TF-CBT for Youth with Parental Substance Use-Related Trauma Implementation Manual

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FORWARD

Parental substance use significantly increases children's risk to experience multiple types of traumas and potentially long-term negative mental and medical health outcomes. This implementation manual addresses the application of an evidence-based child trauma treatment, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) for children and adolescents who experience trauma associated with parental substance use. It was developed through a SAMHSA-funded National Child Traumatic Stress Network (NCTSN, www.nctsn.org) grant to the Allegheny General Hospital (AGH) Center for Traumatic Stress in Children and Adolescents (CTSCA).

The CTSCA sponsored a year-long learning community to 1) implement and modify TF-CBT for youth who experience trauma as a result of parental use; 2) collect data to evaluate these modifications; 3) develop an implementation manual and other resources as needed to describe these modifications; and 4) disseminate these resources widely to TF-CBT therapists, supervisors and trainers, with an ultimate goal of providing effective trauma-focused treatment to children, adolescents, and their caregivers who experience trauma related to parental substance use.

The learning community followed learning collaborative methodology developed by the Institute for Healthcare Improvement, modified by the National Child Traumatic Stress Network for evidence-based child trauma treatments (National Child Traumatic Stress Network, 2023). The learning community consisted of five teams from six NCTSN funded centers, with 22 individuals participating. Each team included a senior leader (TF-CBT supervisor who coordinated the team's participation in the collaborative) and at least two TF-CBT clinicians who directly implemented TF-CBT for youth who experienced trauma related to parental substance use (supervisors also typically implemented TF-CBT for this population). The three TF-CBT treatment developers and another national TF-CBT trainer were members of the learning community; and several learning collaborative members were also consumers, having experienced personal trauma related to parental and/or familial substance use.

All learning collaborative members had previously received TF-CBT basic training, which is described below. After appropriate pre-work (e.g., education about the learning community, team selection, establishment of a listserv to share resources and other information, and database for data collection and analyses, etc.), the learning community began with virtual team introductions and an initial half day virtual learning session. This learning session addressed the types of traumas that youth typically experience related to parental substance use (e.g., child maltreatment with related maladaptive cognitions; traumatic grief from fatal parental overdose; traumatic separation due to removal from substance using parents who cannot adequately care for the youth). Specific initial suggestions for how TF-CBT might need to be modified for youth who experienced these traumas were then proposed, with the understanding that these were the focus of potential evaluation and modifications throughout the course of the subsequent learning community. Data collection strategies and a schedule for case presentations were also finalized during this learning session.

The learning community then convened for monthly virtual meetings during the following year. During these meetings, each team presented a case of a youth for whom a team member was providing TF-CBT for trauma related to parental substance use. The community discussed the case with a focus on challenges, successes, and how to tailor or apply TF-CBT for this population, based on clinical experience of team members in providing TF-CBT to this population, feedback from youth and families receiving the treatment and particular modifications that were being tried, and what was working and what was less successful in this regard. Each month there was also a focus on sequential TF-CBT PRACTICE components, so that each component was discussed in detail about the applications needed for this population during the learning community. Suggested applications were continuously tried and evaluated through using small tests of change (Plan-Do-Study-Act) cycles developed by the learning community methodology. We obtained quantitative data, which included demographic information and posttraumatic stress disorder (PTSD) symptom assessments at pre- and post-treatment. We also obtained continuous qualitative feedback about these applications from youth and caregivers who were receiving TF-CBT, and from the clinicians who were providing TF-CBT during the learning community. Successful strategies were retained while unsuccessful ones were discarded during the learning community. Thus, the TF-CBT applications described in this manual are based on both evidence-based practice and practice-based evidence.

Prior to implementing the applications described in this manual, TF-CBT clinicians should receive basic TF-CBT training. This includes completion of the following (described in greater detail at https://tfcbt.org/certification): 1) TF-CBT*Web*2.0 (available at https://tfcbt2.musc.edu); 2) 2-day live or 3-day virtual TF-CBT introductory training by an approved TF-CBT national trainer (public TF-CBT trainings are available at https://tfcbt.org/training); and 3) at least 12 consultation calls by an approved TF-CBT national trainer while implementing TF-CBT in the clinician's specific setting, using a standardized assessment instrument (TF-CBT consultation calls are available to therapists across the country at https://tfcbt.org/training.) Additional advanced training in topics of special interest (e.g., for children with parental substance use; for traumatic grief; for traumatic separation; for complex PTSD, etc.) may also be useful before starting to implement TF-CBT for this population.

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INTRODUCTION

Parental Substance Use and Trauma

Rates of parental substance use have substantially increased in the United States during recent years, with most American adults endorsing being personally impacted or having a family member impacted by substance use (The Hill, 2023). Moreover, rates of fatal overdoses have significantly increased, with an annual rate of about 70,000 in 2018 to more than 100,000 in 2022, and with more than a million Americans dying from drug overdoses since 2000 (Center for Disease Control, 2023). Recent provisional data has shown the first decrease in fatal overdoses since 2018 occurring in 2023, perhaps due to the increased public availability of Narcan (CDC, 2024). Moreover, only a quarter of individuals with opioid use disorder receive the most effective evidence-based medication treatments (Dowell et al, 2024).

Substance abstinence, use, misuse and abuse occur along a spectrum, and individuals often move repeatedly along this spectrum before (if ever) achieving lasting abstinence. Throughout this manual we will use the term "parental substance use" to refer to parents whose substance use has been associated with negative outcomes for themselves and their children. These parents may or may not have been formally diagnosed with a substance use disorder. However, regarding treatment for their child, it has been determined that parental substance use has contributed to their child's traumatic experiences. It is important for clinicians who treat children with parental substance use to be aware of the wide variety of potential substances of use, and to have at least some working knowledge about current treatments for adult substance use, including medication assisted treatment (MAT) and local community referral resources for these treatments. Some helpful information about these topics is available here:

1) Top Ten Facts Everyone Should Know About Addiction (from American Psychiatric Association): https://www.psychiatry.org/getmedia/e25c07ae-7333-4466-9add-5fe75ffce45e/Addiction-Top-10-Public-FINAL.pdf
2) Medication Assisted Therapy for Substance Abuse: https://www.samhsa.gov/medications-substance-use-disorders
3) Buprenorphine Quick Start Guide: https://www.samhsa.gov/sites/default/files/quick-start-guide.pdf
4) Medication for the Treatment of Alcohol Use Disorder: A Brief Guide: https://store.samhsa.gov/sites/default/files/d7/priv/sma15-4907.pdf
5) Referring to substance abuse treatment: SAMHSA National Helpline: https://www.samhsa.gov/find-help/national-helpline

Although parental substance use itself may not be considered a childhood trauma, it is an adverse childhood experience that places children at increased risk for experiencing a wide range of traumas. In this regard parental substance abuse is one of the ten adverse childhood experiences (ACEs) that predict negative health and mental health outcomes in adulthood (Felitti et al, 1998). These traumas may include **child maltreatment** (e.g., neglect, sexual, physical and or emotional

abuse,) and/or exposure to domestic violence (e.g., Jernbro, Tindberg & Janson, 2022). These interpersonal traumas often cause children to develop trauma-related maladaptive beliefs (e.g., related to themselves, others, the world, etc.), which can lead to additional problematic symptoms. Child abuse and/or neglect related to parental substance abuse also commonly results in Child Protective Services (CPS) removing children from substance abusing parents' care (or in some instances, to family members informally taking over the care of children from the parent with substance use, i.e., kinship care). Such situations can also lead to **Childhood Traumatic Separation,** a term used when children develop trauma symptoms in response to experiencing sudden, unpredictable, frightening and/or chaotic separations from a parent or other loved one (Cohen & Mannarino, 2019; National Child Traumatic Stress Network, 2016). If a parent dies of an overdose or another substance-related cause, the youth may develop **Childhood Traumatic Grief**: a situation in which a child develops trauma symptoms in response to a death that is experienced as sudden, frightening or otherwise traumatic (Mannarino & Cohen, 2011). Parental substance use may also increase children's risk for experiencing **motor vehicle and other accidents, medical injuries, and multiple, complex or other traumas**. Therefore, clinicians need to assess children with parental substance use for the full range of potential trauma exposures and trauma symptoms. When these are present, the youth should receive evidence-based trauma-focused treatment that is tailored for the youth's circumstances and needs. This manual provides descriptions for implementing one such treatment, TF-CBT, for this population.

Trauma-Focused Cognitive Behavioral Therapy

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT, Cohen, Mannarino & Deblinger, 2017, https://tfcbt2.musc.edu) is an evidence-based trauma-focused treatment for children and adolescents (ages 3-18 years, hereafter "youth") and non-offending (non-perpetrator) parents or primary caregivers (hereafter "caregivers"). Currently, it has the strongest evidence of efficacy among child trauma treatments, having been documented to significantly improve youths' posttraumatic stress disorder (PTSD) and other trauma-related (e.g., depressive, anxiety, behavioral) symptoms in 26 randomized controlled trials (reviewed in Cohen et al, 2017). Importantly, TF-CBT has been tested and found to be effective for diverse types of traumas, including child maltreatment (e.g., sexual abuse and multiple maltreatment types, Cohen, Deblinger, Mannarino & Steer, 2004), domestic violence (Cohen, Mannarino & Iyengar, 2011), traumatic grief (Dorsey et al, 2020), and multiple traumas including parental separation (Cohen et al, 2004; Weiner, Schneider, & Lyons, 2009). Studies have also documented TF-CBT's effectiveness for children across a wide age range and from many countries around the world (reviewed in Cohen et al, 2017). Moreover, the impact of TF-CBT on a wide range of negative and positive outcomes, its mechanisms of action and effective TF-CBT training methods also have been studied in numerous scientific investigations as well.

The TF-CBT model includes nine components, summarized by the acronym PRACTICE (Psychoeducation; Parenting Skills; Relaxation Skills; Affect Modulation Skills; Cognitive

Processing Skills; Trauma Narration and Processing; In vivo Mastery; Conjoint Child-Parent Sessions; and Enhancing Safety). These components fit into three treatment phases: Stabilization or Skills Phase (PRAC); Trauma Narration and Processing Phase; and a final Integration Phase (ICE), and are described in detail throughout the manual below, both for typical implementation and their modifications for youth with parental substance abuse. The TF-CBT model is typically provided in 12-16 sessions, with the PRACTICE components provided in sequential order and proportionally such that each phase receives about the same number of sessions (i.e., 4-6 sessions/phase) in typical implementation.

Core TF-CBT concepts and strategies include the following: a) caregivers are integrally included in TF-CBT throughout treatment: caregivers receive each of the PRACTICE components during individual sessions with the therapist (with about half of most sessions spent individually with the youth and half with the caregiver, except for 3-6 conjoint sessions during which some session time is spent jointly with youth and caregiver together); 2) gradual exposure is included throughout TF-CBT such that the therapist models non-avoidance through trauma education and discussion and encourages the youth's and caregiver's gradually increasing mastery over trauma reminders and memories during each sequential PRACTICE component; 3) trauma- behavioral problems are addressed through the use of skills and effective parenting strategies; the therapy is thus not derailed by "crises of the week"; and (4) fidelity as well as flexibility to the TF-CBT model is encouraged such that the structure is followed while adjustments are made to tailor the treatment to the child's and caregivers' therapeutic needs. Details about the TF-CBT model and its typical implementation are described elsewhere (Cohen et al, 2017; https://tfcbt2.musc.edu).

Why TF-CBT for Youth who Experience Parental Substance Use?

As described above, there are many reasons to consider TF-CBT for youth who have experienced trauma related to parental substance use. First, TF-CBT is a widely used and well-established evidence-based trauma-focused treatment for youth who have experienced a wide variety of traumas, including those common among youth with parental substance use (e.g., child maltreatment; domestic violence; traumatic grief or separation) as well as multiple or chronic traumas (e.g., Cohen et al, 2004; Cohen et al, 2011). Second, TF-CBT has been proven to be effective at improving PTSD symptoms as well as other trauma-related difficulties that youth with parental substance use often develop, such as depression, anxiety, and/or trauma-related behavioral problems including substance use (e.g., Paniagua-Avia et al, 2024). It is also effective for the new diagnosis in the 11th version of the International Classification of Diseases (ICD-11) of Complex PTSD, described below; many youth with parental substance use would likely meet criteria for this diagnosis (Sascher, Keller, & Goldbeck, 2016). Third, TF-CBT prioritizes enhancing the youth's safety and building the youth-caregiver relationship, which are often particular concerns with youth who have experienced parental substance use, through including both youth and caregiver throughout treatment, and focusing on building self-regulation, safety, and relationship skills and the caregiver's understanding of and compassion for the impact of the parental substance use on the youth's behavior or other symptoms. Research suggests that

following participation in TF-CBT, youth report increases in overall feelings of resilience including feelings of mastery, enhanced stress responses and greater feelings of relatedness (Deblinger, Pollio, Runyon & Steer, 2017). Finally, although no randomized controlled trials have been conducted to evaluate TF-CBT for youth who experienced parental substance use, data from a pilot quality improvement study were collected from 69 consecutive youth who received TF-CBT at the AGH CTSCA who described trauma related to parental substance use as their primary trauma. These youth received many of the TF-CBT applications described in this manual (which were discussed during the initial learning session of the learning community by Drs. Cohen and Mannarino). These youth experienced highly significant improvement in PTSD symptoms, from a pre-treatment mean score on the Child PTSD Symptom Scale 5 (CPSS-5) of 40.57 (SD=15.1) to post-treatment mean score of 23.69 (SD=15.9), $t=8.672$, $p<0.001$. These scores and improvements did not differ significantly from youth receiving TF-CBT at the CTSCA during that time who did not report parental substance use (Cohen, 2021). Thus, prior to the learning community, there were promising data suggesting that this model would be effective for this population. During the learning community, additional data were collected that confirmed the effectiveness of the applications that were made to the model (described below).

TF-CBT for Complex PTSD

Although the 5th version of the Diagnostic and Statistical Manual, Text Revision (DSM-5-TR) does not include a diagnosis of Complex PTSD (APA, 2022), the ICD-11 includes both PTSD and Complex PTSD diagnoses. In the ICD-11, the PTSD diagnosis requires that individuals develop symptoms in three symptom clusters (intrusion, avoidance, and hyperarousal) in response to either single or chronic traumas. In contrast, the ICD-11 Complex PTSD diagnosis requires that in response to chronic traumas, the individual develop symptoms in the three PTSD symptom clusters, as well as exhibiting significant affective dysregulation; negative self-concept; and disturbed relationships (ICD-11, 2023).

Due to the chronic nature of parental substance use, and the multiple domains of functioning that parental substance use often impacts, it should not be surprising that many youth with exposure to parental substance use meet the above ICD-11 diagnostic criteria for Complex PTSD. Standardized self- and parent-instruments have been developed to evaluate the presence of these symptoms, such as the Child and Adolescent Trauma Screen, 2nd Version (CATS-2, Sachser et al., 2022).

For several years, it was believed that TF-CBT needed to be substantially modified for youth with Complex PTSD (sometimes referred to as “complex trauma”). Proposed modifications included:

1) Moving the Enhancing Safety component from the end to the beginning of treatment (due to these youth’s lack of safety and/or engaging in unsafe coping strategies such as self-injury, substance use, unsafe sexual practices, and/or running away) in some cases, and the need to begin with and continue implementing this component with youth and caretaker throughout TF-CBT;

2) Increasing the length of the initial Stabilization phase of treatment from 4-6 sessions to up to 12 total sessions (due to these youth's greater affective and interpersonal dysregulation, lack of safety and/or poor interpersonal trust of the therapist, and thus need for more sessions to successfully implement the initial PRAC skills);
3) Adjusting the relative overall length of the treatment (from 12-16 sessions to 16-24 sessions) and a corresponding adjustment in the proportionality of the three phases of treatment, with the Stabilization Phase taking up to ½ of the total treatment (up to 12 of the 24 sessions), and the Trauma Narration and Processing Phase and Integration Phase thus each taking ¼ of the total treatment (up to 6 of the 24 sessions); and
4) Identifying and incorporating overarching complex trauma themes throughout TF-CBT (e.g., "the person who should have kept me safe was the one who abandoned or hurt me") and using these to weave together multiple and/or complicated trauma reminders and experiences throughout treatment.

These modifications are illustrated in Figures 1 (for typical PTSD) and 2 (for Complex PTSD) below.

Figure 1: TF-CBT for Typical PTSD

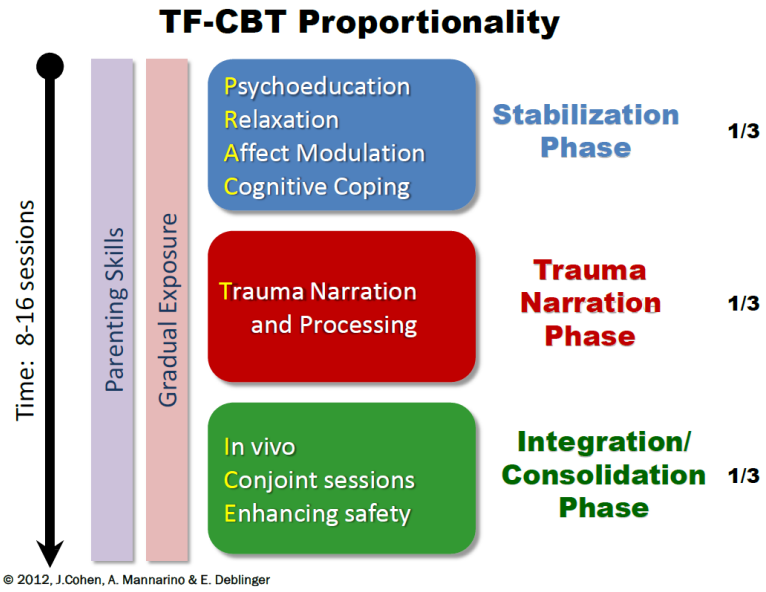
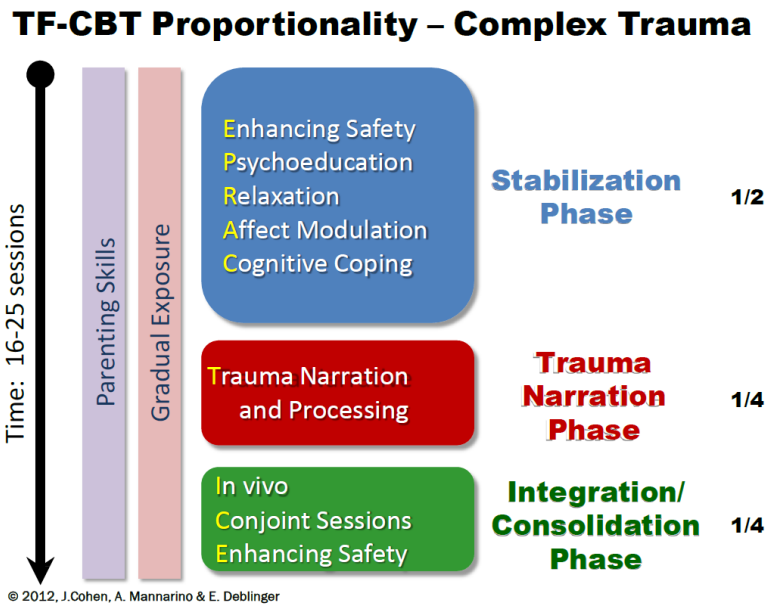


Figure 2: TF-CBT for Complex PTSD



Recent research has clarified that these modifications may not be necessary for youth with IDC-11 Complex PTSD to effectively respond to TF-CBT. Two studies provide empirical support for providing standard TF-CBT without these modifications for youth with Complex PTSD.

The first study was a randomized controlled trial that provided standard TF-CBT in 12 sessions to youth randomized to the TF-CBT condition, regardless of whether youth had PTSD or Complex PTSD, and which documented TF-CBT superiority to wait list for youth across German community clinics (Goldbeck, Muche, Sachser, Titus & Rosner, 2016). The study also compared youth with typical vs. Complex PTSD within the TF-CBT treatment group and found that youth with PTSD or C-PTSD experienced comparable rates of improvement during the 12 treatment sessions. Additionally, although the youth with C-PTSD had initially started with significantly greater levels of PTSD and C-PTSD, by the end of a one-year follow-up, youth in each group had similar levels of PTSD and C-PTSD (Sachser et al, 2016).

The second study was a naturalistic study that assessed youth TF-CBT treatment in 23 Norwegian outpatient clinics at pre-treatment and every 5th treatment session using the Child and Adolescent Trauma Screen (CATS-2) to evaluate the presence of PTSD vs. Complex PTSD, as well as improvement in these respective symptoms. Among the 73 youth, most youth (61.6%), had Complex PTSD, with no group differences based on age, gender, birth country, trauma types, or number of traumas. Results documented that both groups received the same mean number of treatment sessions (17), that youth with C-PTSD experienced a steeper decline in PTSD and Complex PTSD symptoms, that the two groups reported similar rates of PTSD and Complex PTSD symptoms at post-treatment, and that there were no differences in the rates of dropouts between the two groups (Jensen, Braathu, Birkeland, Ormhaug, & Skar, in press). The findings from these studies suggest that TF-CBT as typically provided can result in positive outcomes for

youth with either PTSD or Complex PTSD, without the need for substantial modifications of the original TF-CBT model.

Common Clinical Issues for Youth with Parental Substance Use

As noted above, youth with parental substance use may experience multiple and diverse trauma types. However, certain traumas are particularly associated with parental substance use, such as child maltreatment (often including domestic violence), traumatic grief, and/or traumatic separation. This section describes clinical considerations of each of these traumatic experiences specific to parental substance use.

Parental Substance Use and Child Maltreatment

Youth commonly experience child maltreatment in the context of parental substance use. The parent who is using substances may actively perpetrate child maltreatment (e.g., neglect, physically and/or sexually abuse the youth); and/or may fail to protect the youth from other perpetrators (e.g., when actively using drugs with friends in the home, not protect the youth from others who abuse the youth). When the youth discloses child maltreatment to a peer or adult, or child maltreatment is otherwise suspected or discovered (e.g., by a teacher who observes a youth with multiple bruises; notices a youth coming to school appearing poorly nourished and/or missing many days of school), it is typically reported to and investigated by Child Protective Services (CPS). Depending on jurisdiction, adults may be mandated to report suspected child maltreatment; professionals in child caring roles are almost always mandated reporters. If substantiated, youth may be removed from parental care and placed in foster or kinship care until the substance using parent receives mandated services and is able to appropriately care for the youth. From 2000 to 2017, the rates of children entering foster care due to parental substance use increased from 14.5% to 36.26%, representing 96,672 children (Meinhofer & Angleró-Díaz, 2019). Data from 2020 indicate that 39% of removals of youth by CPS were related to parental substance use (https://ncsacw.acf.hhs.gov/files/statistics-2020.pdf). Many if not most youth with parental substance use are likely to encounter CPS at some point (if not repeatedly). CPS typically turns the care of the youth over to another social services agency within the umbrella of child welfare (CW), and/or to the juvenile justice system. For this reason, we use the term “child welfare” (CW) hereafter to refer to CPS and related social service agencies. It is critical for TF-CBT therapists to understand the CW system, its primary mandate to protect youth from maltreatment, how this interacts with its additional high priority of family reunification, and how this is likely to impact the traumatized youth with exposure to parental substance use to whom therapists are providing TF-CBT.

In these situations, one or more of the following scenarios may commonly occur:

- The youth views parental substance use and maltreatment as normal. When youth grow up in an environment where parents (and perhaps other adults in the home) use substances and child maltreatment occurs routinely, youth may come to accept that this

is “the way things are”. These youth typically have few social interactions outside of school with youth without parental substance use, and thus, they do not have opportunities to see families in which parental substance use and/or child maltreatment are not normative.

- The youth believes or is afraid that they will grow up to be just like the parent with substance use problems. This may result from relatives or others repeatedly telling the youth that they are “just like” that parent, or from the youth’s own internal beliefs. This belief may cause the youth to feel helpless to change the course of their life, to be passive when offered drugs, and to otherwise not take active measures to make healthy choices.
- The youth is highly protective of the parent, despite the parent having failed to protect the youth from neglect and/or abuse (or even having perpetrated these against the youth). This may stem from the youth’s belief that the parent “did the best they could” and that “children and parents should be close to each other” regardless of anything that happens in their lives. The latter belief may be challenged by the youth’s related beliefs that parents should know important things about their children’s lives, and that the parent with substance use problems does not know these things (e.g., the names of the child’s teachers, when important events at school occur, etc.).
- The youth does not care about obeying rules, saying things such as, “no one in my family follows the rules”; “nothing happens if I break the rules”; “adults don’t do what they say they will do”; and/or “no one protects me, so I have to protect myself.” Such youth typically present with significant behavioral problems and benefit from consistent rules and receiving consistent consequences when breaking these as well as rewards for following them.
- One youth is singled out for particularly harsh maltreatment (sometimes based on not being one of the parent’s biological children, not looking like the other children, being older, etc.). This youth is at high risk for developing maladaptive cognitions (described in detail below); while the other youth in the home may align themselves with the parents and scapegoat this youth (perhaps in part to not be singled out for abuse themselves, in part because they come to believe the parental justifications for singling out the scapegoated youth).
- One youth takes on (or is expected to take on) a parenting role for younger siblings when the parents are impaired due to substance use (“parentification”), e.g., being responsible for feeding, toileting, entertaining, getting younger siblings to school. If parents go missing for several days (e.g., during a drug or alcohol binge), this youth may go without food, miss school, etc., to feed and care for younger siblings. This youth may also worry about and take inappropriate responsibility for the parent’s substance use (e.g., check that the parent is safely in bed, breathing, has returned home for the night, etc. after substance use episodes, etc.). If parental substance use is discovered, or anything goes wrong during parental absence, this sibling is often the one who is blamed by the parents (and sometimes the younger siblings will go along with this maladaptive attribution). The

youth may lose their role as the caregiver for younger siblings if the youth is removed from the home and separated from younger siblings after disclosure of child maltreatment, and the youth may experience this as a significant loss.

- The youth blames themselves for the parental substance use and/or the maltreatment (e.g., “If I had been a better child, my parent(s) wouldn’t have chosen drugs over me”; “If I had done something different/better/less/more, my parent would not have used drugs or overdosed, etc.”; “I am unlovable because my parent chose drugs over me”, “ I deserve to be beaten for not doing the housework, taking better care of my siblings, stopping my parents from using drugs”, etc.)
- When/if parental substance use and child maltreatment are discovered/disclosed, the youth who disclosed it (even if unintentionally) is blamed and shamed by the parents (and often by the other siblings) for “breaking up the family”, for not “keeping our family business in the family”, etc. The blame for the out-of-home placement is thus blamed on the youth who experienced the maltreatment, rather than the perpetrating and substance using parent(s).
- When in out-of-home placement, the youth may be ambivalent about, or may not want to visit with, the substance using parent(s). This may be in part due to some of the above issues (e.g., having been singled out for particularly harsh maltreatment while in the parental home, being scapegoated by the other children in the home, being blamed and shamed for disclosing parental substance use and/or maltreatment, and/or for “breaking up the family”, etc.). The youth’s desire not to participate in visits may be exacerbated if visits are not sufficiently supervised to ensure that parents and/or siblings are not blaming or shaming the youth during these visits.
- The youth blames “the system”, including CW, the judge(s), CW attorneys, their own advocate (guardian ad litem), etc. for removing them from their parent’s care and keeping them in foster or kinship care when they want to return home. This often occurs even when the parent continues to use substances and cannot safely care for their children.
- The youth may have lived with one birth parent (e.g., father) throughout most of their lives, with little or no contact with the other birth parent (e.g., mother). This circumstance may have developed for a variety of reasons (e.g., the mother had experienced domestic violence or other abuse from the father; mother was incarcerated; had personal mental health or substance abuse issues; was financially or otherwise unable to care for the child; the father intimidated the mother into giving the child into the father’s care, and/or other reasons). The youth is often unaware of these circumstances or has received a one-sided description of them from the father. After having experienced parental substance use and maltreatment from the father, if the youth is then removed and placed in the care of the mother, the youth may be very angry and resentful towards her for being absent during most of the youth’s life and, in the youth’s perspective, for failing to protect the youth from the father’s substance use and maltreatment (despite the mother typically not being

aware of these circumstances when they were occurring). This can lead to the youth mistrusting the mother and her ability or commitment to keep the youth safe.

Therapists are cautioned against prematurely challenging the common cognitive distortions youth exposed to parental substance use express as this may signal to the youth that rather than being aligned with the youth, the therapist is aligned with the system that has mistreated the caregiver or removed the child from their home. Despite the traumas the caregiver may have exposed the youth to, it is common for youth to still feel attached and loyal to their caregiver(s). Cognitive distortions may be addressed through general psychoeducation, but specific trauma-related distortions should not be challenged until after trauma narration.

Parental Substance Use and Childhood Traumatic Separation

As noted in the above discussion, youth with exposure to parental substance use often experience separation from their parents and/or siblings. Moreover, these separations are often sudden, unpredictable, and occur under chaotic or frightening circumstances (e.g., CW come to the home or school and removes the youth and siblings without explanation; police arrest or remove one or both parents, sometimes under violent circumstances, etc.). When children develop trauma reactions (i.e., PTSD and related symptoms) to a separation from parents or siblings that they perceive as traumatic, this is referred to as Childhood Traumatic Separation (Cohen & Mannarino, 2019; National Child Traumatic Stress Network, 2016).

Even children who have experienced multiple other traumas, including ongoing chronic traumas such as child maltreatment or domestic violence, often identify the traumatic separation from their parent(s) as their worst or most traumatic experience. For example, in a study of children in foster care in the State of Illinois, children identified parental separation as their most common "worst" trauma (Weiner, Schneider & Lyons, 2009). Despite this, Wiener et al (2009) found that children who received TF-CBT as compared to community counseling through the system of care not only demonstrated greater symptom reductions but also were less likely to run away from the foster home or have a disrupted placement. Similarly, in a TF-CBT study in which foster caregivers received enhanced engagement vs. standard engagement, all youth completing TF-CBT exhibited the anticipated symptom reductions with enhanced TF-CBT engagement being associated with an increased likelihood to complete TF-CBT (Dorsey, et al., 2014).

It is important to recognize that youth can also develop traumatic separation while they still live with the parent with substance use, for example, when that parent disappears for several days or longer without explanation (typically during extended substance use), leaving the youth to fear for the parent's safety or survival, while also having to fend for themselves and often to care for younger siblings. In these circumstances there may be insufficient food in the home, utilities may be cut off, the youth may need to miss school to care for younger siblings, or even more dire situations may arise in the parent's absence.

Due to the recurrent and unpredictable nature of parental addiction, (as parental use, abuse, recovery and coinciding ability to care for children wax and wane over time), children often

experience repeated traumatic separations from parents, siblings, and/or other caregivers, interspersed with periods of living back with the parent(s) and/or siblings. Thus, when a new separation occurs, even if it is predicted, well-planned and non-chaotic (i.e., not objectively "traumatic"), it can serve as a reminder of past traumatic separations and thereby contribute to the development or return of trauma symptoms. Unfortunately, youth in foster care frequently experience additional placement disruptions after being placed in state custody, with indications that 25-50% experience at least one caregiver disruption during their time in state custody (Helton, 2011). For children who remain in state custody for more than 12 months, 48% are likely to experience three or more placement changes (U.S. Department of Health & Human Services [DHHS], Administration for Children & Families, 2016). Some specific issues that may arise related to traumatic separation in the context of parental substance use include the following (more details are available at Cohen & Mannarino, 2019):

- Concerns about safety for the parent(s) from whom the youth is separated ("separated parent") are often reality-based since removal often only occurs in the face of severe parental substance use. Additionally, in these circumstances the separated parent is often not in ongoing contact with the youth or current caregiver due to ongoing substance use, which contributes to the youth's fears for the parent's safety. Youth may also be concerned about the safety of separated siblings. Helping the youth to receive accurate information may mitigate these safety concerns.
- Many if not most children experience pain related to prolonged parental separation, regardless of the nature of the child-parent relationship (i.e., whether there was parental substance use and/or maltreatment). The traumatic nature of the separation, as well as having potentially experienced repeated separations from parent(s), siblings, and/or other caregivers, can lead to the development of trauma (PTSD) and related mental health symptoms including sleep problems, depression, anxiety, learning problems, anger and other externalizing behavior problems.
- Youth often have limited or inaccurate information about the parent's substance use and/or the reason for the separation. This can contribute to trauma symptoms and other difficulties adjusting to the separation and current living circumstances. Psychoeducation about parental substance use, its impact on child trauma and CW involvement, and connecting these to TF-CBT components can mitigate trauma symptoms.
- The ongoing uncertainty and lack of information about when and if reunification with the parent(s) and siblings will occur is a source of emotional distress for most youth and is very difficult to cope with on an ongoing basis. The uncertainty of how long the youth will need to remain in the current setting often interferes with the youth's ability to form positive relationships with new peers, teachers and the current caregivers or other children in the current home. Acknowledging uncertainty is important in validating the youth's challenges in this regard. Tailoring coping strategies can provide stress relief.
- Youth may experience conflicting loyalties, for example, enjoying the stability, safety and predictability of the current home and family, while simultaneously feeling guilty and

disloyal to the birth parents for having these feelings. The degree to which one or the other feeling predominates may depend on 1) the extent to which the youth has ongoing contact with the birth parent(s) and siblings; 2) the degree to which the current caregivers support versus undermine the youth's positive connection with the birth parents, family and culture; and 3) the degree to which the birth parent(s) collaborate with versus undermine the current caregivers in caring for the youth in the current circumstances.

- The youth may experience a change or loss of roles, e.g., from being in a caretaking role in the birth parents' home (where they needed to take care of younger siblings and/or the substance using parent), to being able to "just be a kid" in the current home (with both the loss of responsibilities but also with the loss of ability to "be the boss" and make independent decisions impacting others in the home). As in the preceding bullet, the youth may experience conflicting emotions about this role change, alternating between relief and resentment.
- Specific issues may apply to youth whose parent is incarcerated due to substance use issues. These may include the additional stigma of incarceration itself; concerns about the parent's safety, limited or no direct communication with the parent and/or lack of information about the parent while in prison; the uncertainty of when or if the parent will be released from prison; the youth's perceived need to hide the fact that the parent is incarcerated for substance-related (and potentially other) reasons; the potential stress of visiting the parent in prison; perceived or real injustices of the criminal justice system; and concerns about the parent's well-being after release from prison, among others. In some instances, younger children may not know that their parent is incarcerated and may learn about this inadvertently by overhearing family members or others talk about it.
- Because traumatic separation is potentially so difficult, it is important for therapists, CW and other professionals involved in caring for youth who experience parental substance use, to do all they can to assure the stability of out-of-home placements for these youth. This includes providing education about the foster care system for potential foster parents, providing comprehensive and trauma-informed psychoeducation to foster parents about the youth's trauma history and about parental substance use, and if relevant, assisting the foster parents in monitoring the youth's ongoing compliance with taking prescribed psychopharmacologic medications.

Parental Substance Use and Childhood Traumatic Grief

As noted above, fatal overdoses have increased from an annual rate of about 70,000 (2019) to more than 100,000 (2022) (with a recent drop since 2023). These are primarily due to opioid-related overdoses, although other drug classes are also implicated. More than 1 million people have died of drug overdoses since 1999, with a 14% increase between 2020 and 2021 (CDC, 2023). Since most of these deaths are among young adults, the impact on children and teenagers is particularly severe.

When a parent or other important attachment figure dies in a sudden, frightening or unexpected (traumatic) manner, children can develop trauma (PTSD) symptoms including intrusive images or memories of the traumatic death (some youth may have found the parent dead of an overdose and tried to resuscitate them, called 911, etc.); avoidance of reminders or memories of the death and parent; negative cognitions and emotions, and hyperarousal symptoms. These may interfere with the child's ability to negotiate typical bereavement tasks, such as remembering the deceased parent positively and resolving ambivalent feelings about them, incorporating positive memories and committing to positive relationships with living people. This has been called Childhood Traumatic Grief (Mannarino & Cohen, 2011; National Child Traumatic Stress Network, 2019).

A new condition, Prolonged Grief Disorder has been introduced into the most recent version of the Diagnostic and Statistical Manual (DSM-5-TR, American Psychiatric Association, 2022) which in children overlaps considerably with Childhood Traumatic Grief. Some specific issues that can occur for youth who experience Childhood Traumatic Grief in the context of parental substance use include the following:

- Youth may not know that the parent's death was due to substance use. In some cases, the family may be trying to protect a younger child from this information; in other cases, the medical examiner provided a somewhat specific cause of death (e.g. "heart failure related to drug overdose") and the family provided an edited version ("heart failure") to minimize stigma or shame. However, the youth is likely to learn the full information eventually (e.g., from other relatives, the media, peers, etc.) and may feel betrayed that the family lied about this. Generally, it is advisable to provide age-appropriate accurate information about the cause of a death soon after the death, and to answer the youth's questions about this in a supportive and compassionate manner.
- Similarly, there may be ambiguity in cases of death related to substance use overdose, whether the deceased person meant to die by suicide or whether this was an accidental death. In these uncertain situations, some family members may deny any possibility of suicide, but the youth may wonder about it and need the opportunity to explore this further.
- The youth and family may feel stigma, shame or other negative emotions about substance use having caused the death. Substance use is generally poorly understood as a disease and is associated with a high degree of stigma. It can be helpful to provide psychoeducation related to substance use as a disease, as described below in Psychoeducation.
- The youth may fear that they are "doomed" to develop and die of substance use (e.g., they may have been told that they are "just like" the parent who died of an overdose). Providing psychoeducation about the hereditary versus behavioral components of substance use can be helpful to address this type of maladaptive belief.

- The youth (and siblings) may be living with a new caregiver, or with a parent who was not in a primary caregiving role. This parent or new caregiver may be confused about the youth's traumatic reaction, i.e., "why is he angry instead of sad when I talk about the deceased parent?"; "Why doesn't she want to go to the cemetery?"; "Why doesn't he act like his younger sibling who is adjusting well?", etc. It is critical to help the parent or new caregiver understand the differences between typical and traumatic grief and how to support the youth with traumatic grief especially when only one sibling is having traumatic grief responses.
- Given the intergenerational nature of both trauma and substance use, it is not uncommon to work with children who may have lost additional extended family members to substance use. To illustrate, one 15-year-old female with a history of parental substance use disclosed traumatic grief related to the overdose deaths of her father, her aunt (who was at one time a primary caregiver), and her maternal grandmother. The impact of the multiple loses due to substance use highlights both the pervasiveness of substance use throughout her childhood development and the importance of directly addressing substance use in the context of her trauma.

ASSESSMENT AND CASE CONCEPTUALIZATION

Before TF-CBT treatment begins, the clinician needs to complete a comprehensive mental health assessment, case conceptualization and treatment plan in collaboration with the youth and caregiver. This is important to obtain a full understanding of the youth's presenting problems, history, factors that may impact on treatment, and to develop the most effective plan for addressing the youth's identified treatment needs.

For the purposes of this implementation manual, the clinician should gather information about the youth's presenting problems, mental health, physical, educational, developmental and family history with a focus on current and past psychiatric symptoms, trauma exposure and impacts, and parental substance use. The assessment should ideally include individual clinical interviews of the youth and caregiver, as well as behavioral observations and use of standardized instruments such as those described below. Information should be obtained from multiple sources whenever possible (at least from the youth and caregiver in most cases).

Children who are in state custody may arrive to appointments accompanied by foster parents who have known a child for less than one month and have been given little information on the child's history or with agency case managers, assisting with transportation, who have little to no familiarity with the child. For children in state custody, it is important to remember that their child welfare caseworker is likely one of the best sources of historical information on a child, outside of the child themselves (for older children) or biological parents (when they are actively and appropriately involved). Making efforts to connect with a child's welfare worker is an opportunity for improving the quality of clinical care by learning more about a child's history and establishing a connection with a person that is likely to remain more stable with the child than their foster placements. Child welfare workers can also help to build relationships with foster parents and encourage their involvement in therapy. While it is increasingly challenging to connect with child welfare workers directly given the increasing demands on their time in many states, many state child welfare agencies have formal processes for collecting and sharing medical and trauma history information with health care providers. This information may not be consistently shared with providers but may be available when directly requested by the therapist or foster parent. For example, in Tennessee, child welfare completes a health and history form for each child who enters state custody which includes historical information collected from their family of origin (when possible) and additional information regarding the circumstances leading to them entering custody.

Parental substance use is a common adversity experienced by youth who are referred for mental health services. However, many of these youth do not initially volunteer this information at the initial assessment. This may be due to a variety of reasons including stigma, shame, lack of information or awareness of the parent's substance use, and/or protectiveness of the substance using parent. For similar reasons, their caregivers also may not provide this information spontaneously. Thus, it is important for clinicians to specifically seek information from the youth and the caregiver about parental substance use during the initial assessment. When the clinician

has information that the parent has used substances, it may be useful to search Google for drug paraphernalia images as this may help youth to identify these as things that the parents had and/or used in the home (e.g., even younger children have been able to identify syringe, spoon, lighter combo, etc. in this way).

As noted above, parental substance use per se is not a trauma, and the clinician must assess for history of potentially traumatic experiences and trauma symptoms in relation to these traumas. Specific to parental substance use, the clinician should specifically inquire about potentially traumatic events such as child maltreatment, traumatic separation(s), and traumatic death of parent(s) or other important attachment figures, and trauma symptoms related to these. In many cases, youth may minimize or avoid reporting maltreatment unless asked about this in a context that they understand. For example, many youth do not report traditional "physical" neglect (e.g., lack of food, shelter, etc.) until they are asked about "emotional" neglect or simple lack of supervision. That is when the youth may mention parental neglectful behaviors, for example, that "mom was always asleep on the couch"; "dad was always in his bedroom with the door locked"; that they were left alone for hours at a young age; there were nights at a time when parents did not come home at all, or times when they were left with strangers with whom they felt uncomfortable, who "acted weird", etc. It may also be helpful to ask the youth, "How did you know when your parent was drunk or high? How did they act differently?" Some youth will readily provide descriptions such as the above in response to this type of question. Also, it is important to seek this information not only from the youth but also from the caregiver, as many youth may be unwilling to disclose information about traumas, particularly those perpetrated by a substance using parent, during an initial assessment by a clinician they have just met. It is not unusual for such disclosures to occur during TF-CBT, as youth receive more psychoeducation about different types of traumas and their connection to parental substance use and trauma reminders; and as they gain increasing trust in the therapist.

It is also important to understand the cultural context in which the youth and family live as this may explain the youth's reluctance to recognize, acknowledge the significance of, or disclose parental substance use, trauma experiences or mental health symptoms. For example, in some cultural contexts, substance use is common and normative (e.g., alcohol is used at many celebrations and family events and not including it would seem odd.) Similarly, in some cultural contexts, mental health symptoms are viewed as "crazy", so they are either minimized/denied or transformed into a more acceptable form (e.g., somatic symptoms that can be treated by a healer). Also, a parent without legal documentation to be in the U.S. may also be threatened (implicitly or directly) by their partner with disclosure of this if they provide information about the partner's substance use or perpetration of abuse towards the parent or children. The parent without documentation may fear deportation or loss of custody of their children if they disclose this information, attempt to leave the partner, or even seek to protect their children from the other parent. Youth living in these contexts pick up on these cultural/familial cues from their parents and understand what they are and are not "supposed to" tell people outside of their family. Thus, for youth living in this type of context, it is not surprising that they may initially

minimize, underreport, or deny parental substance use, family trauma, and/or mental health symptoms.

An integral part of TF-CBT is using validated, standardized instruments to assess the youth's PTSD and (as appropriate) other mental health symptoms throughout treatment. In addition to the clinical interview, the clinician should use a standardized PTSD assessment instrument to evaluate trauma exposure and the presence and severity of trauma symptoms as part of the assessment process. Examples of such standardized instruments include the Child PTSD Symptom Scale for DSM-5 (CPSS-5, Foa et al, 2020); the Child and Adolescent Trauma Screen-2 (CATS-2, Sachser et al, 2022), and the UCLA PTSD Reaction Index for DSM-5 (RI, Steinberg et al, 2013). The first two instruments are freely available, and the CATS-2 allows clinicians to assess the presence of ICD-11 PTSD and Complex PTSD. The clinician should use appropriate validated instruments to assess the youth for other mental health disorders during the initial assessment when this is clinically indicated. These instruments should be used not only at the initial assessment but also repeatedly to assess progress during TF-CBT treatment. For example, it is common practice for therapists to repeat a PTSD self-report instrument at pre-treatment, after completion of PRAC skills/before starting Trauma Narration; and at the end of TF-CBT. Youth who present with high levels of initial trauma avoidance (for example, those who minimize their trauma experiences, or those with complex PTSD) may have low initial scores on standardized PTSD instruments), so it is especially helpful to repeat these instruments after several TF-CBT sessions when the youth has ideally gained additional trust in the therapist and coping skills, at which time their scores may be much higher than at the initial assessment. This does not mean that the youth's PTSD symptoms have worsened, but more likely, that they are more honestly reporting their true level of PTSD symptoms. At the least, the instruments should be administered at the start and end of TF-CBT to ascertain whether the youth has improved in relation to treatment goals.

In addition to assessing the presence of parental substance use, youth substance use should also be evaluated. The clinician should ask the youth and caregiver about the youth's drug and alcohol use as well as cigarettes and vaping. These questions should include substance type and frequency of use. Two standardized, validated instruments are available, the Brief Screening for Tobacco, Alcohol and Drugs (BSTAD) and the Screening to Brief Intervention (S2BI). Both are brief online tools that take less than two minutes for youth to complete, and are available online through the National Institute for Drug Abuse (NIDA) at: https://nida.nih.gov/nidamed-medical-health-professionals/screening-tools-resources/screening-tools-adolescent-substance-use

The clinician should synthesize the information into a coherent case conceptualization and present it to the youth and caregiver to develop a collaborative treatment plan. When the case conceptualization is that trauma is a core underlying cause of the youth's current problems, it is appropriate to present TF-CBT as a treatment for these problems Conversely, if trauma is not believed to be the underlying problem, TF-CBT or another trauma-focused treatment would not be appropriate.

This is especially relevant related to behavioral issues, particularly unsafe behaviors. Youth with parental substance use typically have been exposed to unsafe situations, have often had long exposure to parental modeling of and normalization of maladaptive (i.e., unsafe) coping strategies, and additionally have elevated genetic risks for developing substance use disorder. All these factors may contribute to increased risk for these youth developing comorbid externalizing behavioral disorders in addition to trauma-related disorders. While there is some evidence that TF-CBT that can effectively reduce some youth substance use and co-occurring externalizing behavior symptoms, these are not the primary goals of TF-CBT. A model that is related to TF-CBT, Risk Reduction through Family Therapy (RRFT, Danielson et al., 2020), is designed and has been evaluated specifically for youth ages 13-18 who have co-occurring PTSD and substance use problems, among other risky behaviors, and who have experienced sexual abuse. Treatment components include psychoeducation, coping, family communication, substance abuse early intervention/treatment, PTSD, healthy dating and sexual decision making, and sexual revictimization risk reduction. In such cases, youth with significant substance use and trauma symptoms should be referred to RRFT, if possible. More information about RRFT is available at https://www.nctsn.org/interventions/risk-reduction-through-family-therapy.

Alternative models include Trauma Systems Therapy for Substance Abuse in Adolescents (TST-SA) or Seeking Safety, which was originally developed for adults but has been modified for adolescents. If the youth has significant substance use or another behavioral problem **without** significant trauma symptoms, they should be referred to an evidence-based treatment that focuses on reducing substance use or externalizing behavior problems, respectively, rather than TF-CBT. If this does not occur, the TF-CBT therapist will likely spend most of the treatment time focusing on the youth's severe behavioral problems rather than on trauma, which will become frustrating for the youth, caregiver, and therapist. Potential options include models like Multidimensional Family Therapy (MDFT), Functional Family Therapy (FFT), and other Cognitive Behavioral Therapies (CBT) that are well-established treatments for adolescent substance use (Fadus et al., 2019; Waldron & Turner, 2008).

Within a trauma conceptualization, the clinician understands (and helps the youth and caregiver to understand) the youth's often diverse affective, behavioral, biological, cognitive, social, learning and other symptoms as being related to past or ongoing trauma experiences. As described above, for youth who have experienced parental substance use, traumas may have occurred chronically (e.g., child maltreatment, domestic violence, or traumatic separations) and trauma reminders and trauma responses thus may occur frequently or even be ongoing for the youth. It is important for the clinician to explain this to the youth and the caregiver when presenting the rationale for providing TF-CBT and how this model will address the youth's problems by developing alternative strategies for recognizing and coping with these trauma reminders. Understanding the youth's presenting problems through a trauma framework—that is, as an understandable and expectable response to frightening circumstances that threatened the youth's life or safety rather than as a serious mental health problem—is often destigmatizing and helpful to the youth and the caregiver and may be highly effective at engaging them in TF-

CBT treatment. If the family and therapist agree to TF-CBT treatment, this means that most of every treatment session will be focused on addressing the youth's trauma experiences, responses and treatment, not on other issues. This needs to be explicitly clear to the youth and caregiver, and they should understand and agree to this before treatment begins. If they are looking for treatment for another problem (e.g., externalizing behavior problems), they are unlikely to be satisfied with TF-CBT, regardless of how well the therapist believes this meets their needs. The treatment plan (agreed to by the youth, caregiver and therapist) should therefore explicitly state that treatment will focus on specifically trauma-related goals, rather than other problems or issues. If this is not the case, then TF-CBT should not be provided.

Including non-offending current caregivers in TF-CBT treatment: The therapist should strive to include the non-offending (non-perpetrator) current caregiver throughout TF-CBT treatment, to the extent that the youth agrees and that it is feasible. As noted above, youth with exposure to parental substance use frequently experience moves between different caregivers (e.g., with intermittent returns to and removal from the birth parent dependent on that parent's current abstinence or substance use and corresponding ability to care for and keep children safe), and often these moves occur without advance notice (and thus, do not allow the therapist time to prepare the youth, current caregiver or birth parent for the transition). These moves often may disrupt the therapist's ability to include a consistent caregiver throughout TF-CBT treatment, or even to provide consistent TF-CBT to the youth themselves, as the most common scenario is that the youth discontinues TF-CBT treatment upon return to the birth parent's home. Clinical judgment may indicate that including the birth parent in some components of TF-CBT may be helpful, particularly when the youth is returning to or has returned to live with that parent. However, clinicians should typically not include the perpetrating parent in TF-CBT, and particularly not share specific trauma-related details of the youth's treatment with this parent, as such parents typically struggle to be supportive of the youth or to validate the youth's description or perception of these details.

In some cases, the youth may be living with the parent with substance use. Including this parent in TF-CBT may pose a clinical challenge for several reasons including that this parent 1) may have been a perpetrator of the youth's past trauma experiences; 2) may have only recently achieved abstinence, have other ongoing mental health issues and/or have other issues that make the therapist concerned that hearing details about the youth's past traumas may challenge the parent's ability to remain abstinent; and/or 3) may be ambivalent or unsupportive regarding the youth's perspective of their past trauma experiences. Ultimately, as in all situations, the therapist will make a clinical judgement about whether it is in the youth's best interest to include a specific parent in TF-CBT treatment. Generally, a caretaking parent with substance use who is currently abstinent can participate in TF-CBT. However, it is important for the therapist to carefully consider whether the parent will be able to support the youth in participating in treatment without it being significantly detrimental to the parent's abstinence/recovery, and without it undermining the youth's ability to be honest and open about their own perspective regarding

their past trauma experiences. The following considerations may be helpful to therapists in making these clinical determinations:

1) In most instances, a caregiver who has a history of engaging in substance abuse or child neglect can only be supportive of the youth throughout TF-CBT if they have a) openly acknowledged their personal responsibility for their actions that contributed to the youth experiencing the past traumas and are willing and able to b) listen to the youth describe their perspective about these traumas, and c) apologize to the youth and make amends for the harm that the youth experienced. Although this may be rare among parents who have engaged in child abuse/neglect or substance use generally, it is somewhat more common among parents with substance use who are in recovery and can recognize the destructiveness that their substance use caused.
2) Parents who are newly abstinent may have significant ongoing mental health comorbidities, and/or multiple other challenges (e.g., medical, legal, economic, housing, etc.) and may be too fragile to hear details about the youth's past traumas and associated negative thoughts and feelings directed towards the parent. Although parental participation in TF-CBT is usually desirable, it should not be pursued at the risk of the parent relapsing.
3) In some situations, the parent who is currently abstinent will prefer not to discuss the past when they were using substances and is less than fully supportive of the youth doing so during treatment. In this scenario, parental participation in TF-CBT will not be productive, and it may be challenging for the youth to participate unless the therapist elicits clear agreement from the parent to allow this to occur.

In all the above scenarios, the therapist needs to be straightforward in describing what TF-CBT entails, i.e., if TF-CBT is to proceed, the youth will be processing their perspective about the parent's substance use and associated trauma experiences, which may include difficult memories and associated negative thoughts and feelings. The therapist should encourage the parent to consider carefully whether this will be overly stressful to the parent, emphasizing that the therapist does not judge, blame or shame the parent for their substance use, but it is important for the child's well-being to be able to talk about it in the context of therapy. It may be explained that if the parent is able and willing to participate in TF-CBT treatment with the youth, it will also include the parent learning parenting and coping skills to support the youth through this process, The therapist may assess the caregiver's functioning as therapy proceeds to make a clinical determination as to whether and/or how much of the trauma narration would be helpful to share with the caregiver based on their stability, treatment responsiveness and the child's comfort level. However, this need not be discussed upfront as the parent hearing the youth's detailed description of their memories at some point in the therapy may or may not occur depending on both the caregiver's and youth's progress in treatment. If the parent prefers not to participate in the treatment, the therapist can still provide TF-CBT to the youth, but it is important for the therapist to elicit from the parent an agreement to support, or at least to not undermine the therapy process (e.g., by agreeing to facilitate transportation to sessions and/or facilitate privacy

during virtual sessions the youth receives in the home; to not demand from the youth details about what is occurring during therapy; and to facilitate the youth in using skills learned during therapy, etc.) If the parent does not agree to this, the therapist should not proceed with TF-CBT with the youth, as it would likely not be productive and could potentially lead to parent-youth conflict or otherwise place the youth in a problematic situation with the parent.

Regardless of the identity of the caregiver, the therapist should conduct the assessment and provide TF-CBT with a collaborative spirit, openness and sincere belief in the caregiver's expertise about many aspects of the youth's functioning, and perhaps about the youth's family and culture (depending on their past relationship with the family). The therapist should thus see the benefit of inquiring about and acknowledging the caregiver's wisdom, hoping to benefit from insight, knowledge and expertise that the caregiver has regarding the youth, family and their history. While TF-CBT is a structured treatment in which the therapist provides specific content each session, it is also a highly collaborative intervention in which respect of family, culture and the therapeutic relationship are paramount (Cohen et al, 2017). Thus, when therapists share information, skills or other TF-CBT interventions, this should be from a stance of cultural humility, recognizing that they are just starting to know and understand the youth, their family and cultural context.

Structure of the manual: The remainder of this implementation manual describes specific strategies for implementing the TF-CBT model for youth with parental substance use and their current caregivers. It describes each sequential PRACTICE component, including a brief description of the component; how the component is typically implemented; and specific implementation strategies for that component for youth with exposure to parental substance use, including for child maltreatment. Each component includes youth and caregiver sections. Where appropriate, additional implementation information is provided related to youth who have experienced traumatic separation or traumatic grief.

ENHANCING SAFETY

(In typical TF-CBT, Enhancing Safety is the final treatment component. However, as noted earlier, youth with parental substance use often present with complex PTSD and significant safety issues. Enhancing Safety is therefore described first in this manual, although safety concerns should always be prioritized regardless of complex PTSD history or symptom presentation.)

Goals: The goals of the Enhancing Safety component are to identify and strengthen developmentally appropriate safety strategies that the youth can utilize in a range of everyday situations and in response to specific safety threats and trauma reminders.

Implementation: The therapist, youth, and caregiver(s) identify potential threats to current and future safety, then collaboratively explore these safety concerns and develop an individualized crisis and safety plan that is responsive to the youth's developmental level and specific needs and concerns. The therapist prioritizes ongoing safety concerns such as self-harm; experiences or threats of violence abuse or other threats to physical safety; and risky behaviors (e.g., substance abuse, running away, risky sex, etc.). Topics may include education about sexual health principles (for older youth) or body safety education (for younger children); problem solving skills; drug refusal skills and bullying prevention/management skills. The youth and (as appropriate) caregiver actively participate in developing and practicing safety strategies to ensure they are feasible for the youth to use. As with all youth, the therapist should assess the youth's access to lethal weapons in the home and eliminate or address this to the greatest extent possible, while optimizing access to support.

Considerations for youth with parental substance use:

As noted in the above Assessment and Case Formulation section, youth with parental substance use may present with a variety of unsafe behaviors, only some of which are trauma related. The TF-CBT therapist needs to carefully assess which of the unsafe behaviors are likely trauma-related versus those that are likely related to other disorders and keep the TF-CBT focus on the former. (Otherwise, the therapist may be constantly diverted from trauma-focused therapy to address behavioral issues that are unrelated to the youth's trauma experiences or responses). The following discussion is focused on trauma-related safety issues. If the youth has serious safety concerns that the therapist believes are not related to trauma, another evidence-based treatment may need to be implemented prior to beginning TF-CBT.

Youth with parental substance use have typically been in unsafe situations and have often developed suboptimal coping strategies. For example, a youth whose parent became physically abusive during a drug binge may learn to run away at the early signs of parental substance use, and continue to use running away as a coping strategy if placed in foster care, despite the absence of the abusive parent, for example, in response to trauma reminders (e.g., the foster parent using a firm tone of voice; other adults or children yelling in the home, etc.).

Whatever the youth's unsafe behavior, it is important for the therapist to 1) **acknowledge** that the youth did their best to stay safe in unsafe situations (i.e., living with ongoing parental substance use and maltreatment) and that the youth's unsafe behavior (in this case, running away) may have served an important safety function in the past (i.e., when the youth was living with ongoing trauma, running away kept the youth safe from physical abuse when living with the abusive parent). In some cases, the youth's unsafe behaviors may have been for the purpose of keeping their younger siblings safe also (e.g., youth who engaged in selling drugs or sex may have done so to get food, shelter or other necessities for their family because their parents failed to do so.) It is then helpful for the therapist to 2) help the youth **consider the current pros and cons of the unsafe behavior**, i.e., now that that parent is no longer present, whether running away is still necessary for their safety, or whether it now may pose more risk than benefit for keeping them safe (e.g., evaluate relative risks vs. benefits to running away). The therapist can then 3) **introduce the concept of trauma reminders** which often serve as antecedents to the youth's unsafe behaviors, help the youth to identify their personal trauma reminders, and connect these reminders to the past traumas and current responses. In the above example, the trauma reminder may be the foster parent using a firm voice reminds the youth of the birth parent becoming emotionally and physically abusive when high; adults or children yelling reminds the youth of the chaos at the birth parent's home when the parent was high and that this often preceded the prior physical abuse. The therapist can help the youth connect these reminders to the past traumas of emotional and physical abuse; and to the youth's current emotional responses (e.g., anxious, upset, angry or out of control) and behaviors (e.g., runs away). Finally, the therapist can 4) **introduce PRAC skills** tailored to the youth's specific reminders, developmental level, interests, etc., model these and encourage the youth to practice these over time to reduce safety risks. Ideally, these should incorporate skills that the youth already likes and can easily use (e.g., listening to music, talking to friends, playing a sport, etc.). For example, if the youth becomes upset when foster mother uses a harsh tone of voice, the therapist can encourage the youth to take some deep breaths like they would when playing basketball, go to their room, and then listen to some music to self-soothe. It is important that the therapist also include the foster parent in TF-CBT as described below and in the Parenting Component, so that this caregiver understands the impact of trauma reminders on the youth's safety and can minimize trauma reminders in the home (while also assuring that the youth stays safe and complies with reasonable behavioral expectations). In this case, this would include helping the foster parent to recognize her using a loud, harsh voice as a trauma reminder for the youth, and modeling, practicing, and encouraging her to use a different voice tone when correcting or setting expectations for the youth.

It is important to recognize that youth who have developed and repeatedly used unsafe coping strategies over long periods of time (e.g., those with complex PTSD) have developed these as ingrained habits. For such youth, it will take some time for newly introduced safety strategies to take hold and become new habits that "displace" the previous ones. Therapists and caregivers

should thus anticipate that prior unsafe behaviors will continue to recur for several weeks, and not view such recurrences as treatment failure, but rather as predictable, expectable events.

Additionally, many youth with parental substance use, particularly those with complex PTSD and/or those who have experienced multiple traumatic separations, have learned not to trust adults, including caregivers (who have often failed to protect them and/or perpetrated trauma, betrayed and/or not been there for the youth when the youth needed them, etc.) and the therapist (who, representing the broader caregiving system, failed to protect the youth and parent when they needed it most, etc.) This can pose a challenge to the therapist and caregiver in establishing a therapeutic relationship with the youth to even start developing safety strategies. For example, the youth may understandably believe that there is no point in investing time or emotions in the current caregiver or therapist, since all previous caregivers and other adults have abandoned the youth. In this situation the therapist may start by using Motivational Interviewing strategies (Miller & Rollnick, 2013) to explore the youth's own reasons for investing (even very minimally) in the therapy.

S**ubstance use** may present as an unsafe behavior among youth with parental substance use. While some youth with parental substance use may be highly avoidant of anything related to substance use, others may use drugs or alcohol for a variety of reasons including avoidance/self-numbing, self-punishment related to self-blame, and/or for attempted mastery (i.e., to prove that they can control substance use rather than the reverse). As noted above, youth with significant co-occurring substance use and trauma problems would benefit from+ RRFT if possible. If RRFT is not available, and the if the therapist conceptualizes the youth's substance use as a trauma response, the therapist should follow the steps described in the preceding paragraph, after providing accurate psychoeducation about parental substance use and the youth's substance use. The therapist should then acknowledge how substance use helped the youth to cope in the past but also address the potential negative effect of substance use on the youth including physiological impacts, substance use as an illness and how ongoing use worsens the illness of addiction over time. The therapist should then help the youth to identify trauma reminders that serve as antecedents to substance use (e.g., intrusive memories and/or negative emotions about child maltreatment, parental overdoses, traumatic removal from the parental home/separation from siblings, and/or traumatic parental death, etc.), and develop appropriate alternative coping strategies, recognizing that these will take time to take hold. Including the caregiver in supporting these strategies is critical as described below. More information about specific strategies for youth substance use is described in the Relaxation Skills section below.

Considerations for youth with traumatic separation:

Youth with traumatic separation are often preoccupied with the safety of the separated family members (parents and/or siblings), particularly youth who were in a caregiving role for those family members, youth who witnessed family members in dangerous situations (e.g., parental overdose, siblings being maltreated, etc.), youth who suspect that the parent continues to use substances, and/or youth who do not have access to accurate information about or contact with

the separated family members. All too often, these youths' safety concerns for their parents are well-founded (e.g., if the parent experiences a serious or fatal overdose). Such concerns can contribute to unsafe behaviors (e.g., running away to try to reunite with the separated family members; using drugs or attempting self-harm based on a misguided belief that if they are doing poorly in the current home, they will be returned to the birth parent, etc.)

When youth with traumatic separation engage in unsafe behaviors, it is important to identify potential trauma reminders related to the separation(s) that may be serving as antecedents to those behaviors as described above. Often, these are thoughts or memories about separation which lead to memories and worries about the separated family memories, negative beliefs (e.g., self-blame) about the separation, or other trauma symptoms related to the traumatic separation. In addition to following the steps described in the preceding section, the therapist should also work with the current caregiver and others involved in the youth's care (e.g., CW) to provide accurate, age-appropriate information to the youth about the separated parent(s) and siblings' current situation, in order to decrease the youth's worries and fears about them to the extent that this is feasible in keeping with the factual information that is available.

If visitation or other contact with the parent(s) and/or siblings is allowed, the therapist can strengthen the youth's use of PRAC skills including safety skills to enhance positive interactions during the family visits or contacts. For example, if a youth feels uncomfortable during a supervised visit with the separated parents and siblings because the parents verbally blame the youth for disclosing the parental substance use and maltreatment and for the youth's and siblings' removal from the parental home, the therapist could help the youth to practice positive coping strategies for such situations, such as how to focus on positive aspects of their time with their parents and siblings, ignoring negative comments by the parents, and cognitively reframing negative comments using cognitive coping, etc. The youth and therapist could also develop a verbal signal that the youth could use if the parental negative comments continue to the point where the youth feels unsafe during the visits. The youth could give this signal to the visit supervisor to intervene and to assure that the youth feels safe during the visits. The therapist, youth, visit supervisor, and CW worker would discuss and agree on these strategies prior to additional visits. In these types of situations, it is essential that the therapist maintains appropriate boundaries between therapy and forensic/custody roles as described elsewhere (Mannarino & Cohen, 2001).

Considerations for youth with traumatic grief:

Youth who have experienced the traumatic death of a parent or other attachment figure due to parental substance use are often preoccupied with their own safety, that of their siblings and/or their current caregiver as well as with larger questions of safety in the world. Such concerns can lead to unsafe behaviors (e.g., running away to a relative that the youth prefers over the current caregiver; fighting with peers in a new school after having to move when a single parent died of an overdose; starting to use drugs due to feeling mistrust of and alienated from others, etc.)

In these situations, the therapist should work with the youth to identify personal trauma reminders (e.g., of the traumatic death and/or the deceased parent) that serve as antecedents to the unsafe behaviors; and develop tailored PRAC skills to respond to these reminders that over time can replace the unsafe behaviors. As described above, these will likely take time for the youth to practice and to take hold so that the youth regularly uses these strategies instead of the unsafe strategies that they have been using since the death of the parent.

Directly discussing the youth's concerns or fears about something happening to them, their current caregiver, or another important attachment figure may also help to alleviate safety concerns. For example, the therapist can ask the youth about whether they are concerned about these things, whether they worry about who would care for them if something happened to the current caregiver, and whether they have discussed this directly with the caregiver. If such a discussion has not occurred, the therapist can encourage the caregiver to initiate this discussion and provide appropriate reassurance as well as a concrete safety plan as described below.

Caregiver considerations:

As noted above, it is important to engage and include the non-offending current caregiver (birth parent who did not use substances or maltreat the youth; kinship or foster parent, etc.) throughout treatment to the extent that the youth agrees and that this is feasible. The therapist should meet individually with the caregiver to share the youth's substance use-related trauma reminders that may serve as antecedents to unsafe behaviors and help the caregiver to understand connections between the youth's past trauma experiences (which the caregiver may not be fully aware of), these substance use-related trauma reminders, and the youth's unsafe/dangerous behaviors. The therapist then should share the youth's new PRAC skills, demonstrate these and encourage the caregiver to support the youth in using these when trauma reminders occur.

It is likely that the caregiver may be inadvertently engaging in behaviors that serve as substance use-related trauma reminders to the youth (e.g., speaking in a harsh tone to the youth or other youth in the home; yelling when youth do not comply with expectations, etc.). The therapist should help the caregiver to understand how such parenting behaviors, although benign in ordinary circumstances, can serve as trauma reminders and antecedents to unsafe behaviors for youth who have experienced chronic trauma. The therapist collaborates with the caregiver to develop alternative strategies for correcting inappropriate youth behavior while not serving as a trauma reminder. For example, the caregiver can speak softly but still provide appropriate consequences for unacceptable behavior. Modeling and practicing this with the caregiver until the caregiver masters these `new parenting strategies and can use them in place of those that serve as trauma reminders, can help the caregiver and the youth to minimize the youth's unsafe behaviors while also assuring that the caregiver can maintain appropriate discipline at home. The therapist should emphasize that it will take a bit of time for the youth's new responses and skills to "take hold" and in the meantime, the caregiver will need to be patient and not expect the youth to immediately change old behaviors. The therapist may find it useful to introduce the

Trauma and the Brain handout, to point out that the youth's behaviors are based on brain changes that have occurred over time and that effecting behavioral changes will also take some time to occur.

As noted above, youth with parental substance use may engage in personal substance use as a coping strategy. While this is never desirable, and may pose a safety risk, it is important for the therapist to help the caregiver address this problem with an appropriate perspective related to the actual safety issues involved, and balancing the youth's other important needs (e.g., for placement stability). For example, a caregiver who had a "no drugs or alcohol" rule in the home and discovered that her foster daughter had used marijuana three times in the past two months to cope with anxiety, told the therapist that she needed to terminate the placement because the youth had broken this rule and betrayed her trust. The youth had come from a home where all the adults in her family used marijuana regularly and she had viewed this as normal until coming to live in the current foster home. The therapist can explore with the caregiver 1) her feelings about the situation (the caregiver feels overwhelmed, helpless, and angry); 2) her underlying concerns about safety for the youth and others in the home (the caregiver does not believe that the youth's occasional marijuana use in itself poses a serious safety risk, but is concerned that this would lead to "worse drug use" and that the youth does not "take seriously" the caregiver's concerns about substance abuse); and 3) whether the caregiver is willing to consider any safety and disciplinary measures short of terminating the youth's placement in her home. After considerable discussion, the caregiver may indicate that she deeply cares about the youth and wants her to remain in her home but needs the youth to commit to not using drugs in her home and to use other coping strategies when she has high anxiety). The therapist and youth can meet to discuss this, and the youth will hopefully agree. The three then meet together to develop specific strategies for addressing the youth's anxiety.

PSYCHOEDUCATION

Goals: The goals of TF-CBT psychoeducation are to provide information about trauma and its impact, normalize and validate youth and caregiver responses to trauma experiences, provide information about TF-CBT and its value, and instill hope for recovery.

Implementation: The TF-CBT therapist provides information about the full range of the youth's trauma experiences and common trauma reactions (including biological, emotional, behavioral, cognitive, social, etc.), connecting these to the youth's personal trauma responses. The therapist also provides psychoeducation about trauma reminders and encourages the youth to start to identify personal trauma reminders. The therapist also provides psychoeducation to the caregiver in this regard, as well as common caregiver responses to a child's trauma experiences. Providing information about neurobiological responses to trauma and how treatment can address these (e.g., practicing skills every day reverses these changes) is often helpful for explaining the rationale of TF-CBT to the youth and caregiver. Culture, development, and youth interests shape delivery.

Considerations for youth with parental substance use:

Youth rarely if ever have accurate information about parental substance use, even when they have lived with this their entire lives. Providing accurate, age-appropriate psychoeducation about substance use is thus one of the most important TF-CBT interventions for these youth. The therapist can start by asking what the youth knows about substance use (using the youth's term for the parent's substance use-related behavior, e.g., "drinking", "using drugs", "shooting up", etc.) The therapist can then provide accurate information about the following issues:

1) Just because substance use happens often in the youth's family or culture (to the point that, this doesn't mean that it is okay or harmless. Identify some of the problems the substance use has caused for the youth or their family (e.g., when my father drinks he fights with my mom, and everyone is tense); to help the youth acknowledge that something can be both common and harmful.
2) Substance abuse is an illness: like other illnesses, neither the youth nor the parent caused the parent to have substance abuse. The parent did not choose to have it, did not have control over getting the disease, and should not be condemned or judged for having the illness. Neither the youth nor the parent can cure the disease of substance abuse.
3) Like with other illnesses (e.g., diabetes, heart disease, etc.), the person with an illness needs to make choices about how to manage the disease that they have. If the person makes healthy choices (e.g., with diabetes: eating healthy, exercising, monitoring glucose, going to regular doctor appointments, taking medication as prescribed, etc.; for addiction, not using drugs or alcohol, staying away from people who use drugs or alcohol, attending AA/NA meetings, using medication assisted therapy [MAT] as prescribed, etc.,) they will likely stay healthy. If they make unhealthy choices such as using drugs or alcohol, being

with users, not attending meetings, not using MAT as prescribed, etc.), they are likely to have ongoing addiction and related illnesses.

4) The National Institute on Drug Abuse (NIDA; 2020) estimates that up to 60% of people who start treatment for substance use disorders will relapse. Given this prevalence, it is probable that many children with parental substance use have witnessed or will witness this relapse process. As discussed below, providing psychoeducation on the course of substance use disorder treatment is typically important to help promote healing and to help enhance future safety.
5) Once people with substance use start to make unhealthy choices, the craving for the drug or alcohol takes over and very quickly they lose control over their choices. People with the disease of substance use ("substance use disorder", also called "addiction") often fool themselves into believing that they can use "just a little" or "just sometimes", but this almost always leads to stronger and more cravings and active addiction. When people are actively using substances, they crave the drug or alcohol so strongly that they choose getting and using it over other things or people in their lives, even their children. This is why it is so important for people who have the illness of addiction to never start using the drug or alcohol, that is, to always make healthy choices rather than unhealthy ones.
6) Provide psychoeducation about the impact of addiction and the impact of specific drugs and/or alcohol on the brain and the user's behavior. Here is an excellent psychoeducational video from the National Institute of Drugs and Alcohol (NIDA) on Addiction and the Brain: https://www.youtube.com/watch?v=s0bqT_hxMwI . For psychoeducational information about specific drugs or alcohol, go to https://store.samhsa.gov/product/tips-teens-truth-about-opioids/pep19-08(Several other "teen truth about" fact sheets are available here). This can lead to a discussion about how the youth knew when the parent was using the substance in question. In some instances, the youth may have observed the parent using (e.g., saw the parent smoke, tie off, shoot up, snort, drink, etc.), whereas in other cases, the youth witnessed the effects of the substances on the parent's behavior (e.g., the parent became sleepy, excited, irritable, left the house for days at a time, etc.).
7) Provide information (and start a discussion) about the impact of parental substance use on parenting—how did this substance use impact the parent's ability to provide necessities such as food, shelter, supervision, positive attention, love, etc. (e.g., When my mom uses drugs, she sleeps all the time and doesn't cook or take us to school.)
8) Follow up #6 by discussing the common impacts of parental substance use on youth i.e., impact on youths' affective, behavioral, biological, cognitive, social, learning and other functioning, emphasizing that different youth respond in different ways depending on their temperament, developmental stage, and other factors (for example, perhaps the youth and their siblings have responded in different ways). It may be important to provide specific information about alcohol-related blackouts (periods during which the user has no memory of what happened), as the youth may have been exposed to frightening or abusive episodes during the parent's blackouts that the parent will not be able to

recollect. (The parent's inability to remember these episodes may have significant ramifications and need to be addressed directly by the therapist with the parent if the parent is participating in TF-CBT, particularly during trauma narration and processing and conjoint sessions.)

9) Describe trauma reminders of parental substance use and help the youth to identify their personal trauma reminders (depending on what their experiences are, these may include reminders of the substance use, related maltreatment of self and/or siblings, traumatic separation(s), and/or traumatic death(s). Help the youth to make connections between a) the initial traumas, b) trauma reminders; and c) current symptoms the youth identified in #7 above.

Providing these psychoeducational interventions will help the youth make sense of their current difficulties and serve as a basis for introducing PRAC skills for coping with the youth's individual reminders and current symptoms. Some outstanding psychoeducational materials for youth with parental substance abuse are available from Sesame Street (and youth of all ages can benefit from these). These include:

- Sesame Street Workshop - Activities for children coping with parental substance abuse challenges https://sesameworkshop.org/topics/parental-addiction/
- Micah asks an older kid about addiction - https://renascent.ca/kids-meet-kid-recovery-addiction-video/
- Parental Addiction video in which a 10-year-old describes her experiences with parental substance abuse – Meet Salia: https://youtu.be/DGgW-f0RyfE
- Karli's 7C's Handout about Parental Substance Abuse: https://sesameworkshop.org/wp-content/uploads/2023/03/Karlis7cs.pdf
- Karli and Me Activity Workbook for Children with Parental Substance Abuse: https://sesameworkshop.org/resources/karli-me-activity-book/

Additional excellent psychoeducational resources about parental substance use include the following:

- Center for Child Abuse and Neglect, OUHSC (2018). Hello, My Name is Addiction. Available at https://secure-web.cisco.com/1iG_sruAxGPSbbMQz44zwuS8-kbRfDvzQdfmo3NDu-PzXQgcz02eqRO2PAGE5eLSQ5fnTY-BEYZ9o0ewMmkupdKH1NrB7ewBXxy_VWMuhaf_axB2xYUkBq48DMeZq2-XYnZWX7MdtYEX1ZQQCE0TDPkDK19DmAciT1_h-FQojWw61Bvw2mL7VfJnt4vkObLTpQVFRgAjeN7Qo5PXuz_rlPJ3tDnvcRag1D-lqwypNFFGQq_InfmcZ3I64oslnmomlZ35jiob9HSJ6yNYPjoyKB83TAp8TpsuSOpLyzMTjROpe4XOuM5UxS3Zy2H3Ccr0N/https%3A%2F%2Foklahomatfcbt.org%2Fwp-content%2Fuploads%2F2019%2F01%2FAddiction-Book.pdf

- Black, C (2018) My Dad Loves Me, My Dad Has a Disease: A child's view of living with addiction, Available at: https://www.amazon.com/Dad-Loves-Has-Disease-Addiction/dp/1942094752

Considerations for youth with traumatic separation:

As noted earlier, youth with traumatic separation very often have concerns about their separated family members. Providing accurate psychoeducation about why the separation occurred (e.g., to enhance child safety, encourage the separated parent to receive needed treatment services, etc.) and how the legal and child protective system works to make such decisions (e.g., laws exist to keep children safe, to protect children from abuse or neglect and to provide needed services to parents of dependent children, etc.) may be helpful to some youth. For almost all these youth, it is important to provide accurate and age-appropriate information about the current location and health of the separated parent(s) and sibling(s). The therapist should collaborate with the current caregiver, Child Protective Services (CPS) and/or other adults to determine the most appropriate way to share this information with the youth. In circumstances where the current location and condition of the separated parent is not known, the therapist should acknowledge this uncertainty and validate the difficult emotions this causes and how hard this likely makes it to focus on adjusting to the current living situation (e.g., current caregiver, foster siblings, new school, peers, etc.). If feasible, the therapist should assure the youth that they will provide information about the separated parent as soon as this information is available. The book Maybe Days (Wilgocki & Wright, 2002) is a useful resource in exploring the uncertainty associated with traumatic separation.

For youth who are separated from the parent(s) with substance use and/or siblings, the therapist should also explore their perception of what would be required for reunification and when this might occur and provide clarification and psychoeducation to address inaccurate information and beliefs that the youth may have in this regard. In some situations, the separated parent may have provided inaccurate information to the youth during visits (e.g., "I've done everything I need for you to come home; your grandmother [current caregiver] is keeping this from happening."). Alternatively, the youth may have inaccurate information about reunification based on their own wishes, beliefs or things they have heard from other sources. Whatever the origin, inaccurate information in this regard may confuse the youth, contribute to their difficulty in understanding why they continue to be separated from the parent with substance use, cause the youth to inaccurately blame the current caregiver for the continued separation, and/or contribute to behavioral, relationship, or other problems in the current living situation. For all these reasons, it is important for the therapist to provide psychoeducation and clarification if the youth's understanding is inaccurate.

Considerations for youth with traumatic grief:

It is very common for adult family members to not accurately share with youth the cause of their parent's substance use-related traumatic death. This may stem from adult trauma avoidance; the adults' well-meaning attempt to shield the youth from additional pain and/or stigma; or a combination of these factors. Depending on the youth's age and developmental level, and the level of exposure they had to living with the parent's prior substance use, they often have some understanding of and insight into the parent's prior substance use and some suspicion about the cause of death, even if they do not overtly ask about or express this. Thus, they may be skeptical of vague explanations that do not adequately explain the cause of death (e.g., the youth may be told that the parent died of "heart failure" or "they stopped breathing" without mentioning that drugs caused this terminal event to occur; if the parent did not have an ongoing history of heart or respiratory disease, this will raise more questions than it answers for many youth). Additionally, the youth is bound to eventually learn that drugs were involved (e.g., from peers, the media, the internet, other relatives, etc.), and when this occurs (even if years later), the youth will understandably feel betrayed, angry, hurt, etc. about being lied to at the time of the parent's death.

For all of these reasons, the therapist should encourage caregivers to provide accurate information about parental substance use-related death, and provide a destigmatizing context in which the youth (and caregiver) can understand this death as being similar to other disease-related deaths as described above, i.e., the parent had a disease (substance use disorder) that, like cancer or heart disease, they did not cause, did not choose to have, and could not control having. Tragically, their parent died after a long (and often valiant) battle with a terrible illness, just as bad and legitimate an illness as cancer, and their grief is just as painful as a youth whose parent died of any other illness. Put in this context, most families will agree to providing accurate information to the youth and to the therapist providing psychoeducation about substance use as an illness as described about. This will allow the therapist to move forward with the PRAC skills as described below.

Caregiver Considerations:

The therapist should provide psychoeducation to the current caregiver about diverse traumas that the youth has experienced, keeping in mind that this caregiver may not know the full extent of these traumas (i.e., the youth may not have shared this information with a new kinship or foster parent or a birth parent who was not the custodial parent when the other birth parent was caring for the youth and had significant substance use problems). The therapist should also provide information about parental substance use, not assuming that the current caregiver knows about the extent of the parental substance use. Depending on the identity of the current caregiver and the degree to which they were involved with the family during the parent's substance use, this caregiver may have the most information about this of anyone in the family, may know almost nothing about it, or anything in between. This may include that the youth lived

with ongoing parental and/or familial substance use to the degree that this was viewed as normal. Accordingly, the youth may not understand that substance use is problematic, and this belief may influence the youth's behavior (e.g., using drugs or alcohol for self-soothing or recreational use and not understanding why the caregiver or other adults object or discipline the youth for this). Depending on the youth's perspective, the therapist, caregiver and youth may need to work together on behavioral rules and consequences in the current home related to substance use.

The therapist should also provide information to the caregiver about the diverse impacts of parental substance use on the youth, tailoring this to match the individual youth as described by the caregiver and youth. These may include different trauma impacts such as affective (e.g., anger, sadness, fear, shame, numbness, affective dysregulation and difficulty reregulating, etc.), behavioral (e.g., avoidance, modeling traumatic behaviors such as problematic sexual or physically aggressive behaviors; self-injuring; risk-taking behaviors, etc.), biological (e.g., somatic symptoms, difficulty eating, sleeping, concentrating, irritability, etc.), cognitive (e.g., negative beliefs about self, others and/or the world, trouble paying attention, learning, etc.), and/or social (e.g., withdrawal from peers, fighting with peers, believing no one can understand them except peers with problems, not getting along with the new caregiver or family members, etc.) In this regard, the caregiver may assume that the youth is just "being bad" or "being just like their (substance using) parent". It is particularly important for the therapist to help the caregiver understand that that many of the problematic behaviors they may be currently seeing are related to the youth's trauma experiences related to parental substance use.

In parallel fashion to the youth, the therapist should help the caregiver to understand connections among the youth's past traumas (including those related to parental substance use), current trauma reminders (helping the caregiver to recognize these based on the youth's self-identification of trauma reminders, including those inadvertently created by the caregiver's actions), and the youth's trauma-related symptoms. As described in the following Parenting Skills section, it may also be important for the caregiver to recognize ways that they themselves may be inadvertently reinforcing the youth's use of less adaptive, problematic coping strategies. The therapist should also provide hope for the youth's recovery through psychoeducation about how the TF-CBT model will provide skills for the youth to use and the caregiver to support the youth in regularly practicing, to interrupt this cycle of trauma reminders leading to trauma symptoms.

PARENTING SKILLS

Goals: The goals of TF-CBT Parenting Skills component are to enhance support of the non-offending (non-perpetrator) caregiver and to optimize parental skills about recognizing and responding to the youth's trauma-related difficulties including trauma reminders, to improve the quality of the youth-caregiver relationship and the youth's overall mental health and functioning.

Implementation: The Parenting Skills component is provided to non-offending caregiver(s) throughout TF-CBT. Ideally the therapist spends about half of each session individually with the caregiver and half individually with the youth. During the caregiver sessions, the therapist provides psychoeducation about trauma impact, trauma reminders, and trauma responses to improve the caregiver's understanding about the youth's trauma-related emotional and behavioral problems. Also, there is specific training in effective parent management techniques (e.g., the use of praise, selective attention, functional analysis of behavior problems, use of behavioral plans, negotiating, etc.) to address the youth's trauma-related behavioral problems.

While children with exposure to parental substance use may have some significant emotional and behavioral difficulties which may lead the caregiver to immediately want help with discipline strategies, it is important to resist the temptation to go straight to teaching caregivers about time out and other disciplinary strategies. Such strategies are not effective when they are used prior to emphasizing the child's strengths and focusing on enhancing the parent-child relationship. Thus, it is critical to assess the child and caregiver interactions and communication patterns to support a nurturing family environment. More specifically, the caregiver should be encouraged to focus greater attention on the child's strengths and prosocial behaviors by offering specific praise. In addition, caregivers are encouraged to consider how trauma can undermine a child's feelings of self-worth and look for opportunities to offer affirmations in the form of global praise (e.g., I'm proud to be your parent; I enjoy spending time with you; I love you) to create a warm family environment (Deblinger, et al., 2015).

The therapist also educates the caregiver about each TF-CBT component so that they can utilize the psychoeducation and skills to further the goals of therapy. For example, coping skills can assist the caregiver in coping with their own stressors, while also modeling the use of the skills for the youth. Caregivers can support and praise the youth for implementing TF-CBT skills both in daily situations as well as in response to trauma reminders (gradual exposure, GE).

Considerations for youth with parental substance use:

As noted above, many if not most youth with parental substance use experience multiple disruptions in their living situation due to their parent's inability to care for them during active substance use. These separations are often sudden and occur under chaotic, even frightening circumstances, and may lead to the youth developing trauma symptoms ("traumatic separation"). Thus, it is important that therapists, case managers, CW and other care providers optimize placement stability and minimize placement disruptions to the extent possible while

also assuring youth safety. To do this, caregivers (and foster parents in particular) can benefit enormously from the following resources:

- Education about the workings of the foster care system and how to navigate the various complexities of this system (who the different personnel are, what the different meetings are for, when reviews occur for foster placements and what potential decisions are made, etc.)
- Information about how to access different types of services (e.g., therapy, case management, psychiatric care, pediatric care, special education, etc.)
- Trauma-informed care and how to advocate for one's foster child: NCTSN's Resource Parent Curriculum (https://www.nctsn.org/resources/resource-parent-curriculum-rpc-online) is an excellent resource in this regard
- How to monitor youth psychopharmacological medications in a developmentally appropriate way. Many caregivers assume that youth can or should take responsibility for managing this on their own, but even teenagers are often not able to do so without adult oversight.
- Excellent resources for implementing effective trauma-informed parenting for youth with parental substance use are available from the NCTSN Learning Center at: https://learn.nctsn.org/enrol/index.php?id=278 (registration is required to view these materials; free CE credits are provided)

Most youth with parental substance use have experienced highly inconsistent parenting with unpredictable (or no) behavioral rules, and unpredictable enforcement of any rules that may have existed. This may have included sudden, strict, unforeseeable punishment for infringement of rules (e.g., severe physical punishment for breaking a rule that the child didn't even know existed), and/or highly inconsistent rule enforcement (e.g., severe punishment at the parent's whim for breaking a rule, when other times this same rule is not enforced at all). In many cases, the youth themselves have been responsible for creating and enforcing behavioral rules for younger siblings. Having such responsibilities may add to youth difficulties in trusting adults, and/or giving up their own authority and having to obey an adult's rules in the home (possibly for the first time). These experiences do not prepare youth to understand or respond appropriately to consistent parenting. Thus, the therapist and the current caregiver (or the parent in recovery who is learning to use consistent parenting skills for the first time) should expect and be prepared for initial difficulties in trying to implement effective parenting interventions with these youth. Often these youth will encounter effective and consistent parenting strategies for the first time, and will need time, new skills, and adult patience to adjust to these approaches.

It is helpful and important for the therapist to provide the rationale for consistency in parenting and explain why this is even more important and beneficial for youth with parental substance use (who have typically experienced unpredictable, chaotic parenting). Specifically, explaining

that predictability decreases anxiety, uncertainty and fear can be very helpful in reassuring the caregiver. When the therapist helps the caregiver to understand that providing a structured and predictable living situation is not being "mean" but in fact is providing a critically important, stabilizing and helpful support structure to the youth, this gives the caregiver "permission" to implement consistent parenting strategies. As youth gradually respond more positively to these consistent approaches, this reinforces the caregiver's use of these strategies.

As noted above, often the current caregiver is a family member (other parent, grandparent, aunt or uncle, etc.) who volunteers to care for the youth, often multiple times, when the parent with substance use is unable to do so. It is often extremely challenging for this caregiver to provide effective parenting to youth who have ambivalent feelings towards them as well as towards the parent with substance use when the youth also feels torn between wanting to stay with the current caregiver versus wanting to return to the parent with substance use. Sometimes the youth may express this ambivalence as anger, defiance, or other negative emotions and/or behaviors towards the current caregiver. If the youth is living with the parent with substance use, the youth may experience anger towards this parent for their past substance use, as well as fear that the parent will relapse and/or ambivalence about giving up the authority and pseudo-parental role they took on during the parent's active substance use. If the parent with substance use has died, there may also be resentment toward the current caregiver because the youth has had to leave their prior home, friends, school, etc., to live in the new home. For all these reasons, it is important for the therapist to inquire about the caregiver's feelings about caring for the youth, acknowledge and validate any challenges that this situation entails, and offer genuine praise to the caregiver for taking on these difficulties and for their commitment to the youth despite these challenges. Through such discussions, the therapist and caregiver can begin to forge a partnership to collaboratively work together to master these issues for the youth's benefit. Finally, it is important to emphasize that some caregivers who are foster parents and/or grandparents may have successfully raised other children and thus may not feel parenting guidance is needed. In these circumstances, it is helpful to express appreciation for their expertise regarding parenting while offering how their knowledge in combination with the therapist's expertise regarding the impact and treatment of childhood trauma can give the child the best opportunity to thrive despite earlier traumas

Considerations for youth with traumatic separation:

Strategies for implementing parenting skills for youth with traumatic separation are described in greater detail elsewhere (Cohen & Mannarino, 2019). As that article describes, for youth with parental substance use, it is particularly important that the therapist address with the current caregiver how to minimize issues the youth may have with split loyalties between the parent with substance use and the current caregiver. Potential strategies can include, as clinically appropriate 1) enhancing ongoing communication and connections with the parent with substance use and/or separated siblings (to the extent permitted by CW and other authorities); 2) optimizing ongoing connection with the youth's culture, language, faith community, food, etc.; 3)

collaborating with the separated parent or other family members to establish consistency in parenting rules and strategies across anticipated living situations (e.g., between the current home and the homes of the parent with substance use, grandparent, etc.); and 4) consideration of including the parent with substance use in part of TF-CBT. Each of these is addressed briefly in the following paragraphs.

As noted earlier, in situations of parental substance use, there is often uncertainty and ambiguity regarding when and if the youth will return to live with that parent. However, family reunification is typically the goal, and many youths hope for this (even if they are ambivalent about it). Given this plan and to minimize split loyalties, it is important to encourage the current caregiver to enhance rather than discourage the youth in maintaining positive connections with their birth family when possible and clinically appropriate. Depending on the circumstances, this may consist of supporting the youth in 1) maintaining regularly scheduled visits and calls with birth family members including providing transportation if needed to visits, supervision for calls if this is required by CW, and supportive listening if the youth wishes to talk about their feelings after these occur; 2) maintaining ongoing emotional connections with their birth family, such as non-judgmental listening when the youth reminisces about the birth family; and 3) help the caregiver to refrain from negative or judgmental comments about the birth family or their substance use, as these are likely to hurt or alienate the youth, which is not (or should not be) the caregiver's intention.

If/when visits with the birth parent occur, it is helpful for the therapist to develop consistent parenting strategies across homes, if this is feasible. This will minimize the youth's split loyalties between the current caregiver and the birth parent and will minimize the youth's anxiety about transitioning to the birth parent's home if/ when this occurs. For this to occur, it is helpful for the therapist to have some communication with the parent with substance use regarding the parenting strategies that the current caregiver is implementing during TF-CBT. This can occur directly (i.e., therapist communicating directly to this parent) or indirectly (e.g., CW working or current caregiver communicating with the parent with substance use). While direct communication is preferable from the standpoint of the therapist knowing exactly what information the parent is receiving and how the parent is responding to this, there may be reasons why this cannot or should not occur especially if the likelihood of reunification is unclear. For example, if the youth or parent with substance use refuses to include this parent in TF-CBT, this should not occur; similarly, if the parent with substance use engaged in abuse or neglect, the therapist should consider whether to include this parent as discussed above. The therapist needs to weigh the risks versus benefits of including this parent in TF-CBT and make the best clinical decision for the youth. Clearly, attempts at engaging the substance using parent, however, might inadvertently encourage false hope especially if that parent has demonstrated repeated relapses and a lack of commitment to recovery and consistent involvement in the child's life. On other hand, when a parent is clearly committed to recovery, consistent parenting and reunification, if feasible, the therapist should provide information to the parent with substance use about the

parenting skills the current caregiver has been using, provide information about why these will be helpful for the youth (e.g., decreasing anxiety about the parent's substance use and decreasing behavioral problems); information about how these have been working; model and practice these with the parent with substance use so that this parent is able to use them effectively, and encourage that parent to utilize these in their home consistently when the youth is in that home. This will ideally optimize consistency across homes when the youth visits as well as when the youth returns to that parent's care. If the parent who is in recovery has their own therapist, it may be preferable for that therapist to provide the aforementioned information, skill building and guidance especially if the therapist is TF-CBT trained.

Considerations for youth with traumatic grief:

Typically, the caregiver in this scenario is a family member from whom the parent with substance use had distanced themselves and their children prior to that parent's death. Thus, the youth may not have a close relationship with this caregiver and may resent this relative for coming in and "taking over" now that their parent has died. As noted above, the youth may also have had to take responsibility for younger siblings and be angry about giving up authority to a new adult figure. A common scenario is that the youth is placed with the grandparent whose child died from substance use. This grandparent is now coping with their own (potentially traumatic) grief related to that death, and their guilt, shame and other complicated feelings related to having raised the parent who used substances and caused harm to the youth now living under their care. This grandparent may engage in overly strict parenting practices to "make up" for their perceived shortcomings as a parent in the past; or alternatively, may be excessively passive in parenting the youth due to their guilt and/or the sudden change in their role from grandparent to parent.

Another common scenario is that youth may be placed with a new caregiver (e.g., an aunt or uncle) who may never have raised children and may be taking on this responsibility for the first time. If the caregiver is caring for more than one youth who experienced the parental death, there are frequently differences in how these youth respond, with one youth having more traumatic responses than other(s) who may have more typical grief responses. One youth may also have more anger and negative behavioral responses related to these traumatic responses, which can be very confusing to a new caregiver. Thus, the therapist should inquire about not only the youth receiving TF-CBT, but other youth for whom the caregiver is providing care following the parental death, and address questions and concerns related to differences in behaviors that may impact parenting responses. It is also very important for the therapist to recognize and acknowledge to the caregiver that the caregiver in this situation is likely having their own personal grief or traumatic grief responses to the death of their relative (the youth's parent) and for the therapist to support the caregiver in these responses.

RELAXATION SKILLS

Goals: The goals of TF-CBT relaxation skills are to develop and practice individualized relaxation strategies that the youth can use, and parents can reinforce the youth to use in a variety of settings to reverse physiological and psychological trauma-related hyperarousal. The caregiver is also encouraged to use relaxation to manage their own stress, while also modeling the skills for the child.

Implementation: The TF-CBT therapist typically asks the youth to describe activities the youth finds enjoyable and/or relaxing (e.g., sports, reading, crafts, games, music, etc.), and uses these as a basis for developing a "toolkit" of individualized relaxation strategies the youth can use in a variety of settings (e.g., going to sleep; at school; with friends; with trauma reminders). The therapist seeks to expand the youth's repertoire of available skills and strategies for specific needs and a range of contexts. The therapist usually demonstrates and asks the youth to try some empirically proven relaxation strategies such as focused ("belly") breathing; progressive muscle relaxation; visualization; guided imagery; yoga; and/or incorporating the youth's favorite music into relaxation strategies, if the youth has not previously learned these skills. Ideally, the therapist meets individually with the caregiver, shares the youth's preferred relaxation strategies, and engages the caregiver to practice the skills as well and encourage the youth to practice these in a structured way for at least 10-20 minutes several times a week and to use these strategies when trauma reminders occur (gradual exposure, GE).

Considerations for youth with parental substance use:

In many cases, youth with parental substance use already use some strategies for physiological relaxation that work for them. Common strategies include writing, drawing, music, and various forms of exercise. The therapist should encourage the youth to continue to use whatever strategies they currently use, enjoy, and work for them to reduce the intensity of physiological arousal. Additionally, the therapist should introduce new relaxation strategies that the youth may not currently use, such as focused breathing, progressive muscle relaxation, visualization, using the five senses, guided imagery, etc., helping the youth to tailor these to their individual interests, cultures, and comfort zones. It is important that youth have a range of relaxation strategies for using in different settings, and that they feel comfortable using these in response to trauma reminders as well as in usual situations. Therapists often find that youth with parental substance use can be very creative in using relaxation strategies, even in challenging or difficult situations. For example, one youth who enjoyed using different smells to relax in combination with using focused breathing, had to testify in court related to whether she would return to her mother's custody. This was very stressful as she did not trust her mother to remain abstinent. She came up with the idea of spraying her favorite scent on her sweatshirt and used this scent to prompt her to use focused breathing while she was testifying in court (she pulled the sweatshirt up close to her nose at times, which was very soothing and relaxing for her). This allowed her to successfully testify despite the trauma reminder of having to recount traumatic episodes related to her mother's substance use during her testimony.

It is often helpful to teach the youth to rate their level of body tension, for example, on a scale of 1-10, with 1= no tension (totally relaxed) and 10=completely tense. It may also help to have the youth draw an outline of their own body (or provide a body outline drawing) to document where in their body they feel tension. The therapist should encourage the youth to rate and record their level of relaxation (or "chilling out") before and after using their chosen strategies daily and in response to trauma reminders; and to bring these ratings into therapy each week so that the therapist can tweak these strategies if necessary (e.g., review whether these are working sufficiently to decrease body tension, and if not, to help the youth identify additional strategies in this regard and encourage the youth to use these daily and in response to trauma reminders until they are successful in reducing the youth's ratings of body tension). If needed, the therapist should help the youth to identify additional specific strategies to use for physiological relaxation, and demonstrate some that may be particularly useful, such as focused (belly) breathing, progressive muscle relaxation, visualization and guided imagery, depending on the youth's developmental level and interests. In order to help the youth identify additional relaxation strategies, the therapist may use a resource such as Dealing with Trauma: A TF-CBT Workbook for Teens (p 14) (https://tfcbt.org/wp-content/uploads/2023/11/Dealing-with-Trauma-TF-CBTWorkbook-for-Teens .pdf).

As noted above, youth with parental substance use have often grown up with adults who routinely use alcohol and/or marijuana for relaxation. If the youth's substance use is significant, they should receive Risk Reduction through Family Therapy (RRFT) as noted earlier, as this model provides very structured interventions to address both substance use and trauma. If RRFT is not available, TF-CBT therapists may choose to address less severe substance use within the framework of TF-CBT combined with RRFT techniques for substance use described here. Since substance use has been modeled as normative, many of these youth use alcohol or marijuana to self-soothe and react negatively when adults object or discipline them for this behavior. It is important for the therapist to both explore alternative relaxation strategies as described above, and also to explain why using drugs or alcohol for tension relief (or other purposes) can entail greater risk for the youth, i.e., due to the youth's higher biological/genetic risk for developing a substance use disorder, drug or alcohol use can more easily lead to over use, abuse and dependence than for other youth. Therapists may be challenged to strike an appropriate balance between encouraging youth to use alternative relaxation strategies while discontinuing the use of marijuana or alcohol, without rigidly condemning and insisting on the immediate cessation of their use. Although such a stance may be consistent with the therapist's and caregiver's beliefs, when done authoritatively and precipitously (e.g., before the youth has had the opportunity to develop alternative coping skills), the youth will almost certainly become highly dysregulated and develop significantly more physiological, emotional and/or behavioral difficulties. Instead, it would likely be more useful for the therapist to use a risk mitigation approach that also prioritizes substance use reduction.

We gratefully acknowledge Carla Danielson, Ph.D., for generously sharing the following RRFT strategies. The therapist needs an accurate understanding of the factors that are maintaining

the youth's substance use and interfering with the youth's ability to achieve abstinence. These may include 1) the youth's lack of effective coping skills (address through providing and practicing PRAC skills—as the youth learns alternative ways to self-soothe and sees that these can be effective, they will be more willing to reduce substance use, so it is critical to implement and have the youth regularly practice effective relaxation and other PRAC skills ASAP); 2) access to substances (address through removing substances in the home—including alcohol, cigarettes, etc., which caregivers may themselves use); 3) low caregiver monitoring (address through teaching caregivers better skills for monitoring substance use); and 4) the youth's poor substance refusal skills, i.e., this is what they do with their peers, they don't have non-using peers, etc. (address by modeling and practicing substance refusal skills and identifying activities and peers that do not involve substance use). It is also important for the therapist and caregiver to develop empathy by recognizing that it is very difficult even for adults with strong motivation to immediately change their behaviors without ever having a slipup (for example, trying to lose weight or quit smoking); so youth will likely have slips along the way also. Additional specific skills and strategies may also be incorporated from the RRFT model as the therapist deems appropriate.

Caregiver considerations

The therapist should share with the caregiver the relaxation strategies that the youth is using, including the daily rating scale and the therapist's instructions to the youth to practice these strategies for at least 15-20 minutes daily and with trauma reminders; to rate the youth's level of body tension before and after using the strategies on the 1-10 scale; and to bring these ratings to weekly therapy sessions. The therapist should encourage the caregiver to support the youth in using these strategies regularly, including when trauma reminders occur (the therapist may need to review with the caregiver what the youth's individual trauma reminders are and how these may manifest in the youth's daily life, and role play with the caregiver the best ways to support the youth in using relaxation strategies when these occur). The caregiver is encouraged to practice and model the use of relaxation skills for their child as well.

AFFECTIVE MODULATION

Goals: The goals of affect modulation are to provide the youth with vocabulary to describe the full range of affective states, and to provide individualized skills to the youth and parent to modulate negative affective states.

Implementation: The therapist typically provides the youth with affective expression skills through games or activities. The therapist also demonstrates and practices with the caregiver, a variety of affective modulation skills tailored for the youth's developmental level and preferences. These may include positive imagery, visualization, mindfulness for teens, ongoing self-monitoring of feelings (rating on thermometer), distraction skills (e.g., activities, social interactions, reading/puzzles, intentionally changing mood via humor, watching funny movie, etc., positive sensations), social support, improving the youth's ability to read/understand others' affective state (e.g., accurately reading facial expressions), physical activities and others. The therapist also encourages the youth to use these skills in response to trauma reminders. The therapist meets individually with the caregiver to teach the caregiver these skills and encourage them to support the youth in practicing these skills daily, including in response to trauma reminders. Caregivers are also encouraged to model and support the practicing of affective expression and regulation activities individually and together.

Considerations for youth with parental substance use:

Youth with parental substance use have often experienced unstable, unpredictable parental affective states, as well as lack of validation or support for their own affective responses. Perhaps as a survival strategy many of these youth have prioritized responding to their parents' affective states over their own emotional needs. It is thus particularly important for the TF-CBT therapist working with these youth to provide skills for them to 1) accurately identify their own, their caregiver's, and others' affective states, including creating a space for the youth to express their often ambivalent feelings about their parent's substance use; 2) obtain compassion and validation for their own feelings; and 3) develop personalized strategies for managing negative affective states, including in response to their personal trauma reminders (which often include invalidation of feelings by parents or other important attachment figures).

Typical TF-CBT strategies for feeling identification, expression and management are usually sufficient for youth with parental substance use. These include Emotional Bingo, feeling brainstorm (having the youth write down as many feelings as they can in 1-2 minutes, then describe different situations when they feel those emotions and with what intensity on a scale of 1-10); or drawing the outline of a human or gingerbread figure, and drawing where they feel different emotions, using different colors for different feelings, including the concept of mixed/blended feelings using blended colors (e.g., if red=mad and blue=sad, purple= feeling mad+ sad at the same time). Through any of these strategies, the therapist can validate the youth's feelings in a wide range of situations, including scenarios in which the youth experienced parental substance use (e.g., "I think I would feel like that in that type of situation, and probably

many other people would too.") The therapist should then tailor affective modulation strategies to help the youth manage negative emotional states, including to their personal trauma reminders.

A recent meta-analysis study documented that for youth with anger, the most effective strategies for decreasing anger are those that focus on decreasing affective and physiological arousal (e.g., focused breathing, progressive muscle relaxation, mindfulness meditation, yoga, cognitive-focused interventions), rather than those that increase physical arousal (e.g., physical exercise, running, yelling to "burn off" aggression, etc.) (Kjaervik & Bushman, 2024). Thus, therapists should focus on the former types of affective strategies for youth who struggle with angry affective responses.

For example, a teen who had intermittent angry outbursts with his aunt (current guardian) had worked with his therapist to develop a variety of relaxation and affective modulation strategies focused on "turning down the volume" of his anger as described above, including progressive muscle relaxation, focused breathing, listening to music, talking to a friend, and mindfulness strategies. However, when he had occasional outbursts, he became extremely infuriated when his aunt responded by yelling, "You can't act this way in my home, you need to stop doing that or leave!" When the therapist explored this with the teenager, he was able to verbalize that his mother (a heroin addict) had been physically abusive to him and eventually abandoned him, as had several other relatives and foster parents who had also been physically and sexually abusive. The current home was the first in which he felt safe and the aunt threatening to make him leave reminded him of all the prior abandonments by caregivers. Communicating this to the aunt helped her to understand that, although his behavior was problematic, her response to him (although understandable in the moment), by serving as a trauma reminder, escalated rather than calmed his affective dysregulation and worsened his behavior. She was able to apologize to him and tell him that she was committed to them being a family, and to working together to help him feel secure and safe in their home and to manage his angry outbursts. He, in turn, was able to apologize to the aunt and say that he needed to know that he would not be kicked out for making mistakes(s). The aunt reassured him in this regard. The therapist suggested that they have daily feelings check-ins (in the evening, each would communicate their feelings and rate them on a 1-10 scale, giving the other time to discuss these feelings, if desired). Both the teenager and his aunt experienced this as very helpful in terms of being able to express positive and negative feelings in a helpful way to each other, instead of having to "guess how each other are feeling", having more open communication about any issues that came up, and not inadvertently triggering the teenager's trauma reminders. The youth's behavior improved significantly thereafter.

Considerations for youth with traumatic separation:

As described above, youth with parental substance use and traumatic separation from parents and/or siblings often need to cope with ongoing uncertainty and ambiguity. This can challenge the youth's attempts to modulate negative emotions and gain affective regulation. It is not

uncommon for parents with substance use issues (whether intentionally or not) to undermine the current caregiver's attempts to provide a stable and predictable home for the youth (e.g., by promising to regain custody soon, telling the youth they don't have to follow the current caregiver's rules, etc.). Other actions by the parent with substance use (e.g., not attending scheduled visits or calling when promised; relapsing after a period of abstinence, etc.) can also significantly contribute to affective dysregulation in youth with traumatic separation. In these situations, it is important for the therapist to 1) encourage the youth to acknowledge their feelings associated with the substance using parent's actions, recognizing that there are often mixed or ambivalent feelings in this regard (for example, anger, worry, fear, etc. that the parent did not arrive as promised, but also love and happiness that the parent cared enough to make the promise in the first place); 2) acknowledge the challenges, uncertainty and confusion (e.g., feelings of split loyalties, competing emotions, etc.) that are often inherent for youth in situations of traumatic separation from the parent with substance use 3) explore coping strategies that the youth can use to effectively manage these negative emotions when they occur; and 4) obtain the youth's agreement to discuss these strategies with the current caregiver, and after having shared this information during individual time with the caregiver, if clinically appropriate, consider a brief conjoint session to address this issue together with the youth and current caregiver (to assure the youth that the caregiver understands and supports the youth in this regard).

Considerations for youth with traumatic grief:

As noted above, youth with traumatic grief related to parental substance use may have multiple negative emotions (e.g., anger, fear, shame, etc.) in response to reminders of the parent's death. The therapist should help the youth and caregiver understand these through Psychoeducation about childhood traumatic grief (as described in Psychoeducation and Parenting Skills, respectively above), in preparation for developing effective affective modulation skills for these responses. The therapist should encourage the youth to 1) describe their personal reminders (including trauma, loss, and change reminders) and their emotions.

ln responses to these reminders, recognizing that the youth may have mixed emotions in response to a specific reminder (for example, seeing a picture of the deceased parent may lead to feelings of sadness that they are gone, anger that the parent used drugs and died of an overdose; and love for the parent and all the good memories they have of the parent); 2) identify a "toolbox" of coping strategies for managing negative emotional responses to specific reminders that the youth has in different situations (for example, talking to the current caregiver—the mother's sister—when feeling sad about the loss of the mother; journaling, using relaxation breathing skills or reading a book when feeling angry about mother's substance abuse) and rating on a scale of 1-10 how these work in different settings, then tweaking them if they are not successful; and 3) obtain the youth's agreement to share these with the current caregiver in order to optimize the caregiver's understanding of the youth's responses and support for their coping strategies. If appropriate after sharing these in an individual caregiver session, the therapist may

have a brief conjoint session with the youth and caregiver to discuss these strategies together with both, and to demonstrate to the youth that the caregiver understands their responses and wants to better support them in coping with these.

Caregiver considerations:

It is often important to provide the caregiver with specific strategies to improve their own and the youth's affective modulation. Caregivers themselves may have had poor role models for coping if the substance use issues were intergenerational. Thus, it is important to support and motivate the caregiver to examine and strengthen their own coping strategies to enhance their ability to serve as a healthy coping role model for their child. Caregivers may need to personally model healthy affective modulation even in the face of youth affective dysregulation. This is extremely challenging, so demonstrating and practicing this with caregivers during therapy can be extremely valuable. For example, the therapist can model reflective listening paired with a relaxation strategy (e.g., focused breathing) to help a youth regain affective regulation. The therapist might suggest that the caregiver take the role of the youth when the youth is dysregulated (e.g., angry, sad, frustrated, etc.), and the therapist take the role of the caregiver. The therapist instructs the caregiver to act like the youth would act in that situation (e.g., "be as angry, frustrated, obnoxious, etc., as your child would typically be in that situation, I want to see exactly what you might have to deal with so that I can show you how you might try to respond in this type of situation to help your child to calm themselves and re-regulate themselves with your help"). The caregiver would then take the role of the youth, and the therapist would model reflective listening, accurately validating the youth's feelings without trying to solve the problem, but merely reflecting calmly, maintaining personal affective regulation to model that this is possible even in the face of one's child's affective dysregulation. After 3-4 minutes, the therapist can end this exercise and ask the caregiver their perspective. Most caregivers will say that their child would not find that type of response very satisfying "because it didn't solve the problem" (of the youth's dysregulated affect). An important step is helping the caregiver to understand that they cannot solve this problem, and that this is a skill that the youth must gain for themselves. The therapist then switches roles with the caregiver, with the caregiver practicing providing reflective listening while the therapist takes the role of the youth. If necessary, the therapist should tweak the caregiver's responses during this roleplay so that the caregiver learns how to provide effective reflective listening responses. Afterwards, the therapist should ask the caregiver how this felt. Many caregivers will have mixed responses, e.g., "I wanted to solve the problem, but I also felt free, like I could just listen without having to fix everything."

COGNITIVE PROCESSING

Goals: The goals of TF-CBT cognitive coping skills are to help youth and parents gain mastery in understanding connections among their thoughts, feelings and behaviors; and to gain mastery in replacing inaccurate or unhelpful cognitions related to everyday (i.e., non-traumatic) situations.

Implementation: The TF-CBT therapist assists the youth and caregiver in considering whether their everyday thoughts are accurate and helpful and, if not, in developing skills to replace inaccurate or unhelpful thoughts with more accurate or helpful thoughts to feel and act more positively. Certain cognitive styles are associated with higher risk for mental health problems (e.g. individuals who have overly pervasive, permanent, and personalized cognitions are at elevated risk for developing depressive symptoms). The therapist typically introduces the cognitive triangle (connections among thoughts, feelings, and behaviors) in relation to common scenarios from the youth's daily life that generate negative emotions (e.g., "Your foster mother yells at you for not coming home last night—what do you think, how do you feel, how do you act?"), and through this process, helps the youth to explore whether their thoughts are accurate or helpful (e.g., "I think she'll kick me out eventually, I lose everyone so it's not worth caring about anyone—I feel hopeless so I stayed out and smoked dope."). The therapist then assists the youth in developing more helpful, accurate and/or balanced thoughts (e.g., "Maybe your foster mom was really worried that something bad had happened to you, how would you react then?"), thereby developing more positive feelings ("I'd think 'maybe she cares about me' and maybe feel less hopeless") and behaviors in the situation (e.g. "Come home by curfew; not use dope; tell my foster mom I won't break curfew again"). The therapist encourages the youth to practice this skill regularly and to track how it works. The therapist also introduces and practices these cognitive coping strategies with the parent.

Gradual Exposure (GE) is used only with the caregiver in this component, by starting to explore the caregiver's maladaptive cognitions related to the youth's trauma experiences. GE is NOT used with the youth in this component, because it is more beneficial for youth to engage in trauma narration before attempting to cognitively process trauma-specific maladaptive cognitions. The process of trauma narration facilitates youth in correcting their maladaptive trauma-related cognitions by helping the youth to better clarify and organize their traumatic experiences. Resources for typical implementation for younger children include using the TF-CBT Triangle of Life app (available at Apple Store or Google Play); teen resources include the What are You Thinking Team (Kliethermes, 2009) and Thought Tracker (available at https://www.tfcbt.org/resources).

Considerations for youth with parental substance use:

As noted above, during this component, the therapist **does not** attempt to process the youth's parental substance use- specific or trauma-specific maladaptive cognitions, but rather, only introduces and practices cognitive coping related to everyday events—that is, the connections between thoughts, feelings, and behaviors, and how by examining and changing negative,

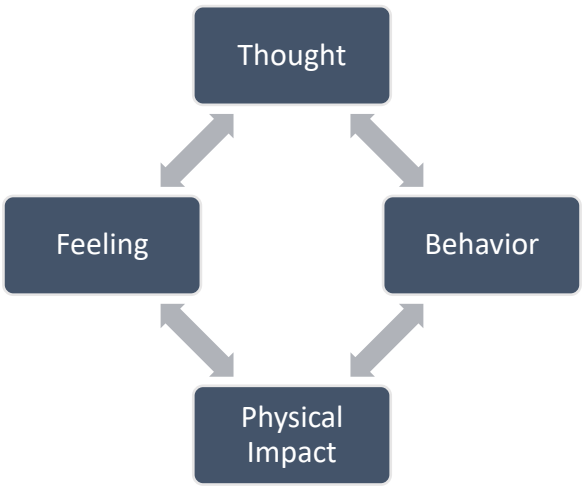
inaccurate, unhelpful or unbalanced thoughts, the youth can modify negative feelings and behaviors related to everyday experiences. Specific maladaptive cognitions related to trauma experiences should instead be identified and processed during the next TF-CBT component, Trauma Narration and Processing. By understanding and practicing cognitive coping during the current component, youth become more prepared to apply these strategies during Trauma Narration and Processing with more challenging negative cognitions related to their trauma experiences and parental substance use.

It is easier for some youth with parental substance use to begin cognitive processing using a comic strip or other "third person" strategy, i.e., the therapist initially starts this process by asking the youth to identify thoughts, feelings and behaviors of another character rather than the youth's own responses in relation to their personal experiences. This both gives the youth some initial distance from the process and allows them to gain some practice in identifying these responses before applying them to their personal experience. Once the youth can accurately identify thoughts, feelings and behaviors of comic characters in different scenarios, the therapist introduces daily situations that the youth may have encountered during the past week in their own life, and asks the youth to identify their personal thoughts, feelings and behaviors in response to these situations. It is helpful to start with a lower intensity situation first and then move to more challenging (upsetting) situations; however, as described above, the therapist should not attempt to address trauma-specific situations with the youth during this component, as these should not be addressed until the next (Trauma Narration and Processing) component.

Since youth with parental substance use (like other youth who have experienced multiple, ongoing and/or complex traumas) often have difficulty with physical regulation, it may be helpful to include a 4th dimension to cognitive processing, i.e., physical or physiological impacts, thus creating a "cognitive diamond", illustrated in Figure 3 below (Deblinger, et al., 2015). As with the cognitive triangle, the therapist should help the youth (and caregiver) recognize that the connections among thoughts, feelings, behaviors, and physical impacts are all bidirectional, and thus, changing any of the factors in the diamond can positively (or negatively) change the other factors in the diamond.

Figure 3: The Cognitive Diamond

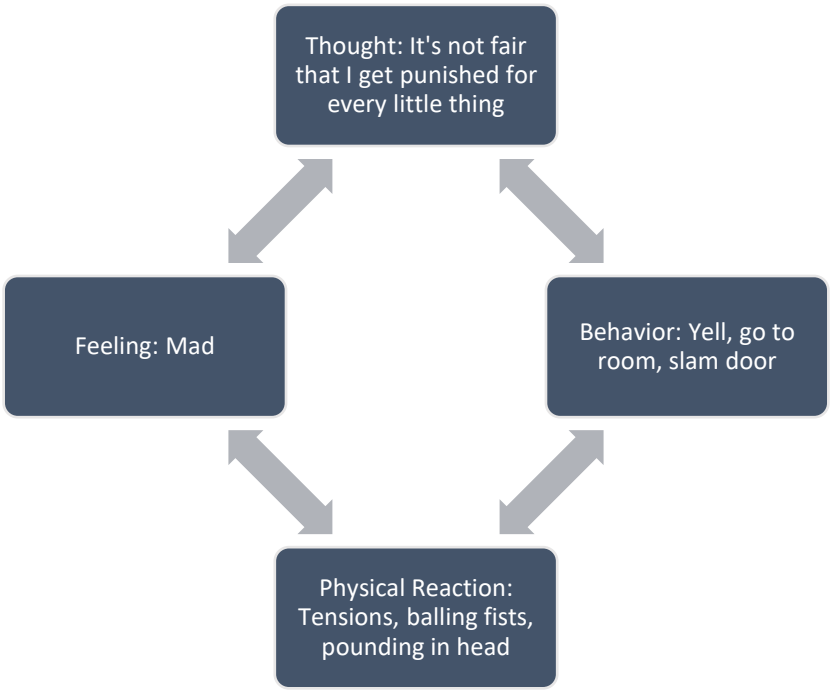
Situation



The therapist may start this component by asking the youth for a time during the past week when they had a negative emotion (e.g., anger, sadness, etc.). For example, in response to this question, a youth identified that "I was mad when my foster mom punished me". The therapist then asked the youth what he was thinking at that time (e.g., "It's not fair that I get punished for every stupid little thing. Other kids don't get punished for doing even worse things."). The therapist then asked the youth what his behavior was in that situation (e.g., "I yelled at her, went to my room, and slammed the door.") He received additional punishment for this behavior. The therapist also asked how the youth experienced this physically (muscle tension, balling up his fists, head pounding). The therapist started (as always with cognitive processing) by validating the youth's thoughts, feelings and body reactions in the situation, expressing understanding for these reactions in the moment and situation, while also expressing curiosity about whether there might be other alternatives. The therapist then diagramed the youth's new response using the cognitive diamond of the situation with related thoughts, feelings, and behaviors as shown in Figure 4.

Figure 4: Youth's Cognitive Diamond

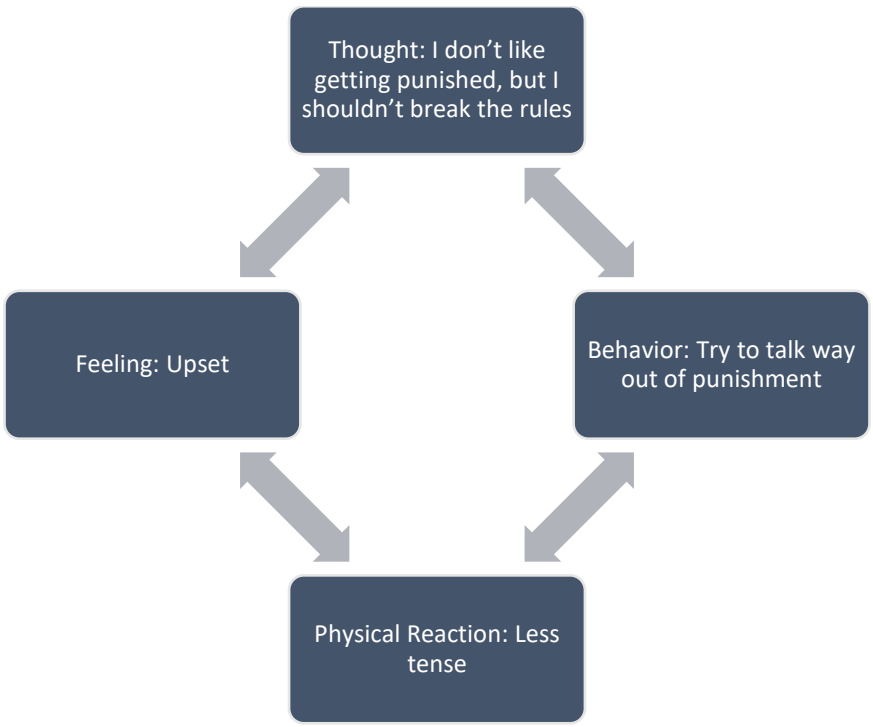
Situation: My foster mom punished me



The therapist then explored with the youth whether his thoughts and associated feelings and behaviors were accurate, helpful, and/or balanced. In terms of his thought being accurate, he said that it was true that some of his peers did not get punished for worse behavior, but some of them got punished for similar things, so his thought was not entirely true or untrue. When considering whether it was a helpful thought, the therapist asked further whether thinking this way made him feel better or got him what he wanted, and he said that it did neither. The therapist explained the idea of balanced thoughts as thinking about a seesaw: thoughts that are tilted all on one side or the other of a situation tilt the seesaw off balance, whereas those that consider both sides of a problem or situation, keep the seesaw balanced so it does not tilt all to one side. In thinking about this, the youth said that his thought was not well-balanced because it only considered his side of the situation and not his foster mom's. The therapist asked how to make his thought more balanced. After some consideration, he said, "I don't like getting punished for every little thing, but I guess I shouldn't break the rules." The therapist agreed that this was a more balanced thought and asked him how he might feel if he had been telling himself this during that situation with his foster mom. He said, "Bad, but like I did something stupid and hoping I could talk my way out of it." The therapist then clarified that his feelings might be upset (because he knows he did something stupid and will likely be punished) and his behavior was to try to talk his way out of punishment, rather than being angry and yelling. In looking at this alternative

triangle, he was able to see that the more balanced thought would have helped him to avoid additional punishment and may also have felt better in terms of his relationship with his foster mom. When asked how his body might have responded to this thought, he said, “maybe I would have felt less tense, less like hitting something.” The therapist and youth drew the new cognitive diamond as illustrated in Figure 5:

Figure 5: Youth’s New Cognitive Diamond



The concept of balanced thinking is also particularly helpful for youth with complex PTSD. Using the example described earlier in Affective Modulation, the youth whose thought was “I always need to be strong and can never trust anyone” said that his feelings related to these thoughts were “safe, and sometimes lonely and sad”, and his behaviors were “fight with people who mess with me; sometimes I push people away who try to get close to me.” While more specific processing of the youth’s thoughts would likely wait until Trauma Narration and Processing (during which the youth would process these in the context of his traumatic experiences in relation to the parental substance use), the therapist could start to examine some potentially more balanced thoughts during this component. For example, in demonstrating the concept of balanced thinking, the therapist might ask the youth for the “opposite” thought to “I always need to be strong”. The youth might suggest a thought such as “I never need to be strong” or “I can never be strong”. The therapist can then draw a seesaw, write these two thoughts on the opposite sides of the seesaw, and then say something like, “Either of these thoughts is kind of

extreme, and having either of them all the time leads to someone being unbalanced, like the seesaw is tipped all the way to one end. What is a way of thinking that could be more balanced? For example, "It's important to be strong a lot of the time AND…how might you finish this thought so that it would be balanced?" The therapist would then encourage the youth to come up with a balanced thought, for example, "AND it's okay to trust someone a little sometimes." The therapist could also develop cognitive triangles (or diamonds) with this youth for each of these alternative thoughts, helping the youth to identify both some potential benefits, but also some costs of each way of thinking.

Caregiver considerations:

Unlike the youth, the caregiver may begin to cognitively process some aspects of the youth's trauma and parental substance use-related experiences during this component. During Psychoeducation and Parenting components, the therapist should have provided accurate information to the caregiver about the youth's trauma experiences and the parental substance use (to the degree that such information is available, and the youth has agreed to share it with the caregiver). The therapist should also have started to identify some of the caregiver's maladaptive cognitions about the youth's trauma experiences and/or parental substance use, if these are present. Often caregivers express such cognitions during early sessions and the therapist may have already begun to use cognitive coping strategies to address some of these during earlier components (e.g., during Parenting Skills if the caregiver has very negative beliefs about the parent with substance use and expresses these to the youth in a way that interferes with positive parenting). This would be entirely appropriate to do with caregivers as needed.

Therapists should introduce general cognitive coping skills to the caregiver in a parallel way as described above (i.e., use general, non-trauma-focused situations to help the caregiver to identify a thought with associated feelings and behaviors, and then identify a more accurate, helpful and/or balanced thought in that situation with associated feelings and behaviors that might better help the caregiver in that situation). After the caregiver has been able to use general cognitive coping strategies in several situations, the therapist can move on to one of the caregiver's maladaptive cognitions related to the youth's trauma or parental substance use experiences and assist the caregiver in applying the same strategies to this maladaptive cognition. A variety of other strategies can also be used in this regard, as described in more detail elsewhere (Cohen & Mannarino, 2017).

For example, a caregiver was repeatedly being undermined by the parent with substance use, who repeatedly made and broke promises to the youth, did not appear reliably for visits, but told the youth that she did not have to follow the rules at the caregiver's home because the birth mother was going to get custody back soon. This caregiver thought to herself that the birth mother "does not care one bit about her child". When she thought this, it made her furious, and at times she felt so angry at the child's loyalty to her mother that she said directly to the child, "Your mother doesn't deserve your love, she doesn't love you back" This resulted in the child crying and hitting the caregiver. The therapist started by validating that the caregiver was in a

very difficult and painful situation and praising the caregiver for her ongoing care for and commitment to the youth. The therapist then diagramed this situation using the cognitive triangle and asked the caregiver for her own appraisal of whether her thought in this situation was accurate, helpful and/or balanced. The caregiver said, “It may have been accurate, but it definitely didn’t help, it hurt my little girl and that was the opposite of what I wanted to do.” The caregiver said that she let her anger and frustration get away with her in the moment and she deeply regretted her behavior. The therapist suggested that negative thinking could contribute to negative feelings, whereas more helpful or balanced thinking could strengthen more positive feelings and actions. She encouraged the caregiver to consider alternative beliefs about the youth’s mother, that she could truly believe and convey to the child. The therapist asked whether the caregiver truly believed that the birth mother cared nothing for her child. The caregiver at first said that she had doubts, but then said that if that were the case, the birth mother could have just given up her parental rights, but she hadn’t done that. In fact, she kept going through treatment and parenting classes, only to go back to using heroin again. During this conversation, the caregiver said, “I guess she has been trying to overcome this for a long time. If she didn’t care about her child, why would she keep going back to treatment time and time again?” Through this discussion, the caregiver came to realize that she had been so angry at mother’s failures that she had never given her any grace for continuing to try to get her child back. When the therapist asked her what a more helpful or balanced thought might be in this situation, the caregiver said, “She must love her child and is trying her best to overcome her demons.” When asked how that makes her feel, she said, “Sorry and sad”. When the therapist asked how this thought and feeling might make her act, she said, “I’ll try to be more patient and understanding and tell (child) that her mother loves her and is doing her best.”

There are many common cognitive distortions that caregivers may have when they are caring for a child whose biological parent has had severe and/or ongoing substance use problems. Some caregivers may feel frustrated, angry or helpless at times when the child is misbehaving or exhibiting emotional dysregulation. It is helpful to encourage caregivers to track their thoughts, feelings, and behaviors during these times between sessions using automatic thought records. When doing so the therapist may see patterns in the caregivers thinking such as “this child is just like her parent and is going to have substance use problems as well.” Socratic questions that may be helpful in challenging such thoughts might include, “what are you doing to reduce this child’s risk of developing substance use problems; what evidence do you have that this child is more aware than most children of the dangers of using drugs and alcohol; what activities do you encourage your child to engage in that will reduce her likelihood of engaging with peers who are using substances?” Other common caregiver dysfunctional thought patterns may include thoughts like, “she idolizes her mother and doesn’t appreciate all I have done to help her; my child takes me for granted.” These caregiver thoughts may be challenged with Socratic questions that include “why do you think children may have a desire to be loved by a biological parent even when they have never met them as might be the case of children who have been adopted? What evidence is there that your child does appreciate some of what you do and wants a relationship

with you?" It is important only to ask Socratic questions for which you believe you have some evidence of helpful responses. In addition, it can be helpful to address distressing caregiver thoughts like these by encouraging brief conjoint sessions during which caregivers and youth exchange specific and global praise (Deblinger, et al., 2017).

TRAUMA NARRATION AND PROCESSING

Goals: The Trauma Narration and Processing Component of TF-CBT consists of describing incrementally more details about the youth's trauma experiences ("speaking the unspeakable") and cognitively processing these to address inaccurate, unhelpful and/or unbalanced beliefs and to contextualize the youth's experience ("making new meaning"). An additional key goal of this component is for the therapist to individually share the youth's narration with the caregiver to prepare the caregiver to support and affirm the youth in sharing their trauma experiences with them in subsequent conjoint youth-caregiver sessions.

Implementation: TF-CBT trauma narration and processing is a guided, interactive process of sharing personal trauma experiences with the therapist in a highly supportive and carefully calibrated process; cognitively processing these traumatic experiences; and the therapist sharing the narration and processing with a caregiver or other supportive adult during individual sessions, in preparation for upcoming conjoint youth-parent sessions. Development of a written "Trauma Narrative" or "Life Story" is a common method employed, and often a highly effective tool for achieving the goals of this component, but it is not essential that a written narrative is developed. The interactive process is more important than developing a specific tangible product, and the youth may choose to develop an alternative product to a written trauma narrative, (e.g., a poem, song, comic strip, play list, etc.) to express the details of their trauma experiences and to cognitively process these. The critical features are that this be 1) a tangible product that the therapist can keep, review and add to with the patient at subsequent sessions; and 2) a product that the therapist is able to be reviewed at subsequent sessions for the purposes of GE, adding to, and for cognitive processing of maladaptive cognitions, and share with the caregiver when clinically appropriate. The following description of this component focuses on developing a written trauma narration, as this is the most common option that youth choose.

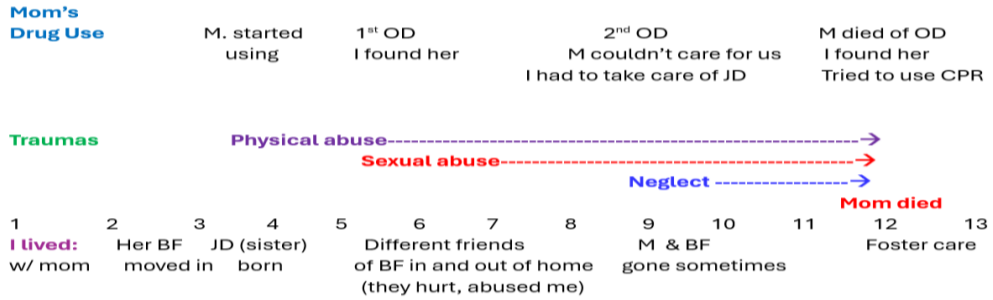
Recent research papers provide useful resources for therapists who are implementing this component. Deblinger et al (2006) and Dittmann & Jensen (2014) have documented that youth participating in TF-CBT often report that the trauma narration and processing component, while difficult, was the most helpful TF-CBT component. These youth have also reported that this component was made easier by having an empathic and supportive therapist. Eastwood et al (2021) documented similar findings among transitional age youth. This research confirms earlier results from the TF-CBT developers that more than 85% of youth involved in TF-CBT studies stated that the trauma narration was the best part of the treatment. These results should encourage therapists who are concerned about the difficulty of implementing this component to keep moving forward. Another study (Yasinski et al, 2016) showed that caregiver avoidance early in treatment predicted a worsening of the child's externalizing symptoms during follow-up. On the other hand, during the trauma narration and processing component, the caregiver's processing of their own and youth's trauma reactions during TF-CBT treatment predicted significant decreases in youth internalized and externalized symptoms, and that caregiver

support predicted lower internalized youth symptoms. Conversely, caregiver avoidance and blaming the youth during this component predicted worse youth internalizing and externalizing symptoms at follow-up. This emphasizes the importance of helping caregivers overcome their own avoidance and blame early in treatment and the value of involving caregivers specifically in their own trauma processing to help them reflect on and process their own thoughts and feelings about parental substance abuse as well as the youth's trauma experiences and reactions.

Considerations for youth with parental substance use:

As noted earlier, parental substance use is not itself a trauma, but places youth at risk for experiencing many (and often multiple and complex) traumatic experiences. It is helpful when starting trauma narration and processing, to **develop a life timeline for the youth.** The timeline should incorporate a) different places/people the youth has lived with from birth to the present time; b) different aspects of the parental substance use; and c) different types and durations of the youth's trauma experiences (including child maltreatment, traumatic separations and/or traumatic deaths). The therapist may guide the youth in using a unique color and/or line on the timeline to denote the parent's substance use, another for changes in the youth's living/placement situation, and a third line to designate the youth's specific traumas. In each case, the line should indicate the duration of specific parental substance use periods, placements, and trauma experiences, respectively. The therapist and youth can then use the timeline to make clearer connections between the parent's substance use and their trauma experiences and responses (and to design a "table of contents" for the youth's trauma narrative). Often these connections become more apparent during the trauma narration process itself. An example of a youth timeline is provided in Figure 6.

Figure 6: Example of Youth's Timeline for Trauma Narration and Processing



For youth with parental substance use, it is usually helpful to include at least one (and sometimes more than one) trauma narrative sections or "chapters" specifically related to the parental

substance use. For example, the youth whose timeline is illustrated above chose to include two chapters specific to her mother's substance use: "Drugs" and "The Worst Day". The latter chapter included her mother's prior non-fatal overdoses as well as details about the day when she found her mother dead of a fatal overdose. In the "Drugs" chapter, she included information about when and how her mother started using drugs (boyfriend moved in and introduced her to drugs), mother's worsening drug use, how this impacted her mother's caretaking (she became less able to take care of her children), and that this was connected to the neglect and abuse the youth subsequently experienced (boyfriend and his drug-using friends were in the home and abused her). This then segued into chapters that detailed the youth's abusive experiences.

Therapists may find it very helpful to use computer applications to assist some youth in creating their trauma narrations, whether providing TF-CBT in person or virtually. These may include drawing applications (e.g., Microsoft Paint), or applications that allow youth to create cartoons with their own characters, backgrounds, and dialogue (e.g., Pixton, www.pixton.com, available in free and paid versions). Many other creative activities for engaging youth in developing trauma narrations have been described elsewhere (e.g., Cohen et al, 2017), and these are often helpful to use with youth with parental substance use. However, therapists must use their clinical judgement in determining the appropriateness of the creative use of the internet with clients. Clinical caution should be exercised when considering any use of computers, computer applications, social media and the internet for this component given the confidential nature of the therapeutic relationship and the potential for material being shared inappropriately.

Youth with parental substance use often have developed maladaptive beliefs about their parent's substance use. These are often related to self-blame for some aspects of the parental substance use (e.g., not stopping or controlling the parent from substance use; having reported the substance use or child maltreatment that led to family separation; not being present in time to prevent a parental drug overdose, etc.) Often, the parent blamed the youth for these situations so the youth is just repeating these accusations; self-blame may also be the youth's attempt to gain some control over out-of-control situations. It is important for the therapist to identify and cognitively process these and other maladaptive cognitions that youth identify during trauma narration, whether related to parental substance use, trauma experiences, or both. Often these are interrelated—for example, "My mom picked drugs over me and all those men abused me because I am just unlovable." In some cases, when the parent was suffering from substance use, they may have said extremely cruel things to the youth—for example, "I wish I never had you, you are useless, you should die, I use drugs because I hate you so much". These types of statements can be extremely damaging to the youth's self-esteem and may result in the youth defending the parent and to varying degrees believing the parent's statements, so it is very important for the therapist to explore and help the youth cognitively process these beliefs and come to more accurate, helpful and balanced views of the parent, themselves, and their relationship.

During cognitive processing for youth with parental substance use, it may be particularly helpful to identify **generalized** maladaptive thinking strategies that the youth has developed over time to cope with the parental substance use and/or complex PTSD. It is important for the therapist to recognize (and to acknowledge to the youth and the caregiver) that these strategies may indeed have served some adaptive purposes in the past when the youth needed to cope with the parent's substance use—that these strategies may have been necessary to keep the youth safe or even alive during some past period. For example, all or nothing thinking ("I always have to be strong and can never trust anyone") may have helped the youth to survive extremely challenging or even dangerous circumstances when the parent was deeply involved in substance use behaviors and not available to protect the youth and their younger siblings. However, now that the youth is living in a safe, predictable home with protective caregivers, this thinking pattern likely does not serve the youth as well. Instead, it is likely to interfere with the youth being able to develop trusting relationships with peers, current caregivers, romantic partners, or other important people. The therapist should use cognitive coping strategies to guide the youth in examining how the beliefs of always having to be strong and never being able- to trust anyone make the youth feel and behave, and while at times these may be helpful, they are also many times not helpful, and that perhaps slightly modifying these beliefs may be more helpful in their current circumstances. Youth may find **balanced cognitions (or balanced thinking)** to be useful in this regard.

As noted earlier, youth who have lived with parental substance use often develop complex PTSD, and therapists can benefit greatly from utilizing cognitive processing techniques that have been developed for these youth. Specifically, in addition to focusing on more accurate or helpful cognitions, the therapist should help the youth to develop more **balanced cognitions** related to their specific trauma experiences. Using the example above, in implementing Trauma Narration and Processing with the youth whose thought was "I always need to be strong and can never trust anyone", the therapist should explore the connection of this belief with the youth's personal trauma experiences (e.g., "When my mom was using drugs she married my stepfather who beat both of us; when she overdosed and went into rehab, I went to foster care where I was beaten and forced to work for food; then my mom died and I ran away. I learned that no one would keep you safe except you.") The therapist explored with this youth whether he had ever met anyone during his years living with his mother or in foster care, who treated him kindly, who didn't hurt him, and/or who may have tried to help him. He was able to identify two peers and two adults (a teacher and a neighbor) who met these criteria, and who he said in retrospect may have wanted to help him but that he "had an attitude, was using (drugs) and would have messed up anything then". He added these memories to his narration, and then with his therapist's encouragement, explored whether he could rebalance his thought of "I always need to be strong and can never trust anyone". He was able to revise this to "I always need to be strong and careful about trusting anyone, but there may be a few good people in the world, and I could try to give them a chance to help me." This was a major shift for this youth and allowed him to consider viewing his foster

mother as someone who might be one of these "good people" whom he could try to trust and allow to help him.

Considerations for youth with traumatic separation:

As noted above, youth with traumatic separation have often experienced multiple episodes of familial separations, not only from the parent with substance use, but also possibly from siblings and other important attachment figures. In developing the youth's timeline and the subsequent trauma narration, the therapist should incorporate each of these episodes, including information about the following aspects of the separation: a) what precipitated the separation (e.g., parental substance use; child maltreatment; something else; or does the youth not know?); b) how the youth learned that it would occur (planned vs. sudden: parent told the youth vs. CW arrived at school with belongings in garbage bag, etc.); c) whether the situation was calm vs. chaotic or violent (e.g., parent explaining that child will live with grandparents for a while so she can go to treatment vs. finding parent dead of overdose or police raid of home); d) circumstances of the separation (whom the youth was separated from, how long, where the youth lived, the youth's contact (if any) with separated family members during the separation, the youth's relationship with the new caregiver and family; and how the youth reacted, etc.).

The therapist should also explore and process any maladaptive cognitions developed and expressed during trauma narration by youth with traumatic separation related to parental substance use. Some common maladaptive cognitions in this regard are described on pp 14-15 above.

Considerations for youth with traumatic grief:

Most youth whose parent dies related to substance use have lived through substantial periods of the parent's substance use prior to the parent's death. Therefore, it is important for the therapist to assist the youth in developing a detailed timeline and trauma narration that describes the details of these experiences, as well as where and with whom the youth has lived from birth to the present, their various trauma experiences, and the interconnections among these as described above. There have often been traumatic separations from the parent with substance use and/or siblings and other important attachment figures, both before and after the parental death, which should also be incorporated into the timeline and the trauma narration. Helping the youth to understand the context of the parent's substance use is extremely important and should be included in the timeline and in the youth's trauma narration. Specific information about the parental death should include the following: a) how did the parent die (e.g., overdose, suicide, homicide, accident, other cause, uncertain?); b) how did the youth find out about the parental death and what were they told at the time and subsequently? (e.g., youth found the parent; told by caregiver; told by another adult; found out another way); c) describe the details of the day the youth found out, the youth's immediate and subsequent emotional reactions, where the youth spent the rest of the day, where the youth lived afterwards, the

funeral arrangements, etc.); and d) when and from whom the youth received support and assistance.

Cognitive processing of the parental death is often extremely important for the youth's future adjustment and development. As noted above, information that youth describe about the context of the parent's substance use during trauma narration is often critical for addressing negative cognitions. For example, a youth's father had been using narcotics for more than a decade and repeatedly refused to consider treatment. This caused the youth and his younger siblings to live in kinship care (with grandmother and aunt) for most of their lives. He had sporadic contact with his father, who occasionally "dropped in" to grandmother's house. He learned about father's fatal overdose when police came to grandmother's house with the news. He reacted by saying, "I should have been able to stop him from using." However, during cognitive processing he was able to recognize that if grandmother and aunt couldn't stop him, it wasn't likely that he would be able to and that this was more his wish than a realistic belief.

Therapists are strongly encouraged to become familiar with and to implement the TF-CBT Traumatic Grief components for youth who experience traumatic grief related to parental substance use. These components are described in detail in Cohen et al (2017), and therapists typically implement these Grief-focused components after completing the TF-CBT PRACTICE components.

Caregiver considerations:

As noted above, including the caregiver is a central tenet of TF-CBT treatment. During the Trauma Narration and Processing component, as the youth is developing and processing their trauma narration, the therapist should meet in individual parallel sessions with the youth's caregiver. During these caregiver sessions, the therapist may 1) share the youth's trauma narration with the caregiver; 2) share with the caregiver the youth's evolving cognitive processing of their narration, and as appropriate, support the caregiver to also cognitively process their personal maladaptive cognitions about the youth's trauma experiences (and/or the youth's parental substance use experiences); and 3) prepare the caregiver for the upcoming conjoint youth-caregiver sessions during which the youth will directly share their narration with the caregiver.

Most of the time, the sharing of the child's trauma narration successfully occurs in conjoint sessions during the final phase of treatment. Moreover, these sessions are often powerful sessions that assist the family in creating open parent-child communication and provide the caregiver an opportunity to become an ongoing therapeutic resource for the child. It should be noted, however, that the sharing of the trauma narration with the caregiver is not a requirement of treatment. There may be instances when the caregiver's own adjustment may be too fragile due to prior substance abuse or mental health difficulties to process the child's narration as

described above and/or engage in a conjoint session in which it is shared. It should also be noted that some youth are adamant about not sharing their trauma narration. Though sometimes children's reasons may be explored and overcome (e.g. fearing the parent will be mad at them for telling), other times the youth may be accurate in feeling that their parent may not be able to cope effectively with the details. Thus, it is preferable not to suggest that narration sharing is a standard part of treatment as this might leave the caregiver and child feeling less successful in their completion of treatment. The therapist can assess the caregiver's ability to cope with hearing the trauma narration by observing their reactions to psychoeducational material and more general information about the child's traumatic experiences shared by the therapist over the course for treatment. If the caregiver seems too reactive to such information, it may be best to share only the child's artwork, the final chapter or select chapters that the therapist and youth agree upon towards the end of therapy.

The therapist should recognize that in many cases, the caregiver does not know the extent and/or the details of the youth's trauma experiences, nor the youth's cognitions about these. For these reasons, it may be important to allow the caregiver enough time to hear, understand and process these to assist the caregiver in becoming optimally supportive of the youth prior to the conjoint sessions. This may take several sessions with the caregiver (especially in the case of youth with complex PTSD who have extensive and complicated trauma narrations for the caregiver to absorb). Thus, although many therapists prefer to wait to share the youth's narrative with the caregiver until it is almost "finished", this may not allow the caregiver to develop as much support as would have been possible had the therapist allowed this process to unfold with the caregiver over 4-6 sessions rather than during a only one or two sessions (e.g., sharing the narration with the caregiver as the youth developed it). The cons of this approach are that the caregiver will hear a more piecemeal and less complete version of the narration, including some unprocessed, more maladaptive cognitions earlier in the process. Therapists should carefully weigh these considerations when deciding when to start sharing the youth's narration with the caregiver. In either case, it is critical that the therapist have shared all the chapters from the youth's narration that will be shared with the caregiver during conjoint youth-caregiver sessions. For some youth, that will include all the chapters while for others as noted above, it may be just select chapters or even just the final chapter.

During these sessions, it is important for the therapist to identify and process caregiver maladaptive cognitions related to the youth's trauma experiences, as well as those related to the youth's parental substance use. Exploring and processing caregiver negative cognitions may help the caregiver to better understand and change negative interactions they have with the youth. These may be especially relevant for youth who have ongoing contact with a parent with substance use, as these interactions are often extremely challenging for the current caregiver. The therapist should help the caregiver to process these difficult cognitions and develop more accurate, helpful and/or balanced thoughts, feelings and behaviors for these very challenging situations. It is also very important when the current caregiver is a relative who had their own relationship with the deceased parent (e.g., was the parent, sibling or other close relative of the

deceased parent), and thus likely may be struggling with their own maladaptive cognitions and/or trauma, prolonged grief or other problematic reactions to the death. Finally, preparing caregivers for the conjoint sessions through gradual exposure and processing in individual sessions with the therapist as described above is critical, as it attenuates their emotional reactions to this material when the narration is presented in conjoint sessions.

IN VIVO MASTERY

Goals: The goals of the in vivo mastery component are to overcome avoidance in real life situations, for those youth who have developed overgeneralized fear and avoidance of innocuous situations. This component is only implemented if the situation is innocuous, i.e., safe. If the situation is not safe, the therapist does not implement this component but rather focuses on the Enhancing Safety component.

Implementation: In vivo Mastery is the only TF-CBT component that is optional, i.e., this component is only implemented for those youth who develop overgeneralized fear and avoidance of real life situations that serve as trauma reminders that are innocuous, and the avoidance of which involve significant functional impairment (for example, avoiding the use of public bathrooms; not attending school or not sleeping in one's bedroom). The therapist implements this component by educating the youth and caregiver about the value of overcoming overgeneralized avoidance of innocuous situations; collaboratively developing a fear hierarchy ("ladder") from the least feared to the most feared situations, and through graduated real life ("in vivo") exposure paired with relaxation or other coping strategies, helping the youth to master and overcome avoidance of the feared situations. Caregiver involvement and buy-in are generally essential to overcoming this type of avoidance, since caregivers have often been allowing if not enabling the youth to avoid the feared situation. Importantly, since this component typically takes several weeks to successfully complete, the therapist may begin this component during the stabilization phase (e.g., as soon as the youth has learned relaxation strategies) if avoidant behaviors are interfering with the child's functioning (e.g. not going to school). On the other hand, some avoidant behaviors that are not as problematic (e.g., avoiding the basement where the sexual abuse occurred) may naturally drop away in response to the skill building and trauma narration and processing work without developing a systematic in vivo mastery plan. Either way, most youth should complete the In vivo Mastery Component soon after completing the Trauma Narration and Processing treatment phase. Resources for implementing this component include an avoidance hierarchy (fear ladder) for developing the youth's individualized in vivo mastery plan.

Considerations for youth with parental substance use:

Many apparently innocuous situations can serve as trauma reminders for youth with parental substance use. For example, youth who return to a parent with (prior) substance use may experience overgeneralized fears of the home or neighborhood in which they previously lived, the school they attended while formerly living with that parent, peers or teachers from that situation and other specific situations. Thus, it is important for the therapist to work with the youth and the parent to identify such potential reminders, and (if appropriate), to develop an in vivo exposure plan for youth who have overgeneralized fear and avoidance of such situations, if necessary.

Youth with parental substance use often have very specific drug-related reminders that they avoid in their current living situations, although these reminders are innocuous (not dangerous), and their degree of avoidance may be interfering with their adaptive functioning. Some examples of innocuous reminders that children with parental substance use may include in their graduated hierarchy during in vivo mastery are the following (note that these are just some examples; the therapist should explore with each youth what their personal reminders are and rank these in the youth's personal hierarchy from least to most feared and avoided):

- Table salt (looks like drugs used by parents)
- White or granulated sugar (looks like drugs used by parents)
- Needles, sewing kits, scissors or other sharp objects (remind youth of needles used during drug use)
- Visits to doctor (youth may anticipate needles being present or "drugs" being prescribed)
- Loud music: specific songs or videos (may have been used during drug parties or to cover up drug transactions; drug users or perpetrators may have played or exposed youth to specific songs or videos during drug use or during maltreatment of youth)
- Nighttime, being in the dark (parent may have awakened the child during the night to take them to drug transactions; drug use may have occurred during nighttime; child maltreatment may have occurred when youth was sleeping, etc.)
- Eating brownies, gummies or other food (the parent may have fed youth food laced with marijuana)
- Pictures of the parent with substance use (or other relatives who were in the home) who did not protect the youth

As with all children who have significant avoidance of innocuous reminders, the therapist should work with the youth and caregiver to help the youth master their avoidance of each of the sequential reminders, working their way through various trauma reminders and/or up the hierarchy until the youth is able to tolerate exposure to all or most of the problematic reminders. The youth should use relaxation, cognitive coping and other PRAC skills during this process, and typically has pride in their accomplishments as they master each feared reminder.

Caregiver Considerations: Including the caregiver in the In vivo mastery process is very important, as the caregiver may also unknowingly allow the youth to avoid some of the above situations and/or encourage the youth's ongoing overdependence on the caregiver. In some situations, the caregiver may derive some benefit from the youth's ongoing avoidance; for example, if the caregiver is lonely at home all day and the youth experiences school avoidance as a trauma reaction to school bullying, the youth's school avoidance may inadvertently also lessen the caregiver's loneliness at home. (Although the caregiver rarely actively encourages the youth's ongoing avoidance for this purpose, it is sometimes referred to as "secondary gain"). Helping the caregiver to recognize the benefits of the youth mastering their fear and avoidance is an important part of this process, as the youth and caregiver move forward

towards healthier functioning.

CONJOINT CHILD-PARENT SESSIONS

Goals: The goals of conjoint youth-caregiver sessions are to a) enhance direct, supportive trauma-focused communication between the youth and caregiver, including (in most cases) facilitating the youth to directly share the trauma narration and processing with the caregiver; b) address other trauma-related issues collaboratively with the youth and caregiver (e.g., trauma-related behavior problems; sexual health; safety concerns); and c) transfer direct, supportive trauma-related communication with youth from therapist to caregiver.

Implementation: During the conjoint youth-caregiver sessions, the therapist typically facilitates the youth in directly sharing the trauma narration and processing with the caregiver. Of critical importance is that the therapist has already shared and processed the narrative with the caregiver during individual caregiver sessions, while the youth was developing it (or shortly thereafter) during the trauma narration and processing treatment phase. The therapist should never share the trauma narrative in a conjoint session until the therapist has prepared the youth and caregiver for this session. At a minimum, this requires that a) the youth knows that the conjoint session will occur; b) the therapist has previously shared and cognitively processed the youth's narrative with the caregiver; and c) the therapist has prepared the caregiver for the upcoming conjoint session. This preparation includes preparing the caregiver for how to respond to the youth's sharing the narrative, including practicing appropriately supportive caregiver responses. If the caregiver is unable or unwilling to provide sufficiently supportive responses to the youth's trauma narrative, the therapist should not proceed with sharing the youth's narrative with this caregiver during the conjoint sessions. Alternative strategies for a conjoint youth-parent session are to 1) identify an alternative adult with whom to share the trauma narration and processing (this requires the youth's assent/consent and, depending on age, the caregiver's consent; as well as several sessions of preparatory work for the alternative adult to learn about TF-CBT treatment as well as to complete the steps described above to prepare specifically for the conjoint sessions); or 2) include the caregiver in conjoint session but not share the entire trauma narration during these sessions. Alternative activities for these conjoint sessions might include a) enhancing trauma-related communication such as discussing sexual health principles; b) developing a family safety plan; c) addressing ongoing behavioral issues; and d) providing praise for each other related to work accomplished. The youth may also choose to only share the final chapter of the trauma narrative, allowing a sense of mastery and meaningful representation to be shared with the parent.

Considerations for youth with parental substance use:

As noted above, youth with parental substance use often experience multiple disruptions in placement and may go back and forth between the parent(s) with substance use and other caregivers. Thus, it is important for the therapist and youth to agree 1) which caregiver(s) the youth will share their narrative with in the conjoint session (this should be the caregiver who has been participating in TF-CBT most consistently with the youth); and 2) whether the youth will also share their narrative with the parent(s) with substance use (if this is a different

caregiver); and if so, which parts of the narrative and under what conditions (e.g., with or without the other caregiver present, etc.) (This should typically only be done if the parent with substance use is currently abstinent and has participated in some part of TF-CBT, i.e., received some PRAC skills and heard the narrative with the therapist prior to conjoint sessions. However, there may be situations in which the therapist and youth agree that it would be helpful to share parts of the youth's narrative with the parent with substance use in the absence of fulfilling these requirements). Under all circumstances, as described above, the caregiver should be prepared for the conjoint session (i.e., meet individually with the therapist to hear the part of the youth's narrative that will be shared with them during the conjoint session, have an opportunity to process the narrative, and ask questions), prior to the conjoint session occurring.

In preparing a parent with substance use for a conjoint session, it is particularly important to explain the purpose of trauma narration, i.e., that it is to help youth "speak the unspeakable" about their traumatic experiences, even when these include painful and difficult memories; and to make more helpful and accurate meaning of these experiences. Assuring from the outset that the parent understands that the purpose is not to demonize, blame or shame anyone, but rather to help the youth to recover from the impact of trauma, is often critical for gaining the parent's trust and engagement to the process. Despite this, it may be extremely painful and difficult for a parent with substance use to hear their child describe events in which they neglected or hurt their child. The parent thus may challenge the youth's descriptions, cognitions, and/or may minimize or deny their own responsibility related to their substance use or the youth's trauma experiences. If the therapist observes that the parent cannot be appropriately supportive of the youth's perspective during this individual meeting, the therapist may decide that it will be more therapeutic to use the conjoint session for a different purpose than sharing the youth's narrative (e.g., safety planning, improving communication, etc.). In this situation the therapist should communicate this to the youth and parent in a supportive but clear manner and proceed with a conjoint session that does not include sharing the youth's narrative.

Considerations for youth with traumatic separation:

For youth with traumatic separation, in addition to sharing the youth's narrative, it is important to address directly with the youth and current caregiver, traumatic separation issues of worries about the separated caregiver, split loyalties (this may vary depending on the youth's specific feelings towards the parent with substance use and the current caregiver, both of which may move on a continuum between anger, resentment and love and gratitude), and difficulty committing to either relationship. Depending on the stability of the placement and the status of the parent with substance use, the youth may benefit from receiving additional TF-CBT Traumatic Separation components (Cohen & Mannarino, 2019) after completing the PRACTICE components described here. Therapists may also integrate these components into the trauma narration and conjoint sessions to some degree, and are encouraged to learn more about them from this article: https://doi.org/10.1016/j.chiabu.2019.03.006

Considerations for youth with traumatic grief:
In addition to sharing the youth's trauma narrative, conjoint sessions for youth who have experienced traumatic grief related to parental substance use should specifically address issues of the youth's concerns for their future safety. For example, what if something happens to the current caregiver? (provide realistic reassurances about the current caregiver's safety and good health); in the event of something happening to the current caregiver, who will care for the youth? (a plan should be in place for this eventuality and communicated to the youth). The therapist should also explore the youth's concerns for their own safety if relevant, and address the reality basis for these, and enhance safety strategies as indicated. Youth who have resolved traumatic symptoms but continue to have difficulties with the tasks of typical bereavement may benefit from receiving the TF-CBT Grief-Focused components, described in Cohen, Mannarino & Deblinger (2017) and Mannarino & Cohen (2011).

In addition to sharing the youth's trauma narrative, conjoint sessions should include developing family safety plans (which can segue into final Enhancing Safety sessions and graduation, described below). For youth with parental substance use, conjoint sessions should include discussion of youth substance use prevention as well as other preventive safety skills that are relevant and tailored to the individual youth's developmental level and situation.

ENHANCING SAFETY (PART 2)

As noted above, most youth with parental substance use should start TF-CBT treatment with some basic safety skills, since they have typically been exposed to risky behaviors and can benefit from learning and practicing these in relation to trauma reminders throughout treatment. At the end of TF-CBT it is often helpful to review and/or provide additional individual safety skills to enhance the youth's ability to maintain personal safety and make safe decisions in the future. For example, the therapist may initiate discussion about drug refusal skills, sexual health (see https://www.nctsn.org/resources/sexual-health-and-trauma), bullying prevention, personal safety skills, or other topics that are relevant to the youth and developmentally appropriate. A review of the above skills is useful for caregivers to support the youth and to reduce the caregiver's risk of substance abuse or relapse given the historical and/or familial vulnerability caregivers and youth may experience. In addition, reviewing how families can minimize exposure to environments that heighten substance abuse risk benefits the whole family as well.

This component is particularly important for youth who have grown up with a substance using parent as they may have been exposed to many situations in which violence occurred, appropriate boundaries were not respected, and less than optimal attention was paid to children's health, well-being and safety. It is important for children to understand that this occurs when substance seeking and substance use becomes a priority over all else because of the nature of substance addiction and its impact.

TREATMENT COMPLETION

At the end of TF-CBT, the therapist should repeat the trauma (and other empirical) assessment instrument that the youth completed at the start of treatment, to evaluate progress that has been made during treatment. In most cases, trauma symptoms will have diminished to a substantial degree. Exceptions may be when the youth initially exhibited significant avoidance or otherwise underreported symptoms at the start of treatment; or when intervening circumstances have occurred shortly before the end of treatment (e.g., placement disruption; new trauma; court appearance; and/or parental substance use relapse, significant injury, illness or death related to parental substance use, etc.). It is expected that the youth's trauma symptoms will not decrease or may even increase in response to these situations which can serve as significant trauma reminders (or new traumas). In such (relatively uncommon) situations it is important for the therapist to use clinical judgment regarding how the youth has responded to treatment, and whether to extend treatment for a few more sessions to determine next steps.

It is important to acknowledge the hard work that youth and their caregivers put into therapy. Youth and caregivers often like to plan along with their therapist a therapy graduation "party" to which they may contribute ideas for celebratory activities, decorations and/or food. Therapists should recognize the youth's treatment completion with a graduation "ceremony", including giving a certificate and/or a special acknowledgement of the youth and family for their hard work. Youth and their families appreciate this and often cherish their "therapy diploma". Moreover, many youths who have experienced exposure to parental substance use and have endured complex trauma, family challenges and/or significant emotional and behavioral difficulties have had few experiences of success. Thus, this is an opportunity to help the youth create a positive memory reflecting a personal achievement that is associated with feelings of pride, happiness and connection to their caregiver as well as the therapist. Substance use and trauma-related reminders unfortunately may be ubiquitous for youth as they go forward in life. However, rather than such reminders only triggering trauma memories associated with negative emotions, such reminders may also trigger positive memories of their therapy success and a joyful therapy graduation experience. During the final session, youth may enjoy preparing or reviewing a final narrative chapter that summarizes what they learned in therapy including the skills and the traumatic experiences discussed. For youth exposed to parental substance use, this is another opportunity to review what was learned about substance use including its impact on the caregiver and the whole family, what can be done to reduce one's risk of substance use and what the child would like to tell other children about substance use. Adults may preach to children about the dangers of substance use, but it is preferable for children to learn to talk to themselves and others in ways that help internalize healthy thoughts and coping behaviors. By consciously discussing and expressing their feelings and thoughts and the choices that they hope to make regarding the use of substances, the more likely children may be to cope with stressors and

adversity in their lives with effective coping strategies rather than resorting to the use of substances such as illicit drugs and alcohol.

In a small number of cases, the youth will need additional treatment for trauma or other problems, in which case the therapist should provide or refer the youth and/or caregiver to the appropriate treatment.

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