# Children, Trauma and the impact of Substance abuse

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## Assessing families and treating trauma in substance abusing families

# Assessing substance abuse in the family

- Included in the psycho-social assessment of the family i.e. history of family substance Use and Abuse. Sometimes will discuss use when won't acknowledge abuse.
- Open ended, non-judgmental questions
- Ask different people in the family, independently.
- Include generational history of use/abuse.
- Integrate into the overall assessment i.e. family financial situation, family system roles and responsibilities. Medical…
- Observe behaviors and in case of home-based, the surroundings.
- On-going assessment

# Parental substance abuse and trauma

- Neglect:
  - Unavailable emotionally (significant relationship is with substance)
  - Unavailable physically (periods of abandonment)
  - Inconsistent in parenting, never know what to expect.
  - Parentification of the child, child manages the home/siblings
  - Disconnect from other healthy resources in family and community.
- Abuse:
  - Physical and sexual abuse directly by the parent/other family member or “friend” of the family.
  - Creating dangerous events that could harm the child directly ie drinking and driving, criminal activity, excessive rage and violence.

# What is Trauma? Influence of parental substance abuse?

- **Violence in families/communities**
- **Being a Witness to or experiencing physical or sexual abuse**
- **Loss of a loved one (divorce, illness, abandonment)**
- **Living with a family member whose care-giving ability is impaired (illness, substance abuse)**
- **Having a life threatening illness**
- **Poverty (unemployment, poor housing, lack of good nutrition and other basic necessities)**
- **Natural Disasters**
- **Refugee and war experiences (terrorism)**

# How prevalent is trauma?

- **26% of children in the US will witness or experience a traumatic event before the age of 4**
- **60% of American adults indicate they have experienced abuse or other difficult family circumstances during child hood.**
- **Children and youth entering services:**
  - **84% experienced at least one traumatic event**
  - **48% have suffered a traumatic loss of a loved one**
  - **47% have witnessed domestic violence**
  - **44 % were living with family member whose care giving ability was impaired**
  - **40% were exposed to multiple types of trauma**

# Traumatic Stress

- Children who suffer from traumatic stress are those children who have been exposed to one or more traumas over the course of their lives and develop reactions that persist and affect their lives after the traumatic events have ended

# Possible signs of trauma in children/teens

- Depression
- Anxiety
- Aggression, rule breaking behavior
- Attempted suicide
- Social isolation
- Sleep disturbances/eating disorders
- Overly sexualized behavior
- Poor impulse control, self destructive behavior
- difficulty in regulating emotions and knowing and describing their feelings
- Unexplained physical symptoms and medical problems
- Substance Abuse

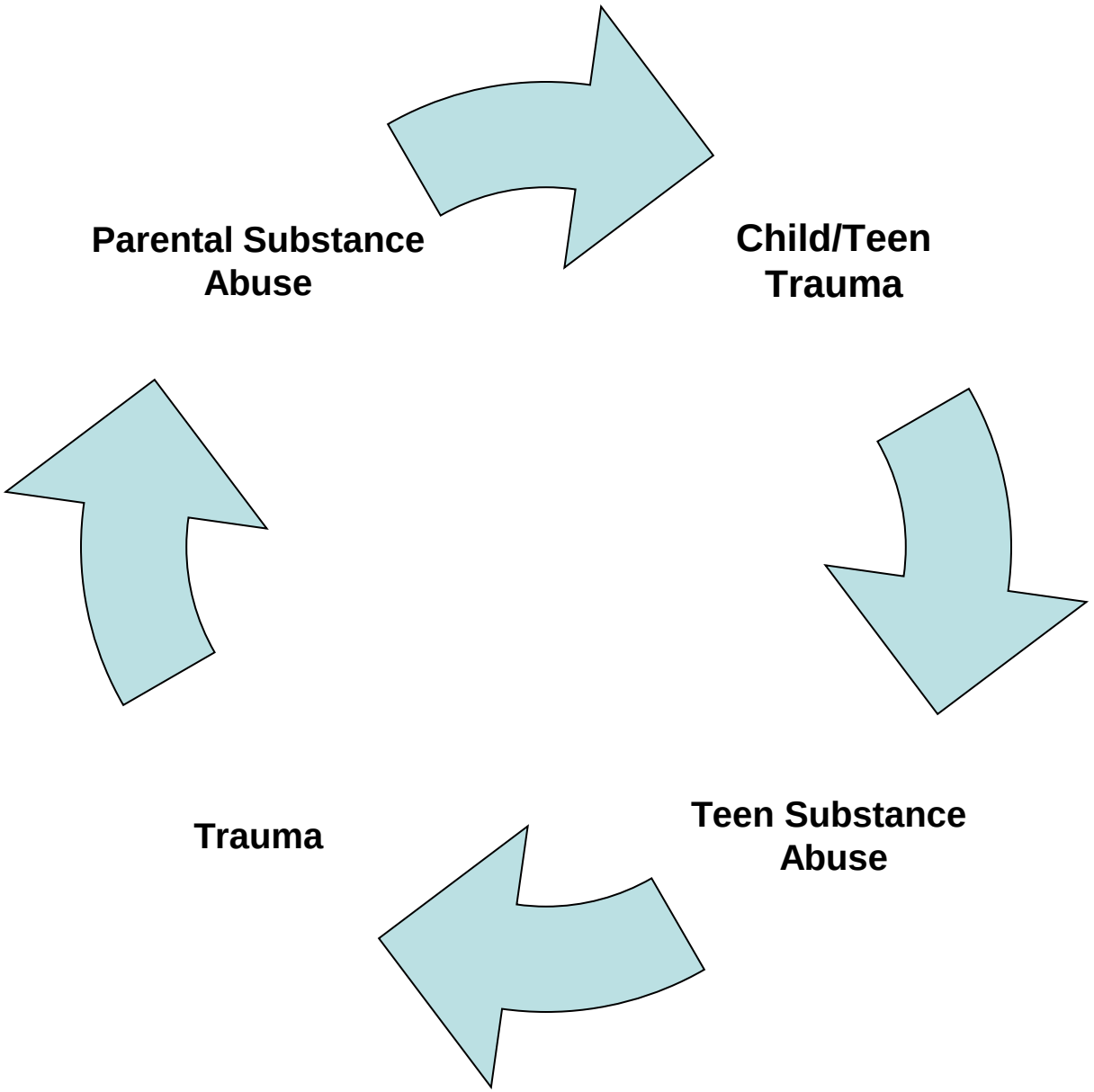
# Trauma, teens and substance abuse

- Teens who experience physical/sexual abuse or assault are 3 times more likely to report past or current substance abuse than those without trauma.
- 59% of young people with PTSD subsequently develop a substance abuse problem
- **Adolescence receiving treatment for substance abuse more than 70% report having a history of trauma**

# Risk factors of Adolescent Substance Abuse

- Family poverty/high unemployment
- Alcohol/drugs readily available
- History of substance abuse in the family
- Norms/rules unclear
- Lack of parental supervision
- History of Trauma

Risk factors for substance abuse are also risk factors for Trauma.


Parental Substance Abuse
Child/Teen Trauma
Teen Substance Abuse
Trauma

# Impact of trauma on Adolescent development and behavior

- Trauma has been shown to adversely effect many of the neurobiological systems responsible for cognitive development and the regulation of emotions and behavior.
- Can mean delays in development that would normally enable them to better consider the consequences of their behavior, make better appraisals of danger and safety, to moderate daily behavior to meet long term goals and to increase abstract thinking to help with problems solving and academic learning.

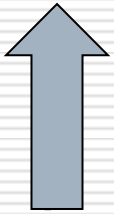
## Dr. Bruce D. Perry, Trauma Conference, Boston, May 2011 (childtraumaacademy.org)

- Examining Child maltreatment through a Neurodevelopmental lens: Clinical Applications of the Neurosequential Model of Therapeutics
- Maltreatment disrupts proper brain development; trauma, neglect and related experiences of maltreatment such as prenatal exposure to drugs or alcohol and impaired early bonding all influence the developing brain

# Trauma and Brain Development

- The brain is organized in a hierarchical fashion with four main anatomically distinct regions:

Cortex (complex functioning)



Limbic system

Diencephalon

Brainstem (basic functioning)

Develops from the bottom up

## Neurodevelopment and trauma

- If the impairment occurs in utero (e.g., prenatal exposure to drugs or alcohol) or in early childhood (e.g., emotional neglect or trauma), this cascade of dysfunction can disrupt normal development. Simply put, the organization of higher parts of the brain depends upon input from the lower parts of the brain.
- When the child has adverse experiences – loss, threat, neglect, and injury – there can be disruptions of neurodevelopment leading to compromised functioning.

# Development

- Many (client) problems are related to disorganized or poorly regulated networks (e.g., the monoamines) originating lower in the brain.

- Yet, our clinical interventions often provide experiences that primarily address the innervated cortical or limbic (i.e., cognitive and relational interactions) regions in the brain and not the innervating source of the dysregualtion (lower stress response networks). **This is a significant problem in the conventional mental health approach to maltreated children; many of their problems are related to disorganized or poorly regulated networks (e.g., the monoamines) originating lower in the brain.**

## What might work best

- An overanxious, impulsive, dysregulated child will have a difficult time participating in, and benefiting from, services targeting social skills, self-esteem, and reading, for example. The field of restorative neurology has for many emphasized the positive impact of repetitive motor activity in cognitive recovery from stroke. This principle suggests that therapeutic massage, yoga, balancing exercises, and music and movement, as well as similar somatosensory interventions that provide patterned, repetitive neural input to the brainstem and diencephalon monoamine neural networks, would be organizing and regulating input that would likely diminish anxiety, impulsivity, and other trauma-related symptoms that have their origins in dysregulation of these systems.

- Inadequate "targeting" of our therapeutic activities to brain areas that are not the source of the symptoms and insufficient "repetitions" combine to make conventional mental health services for maltreated children ineffective.

# Mapping, Targeting and implementing a plan in a stable and supportive relational system

- Simply stated the ideal is to start with the lowest (in the brain) undeveloped/abnormally functioning set of problems and move sequentially up the brain as improvements are seen.
- Once there are improvements in self-regulation, the therapeutic work can move to more relational-related problems (limbic) using more traditional play or art therapies, ultimately, once fundamental dyadic relational skills have improved, the therapeutic techniques can be more verbal and insight oriented using any variety of cognitive-behavioral approaches.

## Co-occurring treatment

- When substance abuse and traumatic stress are treated separately, adolescents with co-occurring disorders are more likely to relapse and revert to previous maladaptive coping strategies. Integrated treatment is recommended when treating young people.
- Trauma makes recovery from substance abuse more difficult and increases the likelihood of relapse.
- *Most common maladaptive coping strategy is substance abuse*, "If I don't do drugs, I feel like I will go insane, because I have all of these thoughts and all this pain in my heart and I can't get rid of it, drugs are the only thing that takes that away." It keeps me not happy but not so sad that I want to die."

# Available Treatments

- Trauma-Focused Cognitive Behavior Therapy: Short term, ages 3 to 18, encourages child to become more aware of how their thoughts about the trauma affect their reactions and behaviors
- Attachment, Self-regulation, and Competency: children ages 5 to 17, enhancing resilience by building tangible life skills and encouraging supportive care-giving system
- TARGET, cognitive behavioral treatment
- Child Parent Psychotherapy (CPP)
- Seeking Safety, developed by Lisa Najavits
- http://www.nctsnet.org/
- http://www.nrepp.samhsa.gov/


# Trauma Affect Regulation: Guide for Education and Therapy

# What is TARGET?

- Educational & therapeutic intervention for the prevention and treatment of traumatic stress disorders
- Group (10 sessions) or individual (10-12 sessions) psychotherapy
- Milieu intervention

## Factors that have a positive effect on healing from a trauma and substance abuse

- Attending to immediate needs of physical shelter, and physical and emotional safety
- Reducing substance use/abuse in the family
- Linkages with the community - friends and neighbors
- Connecting, or reconnecting, with the Faith Community - faith in a Higher Power, and/or experiencing
- Resiliency and development of Coping Skills
- Establishing a healthy and balanced pattern of both eating and sleeping
- Connecting to support groups and helping professionals