



Phoenix Area Indian Health Service

A/SAP COMMUNIQUÉ ^â

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BRANCH CHIEF'S CORNER

The Area A/SAP Branch Chief is the Acting Director for the Office of Health Programs. To reach Ms. Colleen Good Bear directly, please call her at (602) 364-5159.

Expanded service

Good Bear Expands Services to field agencies.

The Alcohol Substance Abuse Program is providing additional assistance to referring tribal agencies. "In our continued efforts to serve and assist you, we have devised an Family Treatment Plan to ease the intake process," Ms. Good Bear stated. She has initiated travel assistance for residential placement of up to 12 qualified adolescents who were originally referred to the Regional Treatment Center in Sacaton. The A/SAP team is further authorized to assist with travel funds for one person escorting the client. Among other technical services, "we have begun providing education and training of providers in the field to empower them with new technologies in addiction treatment," Good Bear added. Recently, A/SAP provided a one-day teaching conference on Disruptive Behavior Spectrum Disorder, and planning two five-day course on Substance Abuse to primary care provider teams.

New Travel Agency Contract Goes into Effect

A/SAP is now under a new contract with SATO in Albuquerque, NM. Based on their procedure, our requirements are as follows:

- The Area A/SAP requires 5 business days for travel arrangements.
- Any referral received after 3:30 p.m. will be processed on the next business day.
- Referring Counselor must identify the client escort. There is a total charge of \$88.50 for any escort change or cancellation.
- Once the travel has been arranged, it is the referring agency's responsibility to fax a copy of the T.O. and the itinerary to the treatment facility.

REFERRAL PROCESS

Steps to follow:

1. The local program counselor (LPC) interviews the client.
2. The LPC assesses the client and in collaboration with the client and family (or extended family) determines the type of treatment needed.
3. The LPC fills out the required intake form/family treatment plan if residential treatment is needed and indicates the recommended treatment facility and tentative **admission date** (The treatment facility will have their own forms that will need to be completed).
4. The LPC sends the intake form to the Area A/SAP for screening and approval.
5. The Area A/SAP will notify the LPC of the client's status.
6. Upon approval, A/SAP provides transportation for the client and for one escort if the client is an adolescent. Expenses will also be paid for one family member to attend family program at the Treatment Center.
7. The client enters the treatment program for a period of 90-180 days if it is an IHS funded RTC. If it is a commercial facility, 45 days will be approved.
8. The Area A/SAP provides transportation for the client to return home when the treatment is completed or if the client is discharged due to non-compliance. Transportation will be provided for an escort if the client is an adolescent.

CIRCLE OF PAIN BY: B. NAYERI, ND AND N. BURTON ATTICO, MD

Is there a Link between Alcohol / Substance abuse and Child Abuse?

Alcohol/substance abuse is often a leading factor in child abuse and neglect that leaves far reaching and lasting emotional scars. The abused child is at risk of later becoming an abuser, subsequently setting a vicious cycle in the following generations. The pain becomes a barrier in healing of the Spirit and of the Psyche (MIND) in the circle of health also known by Native Americans as the “Medicine Wheel.”

April is the month for observance of the national campaigns for both child abuse prevention and underage substance abuse awareness. Due to the rising incidence of child abuse, the U.S. Advisory Board on Child Abuse and Neglect declared a child protection emergency in 1993^[1]. Studies released by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the Center for Substance Abuse Treatment (CSAT) reveal that youth who have an onset of drinking before age 15 have a 4 times greater chance of becoming dependent and twice as much risk of developing alcohol abuse as those who begin drinking at age 21^[2]. A significant number of teenagers tend to minimize the risk associated with consuming 4-5 drinks a day. According to the U.S. Department of Agriculture, the U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, and the National Highway Traffic Safety Administration, the burden of alcohol/substance use on society-at-large is seen in both direct and indirect loss of life. Heavy (high risk) drinking raises the potential for high blood pressure, stroke, heart disease, diabetes, certain cancers, automobile crashes, accidents (with unintentional deaths from falls, burns, and drowning), and rapes and other sexual assaults. It is also a factor in one third of suicides, half of homicides, and one third of reported child abuse cases^[3]. Considering that alcohol is frequently a factor in the three leading causes of death (automobile crashes, homicides and suicides) for 15 to 24 year olds^[4], one can easily speculate that this is also closely associated with neglect.

Exploratory review of current research and publications on the linkages between child abuse and alcohol/substance abuse indicates that the exact relationship is still not clearly known. This is attributed to the fact that most perpetrators are not parents. The data do support the link between experiencing childhood violence and the development of later alcohol or other substance abuse^[5]. A growing literature on childhood adversity reports that exposure to trauma (emotional or physical), especially in childhood, is associated with a specific cluster of mental health disturbances^[6]. Current blinded studies using control groups suggests that exposure to traumatic and chronic forms of stress, including abuse, would be expected to result in a number of cognitive, social, and academic vulnerabilities, which are marked by adolescent perceptions of their families as non-cohesive and chaotic, and of their parents as non-supportive. One study assessed adolescent vulnerability in terms of school failure, perception of inadequate peer and family social and emotional support, and adolescent feelings of hostility, hopelessness, and lowered self-esteem^[7]. The results of another well designed study that included comprehensive diagnostic testing and assessment suggests that: 1) 62% of those who attempted suicide reported that their abuse occurred before adolescence; 2) 75% had divorced or divorcing families; 3) 60% had major depressive disorders; 4) all the abused with a history of suicide attempts had a number of coexisting clinical disorders while the controls did not; 5) all the abused with a history of suicide attempts had a history of disruptive behavior spectrum disorders, and 62% were either alcohol-dependent or alcohol-abusing^[8]. Another study of a general population of adolescents indicates that the associations between reported abuse history and alcohol or other drug use in adolescence and early initiation of substance use. The associations were (continued on page 3)

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stronger at younger ages of onset of abuse history, with relatively heavy drinking by eighth graders where abuse and molestation were combined. For drug use, the associations with reported abuse history were slightly stronger for combined abuse and molestation as compared to non-sexual abuse.

- A gender non-specified study published in a March 1999 study of 639 Child Protective Services case records published by the Center for Research on Child and Adolescent Mental Health Services of San Diego, CA, reports that 79% of the caregivers were found to meet the criteria for caregiver substance abuse.

For early initiation, with history of combined abuse and molestation, marijuana use/regular drinking was stronger than for alcohol/cigarette experimentation^[9]. There seems to be a domino effect based on information supporting the hypothesis of this review paper, especially when the link between childhood maltreatment and subsequent disorders grows. Based on a preliminary research study, there is a strong correlation between a history of child abuse and household dysfunction and an unintended first pregnancy. A study published in an October 1999, issue of *JAMA* used a sample of over 1000 women aged 20 to 50 years whose first pregnancy occurred at or after age 20 years. The results suggest that more than 45% of the women reported that their first pregnancy was unintended, and 65.8% reported exposure to 2 or more types of childhood abuse or household dysfunction. The strongest association between childhood experiences and unintended first pregnancy included frequent psychological abuse, frequent physical abuse. Women who experienced 4 or more types of abuse during their childhood were 1.5 times more likely to have an unintended first pregnancy during adulthood than women who did not experience any abuse^[10]. Conversely, studies among alcoholic women do suggest a significantly higher prevalence of alcohol problems in women with a history of child sexual or physical abuse than in non-abused population samples^[11]. Moreover, findings suggest that women with alcohol or other drug problems are more likely to be punitive toward children^[12].

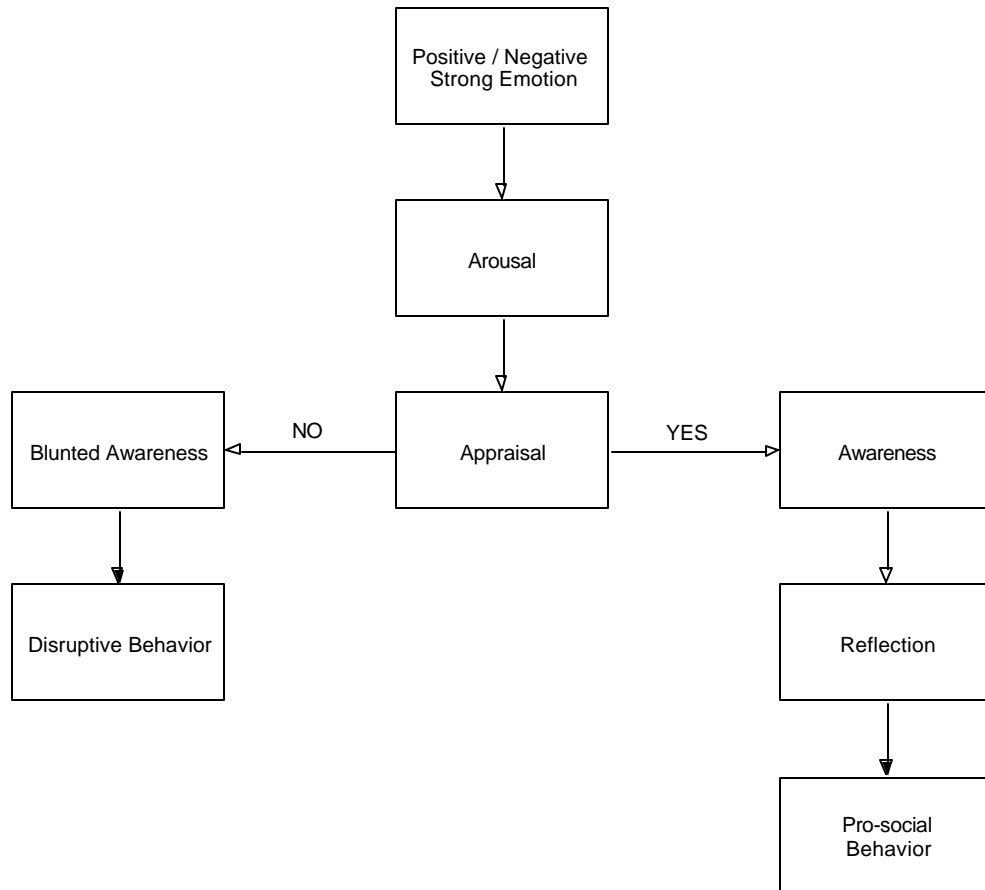
In summary, review of current literature indicates a complex pattern of early dysfunction (premorbidly) among alcohol or other drug-abusing women, especially those with multiple types of childhood abuse. On the other hand, the information about the relationship between alcohol or other drug abuse and childhood abuse among the male population is still insufficient, and treatment modalities in women are limited. Furthermore, the association of childhood abuse with parental mental illness suggests that such etiological factors as genetic and environmental factors are difficult to separate (nature vs. nurture), in determining vulnerability. There are studies indicating that an aberrant neural network development in childhood, whether the result of a toxic environment, or a toxic *in utero* exposure (including poor prenatal care, mothers involved in prenatal alcohol or other drug use or other strong emotional experiences) stunt or arrest the nerve cell structure process or the nerve cell connection development of the brain. (Continued on page 4)

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This results in a neurochemical dysregulation, by way of delinkage (figure 1) of the nervous system connections, which can expose the child to emotional dysregulation and a shut down of cognition and learning abilities that can result in disruptive behavior.

The Delinkage Model

(Figure 1)
ã Nayeri



It is clinically known that abused individuals can themselves become an abuser. Conversely, intervention methods for children have not been without controversy. A recent news account reported on the Administration’s initiative, led by First Lady Hillary R. Clinton, concerning limiting the use of psychotropic drugs in young children. Initiatives leaning toward education and prevention should therefore be the first line of defense while more research on the delivery of effective types of intervention or elimination is being conducted, if we aim to heal the circle of pain.

ASSESSMENT TOOLS	RECOMMENDATIONS
<ol style="list-style-type: none"> 1. MMPI-2 measure of personality traits and functioning. 2. Childhood Trauma Questionnaire (CTQ). 3. Trauma History Questionnaire (THQ), measurement of life trauma and an actual PTSD diagnosis. 4. Structured Interview for Measurement of Disorders of Extreme Stress (SIDES) to assess affect dysregulation, dissociative experiences, and somatization. 5. Beck Depression Inventory to measure depressive symptoms. 6. Suicide Attempt Interview, structured interview that assesses the suicide attempt, including method, precipitating events, past suicidal behavior, and exposure to suicidal behavior of family members and others. 7. Suicide Probability Scale. 8. Structured Clinical Interview for Non-Patient Edition (SCID-NP) 9. Global Assessment Scale based on SCID. 10. Family Adaptability and Cohesion Evaluation Scale- III (FACES III), designed to assess two dimensions of family functioning: Cohesion-the emotional bonding that family members have toward one another and Adaptability-the ability of a marital family system to change its power structure, role relationships, and relationship rules in response to situational and developmental stress^[15]. 11. Child Behavior Checklist. 12. Youth Self-Report 13. Adolescent Social Network Questionnaire. 14. Addiction Severity Index (ASI). 15. Substance Use Disorder Diagnostic Schedule (SUDDS). 	<ol style="list-style-type: none"> 1. Determine the directions for future programs. 2. Comprehensive assessment of childhood abuse and associated features of trauma. 3. Interventions aimed at preventing the disintegration of the family and improving the mother-child relationship. 4. Early identification of diagnosed Disruptive Behavior Spectrum Disorder, which suggests the likelihood of earlier onset of externalizing problem behaviors before the child reaches adolescence. 5. Timely substance abuse intervention for physically abused children-adolescents might prevent the adolescent risk-taking behavior. 6. Bolstering the abused child’s other sources of emotional and social support as an alternative, if the nuclear family remains dysfunctional. 7. Motivational Interviewing. 8. Cognitive-Behavioral Therapies. 9. Efforts to reduce child-adolescent substance abuse, particularly heavy use and use early in adolescence, should consider the possible role of a <i>history of maltreatment</i>. 10. Work with individual abused children-adolescents to modify their hostile attributions and general outlook. 11. Development of social support network. 12. Address cultural beliefs in parenting. 13. Disciplinary skills training for mothers. 14. Cognitive-Experiential Therapy (e.g., energy ball) – A safe and non-threatening, culturally adapted approach to building trust and group cohesion. According to Plato, “we can learn more about a person by playing a game than you could in a life-time.”

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NEXT ISSUE OF COMMUNIQUÉ

- Eating Disorders: Bulimia and Physical or Sexual Abuse.
- Medicine Wheel.

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Articles, comments, requests, and letters to B. Nayeri, are welcome. Articles submitted for publication should be no longer than 3000 words in length, typed, double-spaced, and conform to publication standards. Additional guidelines can be obtained from the publisher at the office of A/SAP.

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