamed Ourselves

Many of us had not been loved and comforted enough by parents.
It didn't help that some of us had parents who called us "druggies" and "losers," and said we would never amount to anything.
Hearing this criticism, many of us secretly blamed ourselves for all our problems. We would find faults and pick ourselves apart. Because we were so hard on ourselves, we tried not to think about our lives.
What we really needed was to be more loving of ourselves. We needed to feel good about ourselves so that we could look at our lives honestly, understand what was happening, and make changes for the better.
We also needed to be more fair in seeing what caused our problems. We had to stop blaming ourselves for everything.

Challenge Four. We looked at our responsibility and the responsibility of others for our problems.

We Blamed Everyone Except Ourselves

Some of us put all the blame "out there." We blamed our parents, our neighborhood, schools, police, and other people for everything that went wrong. We excused our drug use and all our misbehavior without looking at our own responsibility.

If only the world (our parents, our schools, etc.) would change, we thought, then our lives would get better.

Some of our complaints were justified. But blaming the world for everything didn't help solve problems. It left us powerless. We were acting as if we couldn't do anything. By waiting for the world to change, we were not taking control of our own lives, and not doing everything we could do to make things better.

We had to look at our problems in a fair way...without blaming someone else for everything.

Challenge Five: We thought about where we seemed to be headed, where we wanted to go, and what we wanted to accomplish.

Quick Fix

Mind altering drugs work wonders for people who live for the moment. They offer instant fun. They can make you feel happy, brave, energetic, or nothing at all. They can stop you from feeling angry, scared, sad, or hurt. They give you control over what you feel. They give you courage. They're a quick fix.

But alcohol and other drugs don't solve problems. Rather, they create a set of problems of their own. Our challenge was to look at the big picture, to ask ourselves how drugs were affecting our lives right now, and how they might affect our future.

On some level we knew we had been trading momentary pleasure for a grim future. We could see that we were avoiding things. We were letting problems persist. We weren't learning to cope with reality.

It felt better not to go to school and not to work than it did to take responsibility for our lives. This was fine as long as our parents, or other adults, put a roof over our heads and provided our meals. But this couldn't go on forever.

If nothing changed and we kept going the way we were headed, we would become adults without an education, in unhealthy relationships, and unprepared to deal with life. Some of us would end up in prison, or dead, or going to treatment centers, over and over again. We would never be prepared to get jobs that would allow us to live comfortably.

If we wanted more than instant pleasure, we knew we needed to face the challenge of deciding what sort of person we wanted to be, and where we wanted to go. We needed to take the time to think carefully about our future.

Challenge Five: We thought about where we seemed to be headed, where we wanted to go, and what we wanted to accomplish.

Fear of Failure

Many of us had no dreams for ourselves and could see no future. We dropped the goals we used to have. Everything looked bleak. We had no hope. We didn't set new goals because we were afraid we might fail. We thought: If we don't have goals, we can't fail. We said, "Live for today."

It was tempting to ignore the future. We had good excuses for giving up. Many of us came from horrible families and horrible environments. Some of us had parents who abused alcohol or other drugs. We saw no way to escape our homes and neighborhoods, except through drugs. Many of us had suffered from serious school problems, some of them life-long. Many of us came from families that expected too much and pushed too hard.

But we had a choice: face our problems now, or fall further behind and dig a deeper hole for ourselves. We needed renewed optimism and faith that things could get better. We needed to believe in ourselves. We needed to set goals. We needed to trust our inner strength. This wasn't easy, but we had to do it. It was the only good way to improve our lives.

Challenge Six: We made thoughtful decisions about our lives and about our use of alcohol and other drugs.

Keeping One Drug

Not wanting to give up the option of getting high, we tried to bargain by keeping one drug. "OK," we said, "I won't do cocaine and crystal anymore. I'll only smoke bud." (Or, "I'll only drink alcohol.")
The problem was we didn't want to lose the drug effect. We hadn't decided to learn to cope without drugs. So we continued to cling to one of them. We thought we could control our use of that drug. But our own need to get high was so strong that most of us lost control.
Friends challenged us with situations like these: "OK, you say you'll only drink alcohol – and won't use any other drug. But then you get buzzed. You're feeling good. Someone passes you a bong, or cuts a few lines of crystal. What are you going to do?"
The results of continuing to use one drug were generally predictable. We would use that one drug, feel good, start to abuse it, or perhaps start using all the other drugs we planned to avoid. We really had not committed to basic changes. We were trying to slide by without confronting our appetite for drugs.

Challenge Six: We made thoughtful decisions about our lives and about our use of alcohol and other drugs.

Wanting To Quit And Deciding To Quit

We knew what we liked about drugs. We knew that we had hurt ourselves with them. We started to think that we wanted to stop using drugs. We wished we would stop. We thought it would be a good idea to stop. We thought we should stop. We even said we would try to stop. We also said we didn't "plan" to get high. But this never cut it. Maybe we stopped doing drugs for a short period of time. But somehow, situations arose in which we would get tempted and start using again.
There is a big difference between wanting to stop and committing yourself to stopping:
Wanting is wishful thinking, as in, "it would be a good idea to quit."
Committing yourself means taking a stand and deciding to put in the enormous effort required to succeed in being drug-free.
One guy said he was going to quit smoking weed. He meant it. But when he was asked what he would do if a joint were put in front of him, he said: "I'd smoke it in a minute." He wanted to stop, but had not really decided to quit.
Some of us doubted our ability to quit. We had to trust ourselves and be willing to work hard. For some or us, it would be the hardest thing we ever did in our lives.
Some of us were more like kids in a candy store with money in our pockets. We wanted to quit because it was the smart thing to do. But we wanted to keep getting high, too. We wanted it both ways. But, you can't have it both ways. As long as we were unwilling to commit to stopping, we kept on getting high whenever the temptation became strong.
On the other hand, the people who really decided to quit were the ones who were able to stay drug-free. The rest of us had to struggle to take the next step: to move from preparing to stop to actually deciding to stop.

Challenge Seven: We followed through on our decisions... If we saw problems, we went back to earlier challenges and mastered them

Relapse

The decision to stop drinking and doing other drugs didn't stop us from having urges. This surprised some of us. We thought that making up our minds would make it easy. No way! Our liking, even love, of drugs was intense. We wanted them. But we also knew we could be strong and resist the urge. It was our choice.

We had to use our inner strength and the support of others to resist temptation. We had to defend our decision to quit doing drugs, and defend our futures. We had to battle our demons. Some of us lapsed and relapsed. And when we relapsed we wanted to give up. Some of us relapsed more than once. At times, we felt we could never succeed in overcoming our drug abuse or dependence.

We talked with other people and heard about other people who had relapsed, but stuck with their recovery effort until they finally succeeded. Even though we sometimes doubted ourselves, and saw people who gave up, we kept thinking about our choices. We reminded ourselves of the harm from our drug use and the benefits of quitting. We learned from mistakes and recommitted to our decisions to change.

As time passed, we got better at seeing how relapse would sneak up on us. One girl talked about accepting cocaine from a guy she knew. She never intended to use it. She figured she would give it to a friend. But she got high later that day. Why did she accept the cocaine? Didn't she know if she had it, she eventually would get high? As this girl thought about her episode of drug use, she realized the problem started earlier. Why did she even see this guy who she knew did drugs? Well, she wanted a ride to a convenience store, and had called him. She thought she could see him and not be tempted. She should have thought twice about this. It was an obvious step toward relapse. After this experience, she reminded herself that she needed to avoid people who were going to tempt her to do drugs.

We began to realize that relapses begin long before you start drinking or doing drugs. They begin when you start to drift toward a relapse lifestyle.

Notes

Papers presente to the Conference
from the Center for Addiction Studies,
Universidad Central del Caribe

originally presented to the
American Public Health Association
Annual Meeting,
Boston, MA - November, 2000

Service Utilization and Medical Care Costs of Drug Users in Managed Care

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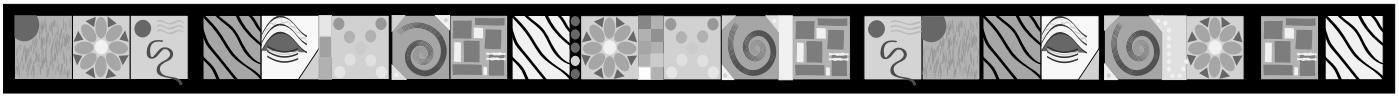

INTRODUCTION

There is evidence in the health care literature that new institutional arrangements and health care practices affect the provision of medical services among vulnerable populations such as drug users. The response to the new strategies in health care buying has been an acceleration in the growth of managed care organizations, including managed behavioral health care plans (Edmunds et al, 1997). Carve-out arrangements have increased rapidly, and currently cover almost 75% of people with private health insurance in the United States (Oss, Drissel & Clary, 1997). In Puerto Rico, carve-out appears to be the most significant recent development and has led to a new "behavioral system of care" industry, consisting of various firms (most of them subsidiaries of large firms in the United States) specializing in mental health and substance abuse services. However, uncertainty about costs and the lack of current data limits the possibility for effective public policies and regulation (Sturn, Zhang & Schoenbaum,1999).

This study aims to describe 1997-99 cost and health services utilization patterns of physical and behavioral health care among a cohort of drug users enrolled in a Medicaid managed care program in Puerto Rico.

METHODS

A total of 564 drug users were recruited between July 1997 and August 1999 from communities under the managed care region. Due to the fact that we examined claims provided by the MCO to determine average cost of health services, subsequent analyses are limited to the 286 drug users that were enrolled in a managed care system within a twelve-month period after study recruitment.

Data collection

Data were obtained through individual interviews and review of MCO expenditures. Claims for all services delivered between July 7, 1997 and June 9, 1999 were obtained and classified into physical or behavioral health according to the type of service authorized. Of 2,356 claims, 60 (2.5%) were excluded from these analyses because of missing information about cost of health services, primarily due to administrative errors. We determined average cost per member, average costs per user and use rates for physical and behavioral care.

Data analysis

Because of skewed distributions of cost-related measures, non-parametric tests were used to assess differences between medians of total costs among subgroups of drug users.

Sample

Individuals were recruited from communities of the North Health Region of Puerto Rico. This region has delivered services to Medicaid enrollees in managed care since 1995. Since 1997, behavioral health services have been administered separately from medical care through a carve-out arrangement.

Drug users not in treatment were recruited following a targeted sample plan based on copping areas (settings were illicit drugs are sold). The sampling procedures used to select drug users from copping areas have been described elsewhere (Robles, Colón & Freeman, 1993). A three-stage random recruitment strategy was utilized for selecting:

- recruitment sites (copping areas or street settings where illicit drug are sold)
- day and time of recruitment
- one participant at the designated site, day and time

Eligibility criteria included

- injection drug use or crack use in prior 30 days
- 18 years of age or more
- not enrolled in drug treatment in prior 30 days
- current residence in the Health Regions that are under study

RESULTS

Table 1. General characteristics of study participants (n=286)

Characteristics	%
Gender	
Females	26.6
Males	73.4
Age:	
18-24	33.6
25-34	37.4
35 or more	29.0
Income Characteristics	
No income in past 6 months	22.0
Some income in past 6 months	78.0
Education	
Less than high school	60.1
High school or more	39.9
Chronic Illnesses*	
No	44.8
Yes	55.2
Any mental health condition**	
No	56.6
Yes	43.4
Type of drug user	
IDU only	53.5
Crack user	24.5
Both	22.0
Ever received drug treatment services	
No	26.6
Yes	73.4

* Chronic illnesses such as diabetes, bronchitis, asthma, heart diseases, hypertension, arthritis, cancer, cirrhosis, HIV, TB, Hepatitis B or C or emphysema.

**Conditions such as major depression, general anxiety disorder, specific phobia, social phobia, agoraphobia or panic attack.

Table 1 displays the general characteristics of the study cohort. Drug users were mostly males (73.4%), age 34 or less (71.0%), and possessed less than 12 years of education (60.1%). A considerable proportion of drug users had experienced a chronic illness and mental health condition such as major depression, anxiety disorder, panic attack or social phobia. More than half of the individuals (53.5%) are IDUs and almost 75% reported having received drug treatment services in the past.

Table 2- Mean cost and use of health care services by 286 drug users enrolled in a managed care system*

Variable	Total	Emergency Care	Physical Care	Mental Health	Substance Abuse	Alcohol
Total cost per member	$385.02	$51.49	$287.72	$7.99	$37.53	$0.29
N of members with any health care use	195.0	102.0	167.0	33.0	45.0	2.0
N of users of any health care use as percent of total members	68.2	35.7	58.4	11.5	15.7	0.70
Cost per user of any health care services	$564.69	$144.38	$492.74	$69.21	$238.53	$41.00
N of inpatient days per user	—	—	1.57	0.12	0.56	0.00
N of outpatient visits per user	—	—	3.21	1.42	1.60	0.50
N of emergency visits per user	—	2.36	1.36	0.33	0.04	0.50

* Excludes cost related to medical prescriptions.

Figure 1. Cummulative distribution across physical service cost categories by gender

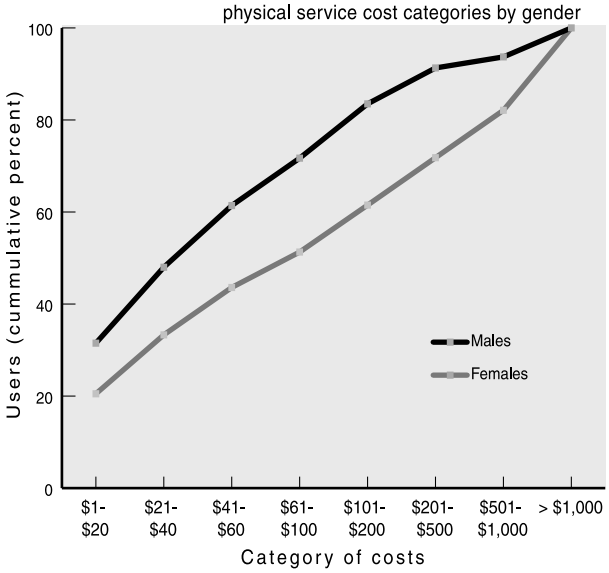

Table 2 presents mean costs and utilization for both physical and behavioral health care. The table also lists the number and fraction of members using the service type. The categories in this table are not mutually exclusive; that is, a patient with some behavioral and physical health services use can appear in more than one column of the table. However, costs are divided according to individual claims. The annual cost per member for total health care services was $385.02. Behavioral health care services accounted for approximately 12% of the overall cost of medical services in this sample, which was calculated by dividing the cost per member for behavioral care ($45.81) by the overall cost per member ($385.02). A total of 195 subjects (68.2%) used at least one physical or behavioral health service. The majority of the sample (58.4%) used physical health services and a considerable proportion of drug users received emergency room care (35.7%). Among the behavioral health services, there is a higher use of substance abuse benefits (15.7%). Cost per user was significantly higher for physical health compared to other health care services. Among the behavioral care services, cost per user was considerably higher for substance abuse compared to alcohol or other mental health services. Users of physical health services spent a higher number of days in inpatient care compared with users of behavioral health services. Average number of outpatient and emergency visits was also higher for physical services compared to behavioral health services.

Significant differences were found only for the average costs of physical services when analyzed by characteristics previously shown in Table 1. Gender was the only significant variable associated with average charges for physical services. Specifically, females had significantly higher annual charges for physical services on average compared to males ($Z = -2.168$; $p = 0.03$).

Figure 1 presents the cumulative distribution of members across cost categories and confirms that physical health service costs were different for females and males. For instance, 61% of males incurred less than $60 in physical health service costs compared with 44% of females.

CONCLUSION

We analyzed this dataset which represents a specific population, and we do not seek to generalize our findings to managed care enrollees with other types of insurance. Our results of mean costs and use of health care services are one of the first applicable to a cohort of drug users in Puerto Rico. This study shows that the total cost of medical care services was considerably low for this population. Moreover, in our sample, which consisted exclusively of drug abusers, behavioral health care services accounted for only 13% of the overall cost of medical services. It is noteworthy that total costs per member associated to emergency care were relatively higher than those associated to any kind of behavioral health care service. The fact that more than one-third of the sample utilized emergency room care suggests that managed care has not been able to reduce substantially this expensive service. Similar studies in the U.S. have also reported that drug users show high utilization of emergency room care (French et al, 2000; Stein et al, 1993).

Females had significantly higher average annual charges for physical services compared to males, which suggests that they confronted more medical problems than their gender counterparts. Other studies have shown that women are more likely to seek health care services at a later stage of disease than men.

ACKNOWLEDGMENT

This research was funded by SAMHSA, Center for Substance Abuse Treatment, Grant # 4 UR7 TI11280.

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Access and Quality of Care in Managed Care for Adolescents

Substance Abuse Treatment in Puerto Rico: Implementation Survey

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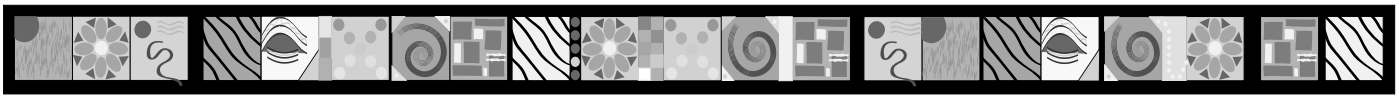

INTRODUCTION:

In 1994, Puerto Rico joined the United States mainland in changing its public system of care to a privatized managed care system. Before the implementation of managed care, the public drug treatment system of the island was owned by the government, where all providers were salaried employees or under contract by the government. Medicaid funds, capped at 129 million dollars per year, were used to subsidize the government-owned and operated public health sector. There was no payment to private sector providers and there was no freedom of choice for recipients. The privatized system was small and accessible to the wealthy elite.

The aim of this study was to detect the structural features of the managed care service system for adolescent substance abusers during the early stage of its implementation. This information is important to help us to understand how the transition to managed care has influenced adolescent health care services.

METHODS:

This study is part of a SAMHSA/CSAT initiative to begin understanding the range of managed behavioral health care services provided to adolescents with substance use disorders nationwide. Six research teams and a coordinating center designed and implemented a multi-site study via a cooperative agreement.

The information for this study was collected through multiple methods: key informant interviews, document review, analyses of extant data from multiple data systems, and chart reviews. A total of 202 phone calls were made to arrange 21 key informant interviews. Twenty-five additional phone calls and 19 personal visits were made in order to obtain supplementary information from key informant interviewees. Key informants for this study were derived from three categories of agencies or organizations: the Criminal Justice System, the Mental Health and Anti-Addiction Services Administration (MHAASA), and private providers (managed care and community-based organizations). In each of these categories, an effort was made to interview key informants at the central office administrative level, and key informants directly providing adolescent substance abuse services. Data was also collected from 150 patients 12 to 18 years old recruited within 45 days of admission to a drug treatment service and re-interviewed six months later. Study participants were recruited from outpatient and inpatient programs.

Table 1. Specific Issues Related to Managed Care Implementation

Access to Services

Financial issues

A. The cost of establishing facilities results in limited access.

B. Patients incur expenses for transportation and food because sites of service are distant.

C. Uncoordinated and ineffective services to youth with multiple necessities (special populations).

Policy issues

A. Assigning only one MCO to a major geographic area (Health Region).

Clinical issues

A. Limited multi-disciplinary teams with specific preparation in child and adolescent health.

Availability/Appropriateness of Services

Financial issues

A. Establishing residential treatment programs represents a significant expense for MCO. This service is currently not available in PR.

Policy issues

A. Limits in the number of visits and the duration of treatment services contrasts with the previous treatment system in which these types of limits did not exist.

B. The policy of not paying for certain services related to court-referred youth (e.g., interviews with family members, reports to the court, court appearances), inhibits some providers from accepting these youth.

C. Lack of professionals to provide services to juvenile justice youth who have completed their sentence but who need additional treatment.

Clinical issues

A. Limitations in services affect the continuity of care for youth.

B. Number of authorized treatment visits/days is not sufficient to meet the medical needs of some adolescents.

Quality of Care

Financial issues

A. There is a lack of comprehensive planning and funding to provide specialized training to substance abuse program personnel.

Policy issues

A. Procedures for addressing grievances related to treatment services are more formal.

B. The requirement of specialized training in substance abuse limits the number of available personnel but ensures that youth are provided services by more highly trained professionals.

C. Lack of a comprehensive, independent plan to evaluate treatment outcomes.

Clinical issues

A. There is a failure to apply uniformly criteria to evaluate psychiatric and substance abuse-related disorders among youth.

RESULTS:

Table 1 summarizes the findings of the survey between organizations that provide drug treatment services for adolescents. This table shows that man-

aged care organizations (MCO) (1) provide a limited access to care, (2) uncoordinated and ineffective services to special populations and (3) less facilities where services were provided. Moreover, the policy of not paying for certain services related to court-referred youth, inhibits some providers from accepting these youth. Clinical services were limited in the number of visits and the duration of treatment when compared with the previous treatment system. These limitations in services impact negatively the continuity of care for these youngsters. However MCO have in place formal grievance processes related to the access and quality of services. Although the requirement of MCO of specialized training in substance abuse (certification) limits the number of available personnel, it ensures that youth are provided services by more highly trained professionals. There is a lack of a comprehensive, independent plan to evaluate outcomes (i.e., effects) of managed care drug treatment services (e.g., six and 12-month follow-up interviews following completion of treatment.).

Table 2. Profile of Adolescents in Drug Treatment Under Managed Care (N = 150)

Sociodemographics	N(%)
Gender	
Male	131 (87.3)
Female	19 (12.7)
Age	
13-15 years	39 (26.0)
16 years	35 (23.3)
17 years	50 (33.3)
18 years	26 (17.3)
Mean Age	16.4 (SE=0.09)
In school before entering treatment	
No	48 (32.0)
Yes	102 (68.0)
Employment	
No	115 (76.7)
Yes	35 (23.3)
Health Related	
Perception of Health	
Excellent/Good	123 (82.0)
Poor/Bad	27 (18.0)

On March 2000 we ended the recruitment of 150 adolescents receiving drug treatment services under managed care. Table 2 shows a profile of this sample. Eighty-three percent of adolescents were male and 32% were out of the school system at treatment entrance 6 months earlier. The mean age of the group was 16.4 years. Twenty-three percent reported employment status and 18% perceived to have poor/bad health.

Table 3a. Adolescent Drug Treatment Experience Under Managed Care (N = 150)

Drug Treatment	n (%)
Court Ordered to Enter Treatment	
No	27 (18.0)
Yes	123 (82.0)
Reason to Enter Treatment	
Drugs/Alcohol	130 (86.7)
Mental Health	3 (2.0)
Both	16 (10.7)
Other	1 (0.7)
Type of Drug Treatment	
Outpatient	132 (88.0)
Outpatient - Intensive	4 (2.7)
Residential	14 (9.3)
Mean Days in Treatment	22.4 (1.09)
Taking Medication for Emotional/Drug Problem	
No	138 (92.0)
Yes	12 (8.0)

Table 3a shows the variables related to the actual drug treatment. Eighty-two percent of the sample reported to have a court order to enter treatment and 88.7% indicated the use of alcohol/drugs as the primary problem to enter. The school system and drug/alcohol & mental health provider were the other two sources that referred adolescents to treatment. Outpatient drug treatment services were used more by managed care - 91%. Residential modalities were reported by 9% of the sample - this service was provided by non-managed care organizations. Overall 8.0% of the adolescents indicated the use of medication in the previous six months for drug/mental health problems.

Table 3b. Adolescent Drug Treatment Experience Under Managed Care (N = 128)

	n (%)
Drug Treatment Services	
Individual therapy	101 (78.9)
Therapy sessions with family	85 (50.8)
Peer therapy sessions	51 (39.8)
Peer and their families therapy sessions	13 (10.2)
Satisfaction with Services	
Staff were willing to see the adolescent as often as necessary	109 (85.1)
Services were available at hours convenient for the adolescent	108 (84.3)
Staff helped with psychological or emotional problems	104 (81.3)
Immediate assistance in a crisis	88 (68.8)
Location of services was convenient	86 (67.2)

In Table 3b we observe some of the services received and the satisfaction with the treatment services. Individual counseling sessions were reported by the majority of the sample (78.9%) but only half of the sample (50.8%) had therapy sessions with the family. The adolescents reported satisfaction with the frequency and business hours of the services. Thirty-one percent indicated not receiving immediate help in crisis situations and 32.8% reported that location of services were not convenient.

CONCLUSION:

The Medicaid-funded Puerto Rico drug treatment system is in the middle of a process of change from a government-owned centralized system of care to a privatized managed care system. Our results show a need for more facilities and services, especially residential treatment. The lack of licensed professional drug treatment providers also seems to be an important limitation to the availability of services for adolescents in Puerto Rico.

ACKNOWLEDGMENT

This study was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), through Grant # 5 UR7 TI11331.

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