CADA
COUNCIL ON ALCOHOLISM & DRUG ABUSE
of Northwest Louisiana

The Edna I. Davis
Family Support Program

Adverse Childhood Experiences and Trauma: Changing History

Kent Dean, PhD, LAC, CCGC, CCS
Director, CADA School of Addiction and Behavioral Health

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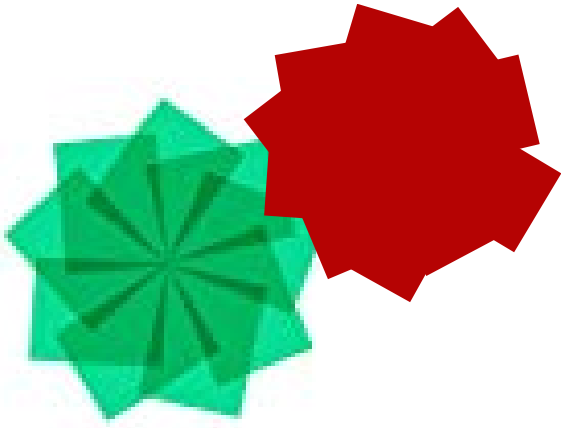
1. Prolog: Getting Perspective on Perspective



Our subject today is trauma-informed care, creating a safe-harbor environment for welcoming and helping those affected by the legacy of childhood trauma. The trauma-informed approach doesn't refer to the provision of professional trauma interventions; it's more like disinfecting a wound site for reparative surgery and creating a sterile field so the operation can be performed by professionals safely with minimized post-surgical risk of re-infection. Ok, if you have one, please raise your filter.

When I hold up my filter, what color do those of you with no filters see? I say the tile I'm holding is red. You probably agree with me. We've all been taught that this frequency of light entering our eyes has been given the name "red." That last statement carries the tacit assumption that there wasn't some sort of conspiracy by all of our teachers to teach us the wrong colors.

What color do those of you with filters see? You'll say it's more green than red. You've been taught that this frequency of light entering your eyes has been given the name "green."

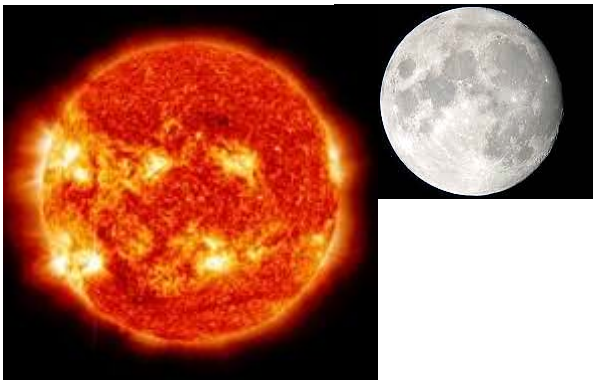
Here's the thing: We're going on the premise that no one in the room knows they have or don't have a colored filter. When someone has red-green colorblindness, for example, they tend to see red, yellow and orange in a greenish hue, *and they don't intuitively know that they're color-blind.*

During my first eye exam, my eye doctor asked me to track my gaze on his pen light as he moved it. I said, “Sure. Both of them?” When he asked me how many I saw, I thought to myself, “Doesn’t he know there are two of them; how many does he see?” Only then did I come to know that I have a condition called diplopia, or “double vision.” I learned that seeing two of everything isn’t normal and that most people see only one image, although it’s a composite produced by their two eyes. Since my brain never learned how to fuse the images as it does for all of you, I’ve always seen this way, and I always will.

Surgery to try and fix the amblyopia (“wandering eye”) causing the problem was ineffective, but I’ve adapted, and I live with it very well today. I got the best care then available; a better outcome is possible now. Medicine—and counseling—can’t be practiced with resources that don’t yet exist. Second only to “do no harm,” our first obligation as counselors is to do our best under current recognized best practices.

What does this have to do with anything? Simple: It’s all about perspective.

2. Do You Believe in Time Travel?

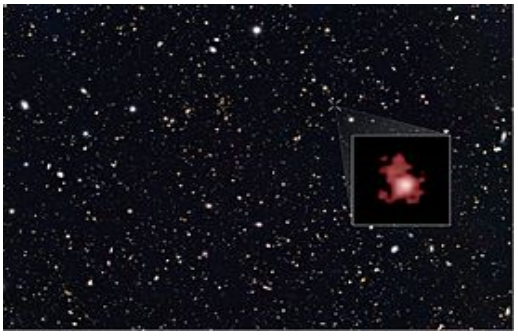


Look up into the sky, and you’ll be looking at a time machine; for example, the light from our sun takes about nine minutes to travel to our eyes. Light from the moon arrives in just a little over a second.

"And God said, 'Let there be light,' and there was light."

As we look further back, say, at the Alpha Centauri star system (the two bright stars in the lower right of the photo above), we realize that light from those three stars (only two of which are typically visible) will have taken some four years to reach our vantage point; and, of course, a great many of the other stars in the sky are much, much further away than that. We're not seeing these celestial bodies as they are *now*; we're seeing them as they once were, often in the immediate past.

But what if we want to experience the light of those bodies closer to the time of origin? Well, then, we have to go back in time. How to do that? A very powerful telescope, such as the Hubble, can transport us back there.



GN-z11 from 32 billion light-years

This is an image of galaxy GN-z11, to date, one of the farthest galaxies ever imaged. It's about 32 billion light years away, only some 400 million years after the Big Bang. We see event that there are two ways to get to the source: we can wait for the light to come to us here on Earth, or we can set out on the journey toward the source and get as close as possible without running the risk of getting burned up by the stars. The Hubble telescope's mirror was ground wrong and later replaced. It now sees clearly this cataclysmic big bang event, which happened so long ago and which now makes itself at least partially known by its remnants from earlier in the life of the universe. We know it happened because we can detect the effects of its having happened resounding in the current universe.

Likewise when we assess the addictive disorder patient, we can see remnants from earlier in their lives, the cataclysmic effects of which still reverberate here and now. Just as astronomers couldn't understand the modern universe without having knowledge of its earlier characteristics, the adverse events our patients have suffered earlier in life, as re-enacted in their motivation and behavior in the here and now, is made much clearer when we have a more focused, less "blurred" understanding of their experiential antecedents.

Planets gravitate around stars; stars orbit in galaxies. In families: children revolve around parents, and parents revolve around their parents and other ancestors and others in whose constellation they've gravitated.

Trauma informed care begins with the premise that human beings manifest what has happened in the past in the here and now. If they've had healthy antecedents, that's what they present; if not, then we see disordered thinking, feeling, and relating patterns. Trauma-sensitive treatment allows the patient to examine the past without running the risk of being "burned up" by reliving harrowing events.

3. Trauma's Children: Family "Roles" (Adapted from Polson and Newton)

What does all this have to do with trauma? People in families affected by addictive disorders (and, for that matter, other mental illnesses) and the attendant traumatic stress find themselves in a downward spiral of makeshift coping with impossible situations.

It's like being raised in a fun house with distorting mirrors. If that's all children see, they never realize that the mirrors aren't presenting a normal picture of themselves and their world. ("What's normal is what you're used to," as the saying goes.) Only later, in the real world, do they begin to notice the discrepancy between what they've always experienced and how things are outside the "fun house." Out of this improvised coping with events that are, as often as not, traumatic, come inevitable distortions of interaction among family members and others affected by the addiction, such as friends and employers.

These so-called "family roles" (a designation that, perhaps, makes them seem less conscious and deliberate than they may be at the outset) are "played out" daily, just like a script, and not only in the dysfunctional family of origin. Behavior patterns adopted by various family members become their *modus operandi* for life in general, both at the time and, unless they're revised, for life. This long-term, automatic, unconscious re-

enactment of older, established behaviors means simply that humans repeat what they've learned and practiced through repetition. "Practice makes perfect." Given how people tend to react to threat, i.e., fight or flight, children in disturbed, traumatic situations generally adopt either a defensive, aggressive stance toward the world, or they retreat into fantasy and isolation.

To put it plainly, these family "roles" adopted to enable children to tolerate the intolerable represent a marked stunting of normal childhood psychosocial development, and this impaired ability to relate honestly can plague them in all of their relationships for the rest of their lives. Adopting the roles makes it impossible for the child to have a healthy, normal childhood. Carried into adolescence and adulthood, these behaviors can inhibit the formation of mutually-nourishing relationships.

Original work regarding family roles was conducted by Dr. Virginia Satir, then adapted by Dr. Claudia Black and others to fit families affected by addiction. In *Not My Kid, a Family's Guide to Kids and Drugs**, Beth Polson and Dr. Miller Newton describe predictable roles that children and play in families affected by addiction. (Note: In real-world families, a child may assume more than one of these roles, either sequentially or concurrently.) The classic "roles" are:

The "Good Child" (a.k.a. "Hero"): a child who becomes a high achiever or overachiever outside the family to escape the dysfunctional family environment, defining him/herself independently of his/her role in the dysfunctional family, currying favor with parents, and/or shielding him/herself from criticism by family members;

The “Problem Child” (a.k.a. “Scapegoat”): the child who causes most problems related to the family's dysfunction and/or who "acts out" in response to preexisting family dysfunction, in the latter case often in an attempt to divert attention paid to another member who exhibits a pattern of similar misbehavior;

The “Caretaker”: the one who takes responsibility for the emotional well-being of the family, often assuming a parental role (even if unwillingly);

The “Lost Child”: the loner, the inconspicuous, quiet one, whose needs are usually ignored or hidden;

The “Mascot” or “Family Clown”: the comedian, who diverts attention away from the increasingly dysfunctional family system;

The “Mastermind”: the opportunist who capitalizes on the other family members' faults to get whatever he or she wants; often the object of appeasement by grown-ups.

Why would anyone choose such constricting patterns of relating to others and to the wider world? The simple, stark answer: survival and repetitive training. Now can be the time to feel free to break the “rules” and examine the “roles” you’ve perhaps felt you had to play in life. All that matters is the willingness to accept yourself as you are. The

good news is that any script can be re-written, and, as the author of yours, you have the chance and the invitation to begin doing so. Although you can't alter the past, you can, indeed, change history!

***Beth Polson and Miller Newton, *Not My Kid: A Family's Guide to Kids and Drugs*, Arbor Books/Kids of North Jersey Nurses, 1984.**

4. Grand Opera Is Not for Children

"What an amazing voice for a child so young!" "She's so tiny; where does all that sound *come* from!?" "Even at his young age, he was born to sing opera!" These and other exclamations of surprise and delight greet the latest wonder-child appearing from time to time on television performance contest shows. The young singers wow audiences with their seemingly-mature, full-throated vocal production. Cause for celebrating their prodigious talent, indeed! Or is it? What if we are, in fact, hearing a disaster, perhaps even a tragedy in the making? That said, how is encouraging youth to over-sing related to juvenile substance abuse?

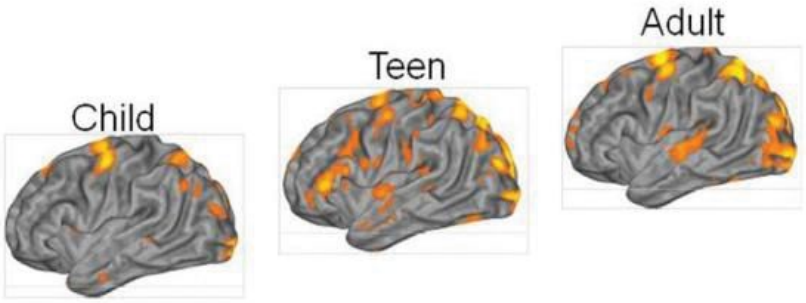
Eduard Magnus: Jenny Lind (1862)

Our concern is for children and adolescents who use any drug, including marijuana or alcohol, whether or not they have a family history of addictive disorders. In no realm of their functioning are children merely small adults. It is never safe for children to use alcohol or drugs because they have not had time to mature physically, cognitively, or emotionally.

Youth substance use poses a situation similar to that of a child or adolescent trying to sing grand opera. Their vocal physiognomy is just not developed to the point that such high-impact singing is safe or sustainable. It takes at least 20 years for the larynx, vocal folds and adjoining support structures to finish maturing. (It should be

remembered that even trained, adult singers run the risk of vocal problems from time to time when they over-sing. All the vocal coaching in the world isn't going to change the reality that young people can and do permanently damage their vocal apparatus trying to sing material that is beyond their vocal capacity before they're physically able to do so safely.) The vocal folds which produce musical tones are a highly delicate, extremely fragile, easily damaged organ.

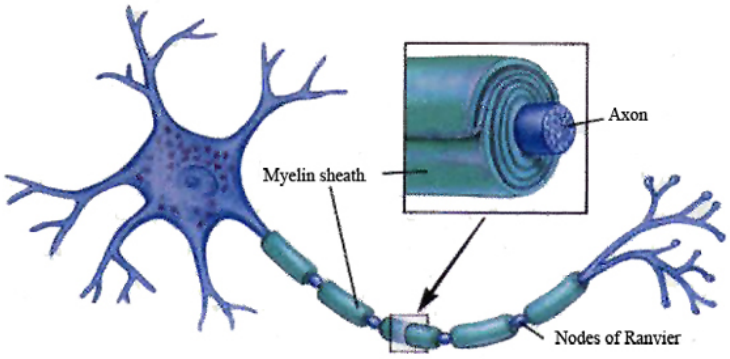
(An example out of history: Jenny Lind, the “Swedish Nightingale,” gave her first performance at 18. Vocal damage forced her to retire by the age of 29.)



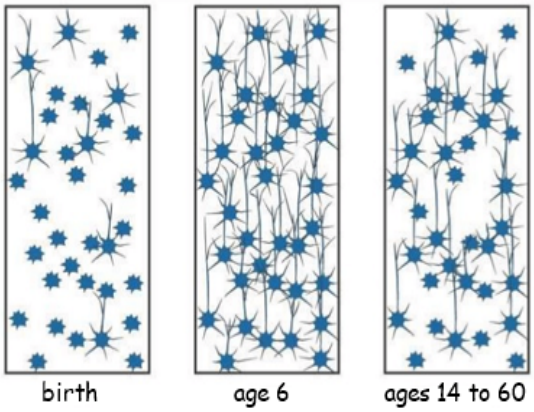
Similarly, other concerns notwithstanding, the reward and cognitive centers in the developing brain are just not matured sufficiently in children and adolescents to accommodate use of any drug, making exposure to chemicals potentially catastrophic. To understand the risk of substance use in children and adolescents, it’s necessary to spend a little time covering how the brain matures. From childhood into early adulthood, important events take place that give us the bran we’ll have as adults:

From early stages of adolescence into adulthood, the brain experiences major growth and pruning. Initial developments begin near the back of the cortex, and tend to finish in the frontal areas (e.g. prefrontal cortex). There are several key ways by which the brain remodels during various stages of development.

Myelination: Brain nerve fibers are sheathed with a substance called myelin, a lipoprotein providing insulation for nerve cells to transmit electrical signals effectively. During developmental stages, the process of myelination promotes healthy brain functioning and allows for more complex functions.



Synaptic pruning: During maturation, neuronal synapses are eliminated or “pruned” selectively. This process of elimination peaks during the teen years and wanes in late adolescence/early adulthood, extending even into the mid-to-late 20s. Pruning facilitates more efficient brain functioning, a “use-it-or-lose-it” proposition.



* brain grows rapidly during early years of life;
* maturing neurons increase the number of axonal and dendritic synapases (age 6);
* however, synaptic pruning removes weaker synapases (starting in age 14 and throughout life);
* that is, synapases that are not frequently stimulated;
* synaptic pruning is an adaptive process;
* aging, stress, and neurodegeneration can cause synapse loss with or without loss of neurons.

https://www.slideshare.net/adonissfera/neuroplasticity-and-neurodegeneration

Increased connectivity: The connections between brain regions that are used regularly appear to be strengthened, thus making communication more efficient. The brain is able to transmit greater amounts of information between regions and becomes better at planning, dealing with emotions, and problem solving.

Executive functions: A majority of the executive functions that we develop are via the prefrontal cortex. This allows us to help assess risk, think ahead, evaluate ourselves, set goals, and regulate our emotions.

A generalization that can be made about the developing brain is its gradual evolution throughout childhood and adolescence into adulthood toward increased emotional and behavioral equilibrium. Compare the tantrums and “meltdowns” of toddlers when they don’t get their way to the reasoned and emotionally-congruent reaction and restraint of adults (well, at least *mature* adults) who, although disappointed, retain the will and the power to conduct themselves in an age-appropriate manner. This gradual development of self-control is made possible by the growth of reliable connections involving executive function in the frontal cortex. Although, under ideal circumstances, many of these functions are developed during teenage years, they are still undergoing development and strengthening until the mid-20s.

It’s folly to expect the developing brain to be able to cope effectively with the intense reward and emotional and cognitive shifts associated with substance use, even

at a low level. The brains of youth are no more able to process such signals effectively than their vocal apparatus can withstand the rigors of high-level singing.

The “rush” of emotional stimulation and pleasurable experience overwhelms the areas of the brain that are meant to moderate that experience with clear thinking. Due to the power of the ecstatic response, the childhood need for instant gratification quickly becomes ingrained, with little or no nuance of the pleasureful impulse.

If you also factor in the reality that the child/adolescent may be experiencing a painful, even traumatic home environment (e.g., an abusive parent or the trauma of witnessing violence in the home), which is, in itself, warping the brain’s development of executive function behavioral self-control, you have a recipe for disaster. The youth hyper-learns that using alcohol or some other mood alterer soothes the rage and terror they’re experiencing on a daily basis.

You cannot over-drive any part of the human body for very long at all without sustaining permanent damage. In juvenile substance use, the immature reward pathways become over-driven and develop a “hair-trigger” response to emotions engendered in the outside world. **This over-driving of the reward circuits primes the child to seek solace and comfort in substances or in other addictive behaviors.** Just as young singers have to be prevented from over-singing to avoid permanent damage to the vocal apparatus, prevention or early intervention in the traumatic environment and rescue from use of substances is the only known way to prevent the child being set up for catastrophic problems both in childhood and later in life.

5. Buried Treasures: Liberating People from Dysfunctional Families

Have you ever dreamed that your arms and legs weigh several hundred pounds and that it requires a supreme effort even to move very sluggishly? You know how it feels: there’s little-to-no freedom of movement, and every exertion has to be painstakingly planned and fought through. For most people, such a dream is just an infrequent and mildly-disturbing nightmare, but for those reared in families affected by addiction and other mental illness, such a sensation is part and parcel of their waking, day-to-day existence. For them, the belongingness and validation most people take for granted are absent, buried under the weighty imperatives of secrecy and “keeping up appearances.”

It's long been known that people reared in family systems affected by the chaos and, often, violence engendered by mental illness (including addictive disorders undergo predictable alterations from normal psychosocial development. The basic task of survival is too often at a premium in these dysfunctional systems.

Early on, children find themselves enmeshed in traumas of verbal and physical abuse, sexual abuse and abandonment; profoundly chaotic and unpredictable situations, which ill-equip them to live effectively in the real word of adult responsibility.

The so-called “Three Ds” apply here: Dependency, Debility, and **Dread.** Little wonder, then, that these children grow to become rootless, constricted, ragefully-fearful and emotionally stunted adults.

The working premise is that *everyone*, identified patient and loved ones alike, develops dysfunction in families affected by mental illness (including addiction).

Stage I: Survival in the Family. Special rules seem to apply in families affected by addiction and other mental illness. They are,

1. Don’t talk. Don’t name the problem, or, for that matter, even think consciously about the problem. Ignore it, not only in conversation but also in your own, private thoughts. Banish it from your personal awareness.

2. Don’t trust. Since frightening things happen unexpectedly, and since you can never know when another frightening event will take place, always be on the lookout for “the other shoe to drop.” The only thing you *can* trust is the inevitable shock when the next bad thing happens.

3. Don’t feel. Keep your emotions in constant check so they don’t lead you astray. Don’t ever let anyone know what you’re feeling because, if you do, they will know and they will retaliate against you and hurt you. They may even kill you.

4. Don’t make waves. Be steadfastly loyal at all times. Never say or do anything that would alert anyone in or out of the family that you know what is happening. If you accidentally make it public, there will be catastrophic repercussions to the whole family, and it will be all your fault.

5. Be self-negating. Focus rigidly on others all the time. Never take the time away from being other-focused to attend to your own needs. Your needs don’t matter. All that matters is that you take care of others.

6. Always remember that you’re: crazy, guilty, evil, responsible, different, bad, and, above all, alone. Striving to live by these rules yields a crisis in the life of the patient. They have only two options: getting help or suicide because they’re telling themselves, “I have to be superhuman, and anything less is not good enough.”

If people reared in dysfunction get help, they can then move to Stage 2: Awareness of Family Issues. Break the rules in a controlled, constructive way:

1. Do talk. Name the problem. Think consciously about the problem. Don’t ignore it. Make it present, not only in your own, private thoughts but also in conversation with select other people. There may well be people in and out of your family who would prefer you keep secrets. Remember, though, that some secrets keep people imprisoned and buried under shame, and you’re working to unbury yourself.

2. Do trust. Although frightening things do happen unexpectedly, and although you never know when another frightening event will take place, always be aware that the

"other shoe" doesn't have to fall on you. The only thing you need to trust is your personal ability to withstand whatever happens and your ability to free yourself from situation that could harm you. With knowledge comes responsibility, and you no longer have to retreat behind a wall of powerlessness.

3. Do feel. Keep your emotions in constant awareness, but don't allow them to guide your behavior unless the proposed action is also in line with what your reasoning ability dictates it should be. You have to take responsibility for your feelings as well as your behavior. Other people don't make you feel an emotion; that's an inside job.

4. Do make waves. Dare to be disloyal to those who would harm or neglect you; they don't deserve your loyalty in any event. Summon the courage to say or do anything that would alert caring people in or out of the family that you know what is happening. If what you say it is made public, there may be repercussions to the family, but the repercussions are not your fault, and they can bring about healing. Remember: you didn't create the problem, and you don't have to live in it or take responsibility for it.

5. Be self-enlightened. Focus flexibly on yourself when you need to and on others when appropriate. Take time away from being other-focused to attend to your own needs. (Your needs matter, too, after all.) It also matters that you care for others when appropriate. There's a world of difference between being truly selfish and acting in one's own best interest. Enlightened self-interest is one of the hallmarks of a mature personality, as you remind yourself, "I'm only human, and that's good enough."

Always know that you're not: crazy, guilty, evil, responsible, different, bad, or alone. Remember that guilt says, "My behavior is bad." False guilt claims that. "My behavior is bad" even when you haven't done anything wrong. (Remember, just because someone is angry with you doesn't necessarily mean you've done anything wrong.) Shame says, "I'm bad," which is, typically, throwing the baby out with the bathwater.

Stage 3: Dealing with Family Issues

1. Liberate the child while cultivating the adult. When you're an adult, it's too late to have a happy childhood, but it's never too late to grow into an appreciation of the beauty of life.

2. Feel your emotions. All of them.

3. Express all your emotions appropriately at the appropriate time.

4. Dare to be silly sometimes, knowing that a sense of fun is often just the right corrective for many tense situations and temporary bad moods.

5. Tolerate, then accept love. Like salve on a wound, love can be uncomfortable at first

6. Love others.

7. Behave responsibly, not over-responsibly or under-responsibly.

8. Learn to trust your perception of reality. Just because you grew up in a “not-so-funhouse” full of distorting mirrors doesn’t mean that’s how things look in the real world.

Finally, remember: Courage can feel like fear. Hope can feel like despair. Faith can feel like doubt. Love doesn’t feel like anything because it’s not a feeling; it’s self-sacrificial (but not self-destructive) behavior directed toward the welfare of another.

Distortions of personality arising from the “not-so-funhouse” environment of a dysfunctional family can include a deep dependency on others for self-validation and autonomy. As an example of this strong tendency to remain dependent, let me share with you an anecdote about a patient of mine some years ago (and the circumstances have been altered to protect the privacy of the patient):

I once had a patient who was very dependent emotionally, and he said that his greatest fear was of making a mistake and being condemned for it. He said he needed a new blazer to wear for work, and I asked him if he had gotten one yet. “Oh, no,” he said. “I’ve thought about getting one, but I haven’t gotten around to it yet.

Since one of his foibles was a tendency to procrastinate, I made a behavioral agreement with him that he'd go purchase a blazer before our next session in a week and wear it to the session. He agreed to do that.

When he appeared the next week, he wasn't wearing a blazer. I asked him if he'd remembered that he'd wear it to the session. "To tell you the truth," he admitted, "I didn't pick one out." I asked him if he'd gone to the clothier to carry out his purchase. "I did," he said. "Honestly, I just couldn't figure out what I like. I didn't know which of all the coats they had there was one that I liked. He hesitated a bit and then confided, "You see, I don't know what I like. I mean … I don't want to make a mistake."

I immediately congratulated him vociferously on just having gone to the store in the first place, and I made a suggestion: "What if you go back to the store and pick out a blazer that you think someone else would like you to wear? Just make sure that, if you get it home and decide you really don't like it, you can take it back for a replacement or a refund? Could you do that?" He agreed to do so.

While I'd love to say he next appeared proudly decked out in a fine, new blazer of his choosing, he didn't. He'd gone back to the store, all right, but he was still hobbled by this fear of getting the "wrong" blazer. I praised his persistence and asked him if he'd seen any blazers there that he was certain that he *didn't* like. "Yeah, there were some I thought just 'weren't me.' "

"Great!" I said. "Go back and getting one of the ones that's in the group that you *didn't dislike*, and be sure and wear it to the session; will you do that?" He agreed. I reinforced to him that I wanted to see the blazer not to pass judgment on it but to allude to it to praise his having made an autonomous choice.

The next week, he came wearing his new blazer (which he had to have for work, anyway). I congratulated him heartily on this accomplishment, being careful not to indicate whether or not I thought the blazer was becoming to him. I made it clear to him that his choice was his alone to make, and no one—including me, of course—had the right to contradict his sense of taste in choosing this particular blazer.

My intuition is that he knew all along that this blazer was the one he wanted but that he had to permit himself to come to that conclusion in his own time and at his own pace, not mine (or anyone else's).

6. Epilog:
Love Really Is the Answer

Paul the Apostle (c.5-c.67): First Epistle to the Church at Corinth (c.54): 12:31-13:13:

"Brothers and sisters: strive eagerly for the greatest spiritual gifts. But I shall show you a still more excellent way.

"If I speak in human and angelic tongues, but do not have love, I am a resounding gong or a clashing cymbal. And if I have the gift of prophecy, and comprehend all mysteries and all knowledge; if I have all faith so as to move mountains, but do not have love, I am nothing. If I give away everything I own, and if I hand my body over so that I may boast, but do not have love, I gain nothing.

"Love is patient, love is kind. It is not jealous, it is not pompous, it is not inflated, it is not rude, it does not seek its own interests, it is not quick-tempered, it does not brood over injury, it does not rejoice over wrongdoing but rejoices with the truth. It bears all things, believes all things, hopes all things, endures all things.

"Love never fails. If there are prophecies, they will be brought to nothing; if tongues, they will cease; if knowledge, it will be brought to nothing. For we know partially and we prophesy partially, but when the perfect comes, the partial will pass away.

"When I was a child, I used to talk as a child, think as a child, reason as a child; when I became a man, I put aside childish things. At present we see indistinctly, as in a mirror, but then face to face. At present I know partially; then I shall know fully, as I am fully known. So faith, hope, love remain, these three; but the greatest of these is love."

Élisabeth Louise Vigée Le Brun (1755-1842):
Portrait of Countess Anna Stroganova with Her Son (ca. 1795)
Oil on canvas, 90.5x73cm
Stroganov Palace Museum, Leningrad, 1931

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