ADDRESSING PARENTING CHALLENGES FOR MOTHERS IN TREATMENT FOR SUBSTANCE USE DISORDERS WITH THEIR YOUNG CHILDREN

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- **Project Partners:**
  - Institute for Health and Recovery, Cambridge, MA
  - Jewish Family and Children’s Service of Greater Boston, Center for Early Relationship Support
  - Boston University School of Social Work
  - Boston Medical Center Child Witness to Violence Project (CWVP; BRIGHT I)
Today’s Presentation

• Brief background and theory:
  • Trauma, addiction and parenting
• Core treatment concepts
• Case example
• Select quantitative and qualitative evaluation findings from BRIGHT I and II
• Summary/Q&A
“…When I was using I just didn’t really pay attention,… my kids pretty much just did what they wanted ‘cause I would just give them whatever they wanted so that I didn’t have to … deal with him crying or, you know, whatever.”

- Project BRIGHT Client
Parenting and Trauma

- Adults who have histories of chronic, early, or relational trauma often experience:
  - Difficulties in interpersonal relationships
  - Challenges perceiving and attending to the needs of themselves and others
  - Periods of hyper-arousal and periods of affective numbing
  - Trouble with memory formation, cognitive processing, and attention
  - Physical and physiological changes which may impact mood, energy/arousal, and health/illness

- Impact on parenting
  - Caring for infants and young children requires capacities in all these areas
What About Trauma, Addiction & Parenting?
How Do Drugs Affect the Brain?

**DRUGS OF ABUSE TARGET THE BRAIN’S PLEASURE CENTER**

**Brain reward (dopamine) pathways**
- Frontal Cortex
- Nucleus Accumbens
- Ventral Tegmental Area

These brain circuits are important for natural rewards such as food, music, and sex.

**Drugs of abuse increase dopamine**
- **Food**
  - Dopamine Transporter
  - Dopamine Receptor

  Typically, dopamine increases in response to natural rewards such as food. When cocaine is taken, dopamine increases are exaggerated, and communication is altered.

- **Cocaine**
  - Dopamine Transporter
  - Cocaine
  - Dopamine

Caring for Generations
JF&CS

BU School of Social Work
Parenting and the Neurobiology of Addiction

- The common drugs of addiction impact directly or indirectly on the dopamine circuitry of the brain, leading to changes in pleasure/reward interactions.

- Previously rewarding patterns in relationships, parenting, self-efficacy and self-care are no longer as rewarding

- Specifically, the pleasures involved with parenting (close physical contact with infant, enjoying infant’s growth and development, feeling connected with infant emotionally, etc.) are no longer as gratifying

- Little ability to tolerate the challenges of parenting (crying, needy infant, sleep deprivation, attunement to infant’s needs, etc.)
Drug Addiction and Parenting: A Problem of Dysregulation (Suchman, 2011)

- **In utero exposure** – Implications for regulation problems across developmental spectrum (e.g., NAS, ADHD) (Bandstra et al., 2010; Keegan et al., 2010; Lester & Lagasse, 2010)

- **Caregiving environment** – Problems with maternal responsiveness, emotional involvement, withdrawal, intrusiveness, reciprocity, contingency (Mayes & Truman, 2002)

- **Disruptions in early and adult attachment** - Mothers often come to the parenting role without the experience of a secure attachment

**

- **Implications for parenting interventions** – Traditional parent skills training doesn’t work because it assumes that parents can tolerate the emotional stress of parenting and experience it as rewarding (Suchman et al., 2006)
Parental Substance Abuse Often Associated With...

- **Mental health difficulties** including anxiety, depression
- **Poor sense of “self”** in attachment relationship including internal representations of self, childhood, parent figures
- **Unplanned pregnancy**: Guilt, shame, ambivalence, fear
- A history of **childhood trauma**
- **Current trauma** including community and interpersonal violence
- **Life stressors** (relationship disruption, moves, interrupted education)
- **Limited disclosure** due to fear of losing child lack of access to services and treatment
While certainly not a guarantee, children exposed in utero may have different abilities to explore, signal distress, experience regulation, or appreciate physical discomfort.

“The substance-exposed mother and child are difficult regulatory partners for each other, as the exposed infant often has an impaired ability to regulate his states ... and needs more parental help. At the same time, the mother usually has a reduced capacity to read the child’s signals. This combination easily leads to a viciously negative cycle that culminates in withdrawal from interaction and increased risk for child neglect and abuse.” (Pajulo et al., 2006)
• Children raised by parents with SUDs are highly represented in the population of children in protective custody
• In utero exposure is one cause of poor outcomes for children; complex interplay of relationship with caregivers, caregiving practices and home environment also predictors (Salo & Flykt, 2013)
• Compromised parenting can impact the attachment relationship and the development of the secure base from which the child grows and explores the world
• Possible negative outcomes for child include: depression, impulsivity, self-destructive behaviors, and impaired cognitive, social and emotional development (Van der Kolk, 2005)
How do we intervene with mothers with SUDs and infants/young children who are substance impacted?
Building a Model

**Begin**
- Evidence-based practice focusing on the dyad to address parent-child relationship, parent trauma, child trauma

**Adapt**
- For the realities of the community needs: length of tx, client age, location of tx...

**Expand**
- Focus on emotion regulation to support parents and infants whose regulatory capacities have been affected by addiction
- Incorporate reflective function as key mechanism for modifying the intergenerational transmission of trauma
Child-Parent Psychotherapy

- Developed by Lieberman, Van Horn and colleagues (manual: Don’t Hit My Mommy)
- Dyadic, attachment-based treatment for young children exposed to interpersonal violence
- Goals: Improving the parent-child relationship and returning child to normative developmental trajectory; develop perspective on traumatic experience; restore trust in parent-child relationship
Key Interventions Modalities

- Promoting developmental progress through play, physical contact & language
- Offering unstructured reflective developmental guidance
- Helping parents provide appropriate protective behavior
- Translating the meaning of children’s feelings & actions for parents
- Providing emotional support & empathic communication
- Providing concrete assistance with problems of daily living
Context: Project BRIGHT I & II

- **BRIGHT I: Family Residential Treatment programs**
  - Parents and children often recently separated/reunified
  - Average stay 9-12 months, many outliers
  - Families focused on substance abuse tx
  - Few clinical services for children under 5

- **BRIGHT II: Outpatient Opioid Treatment Programs**
  - Parents are seen daily at the clinic often with their young children in tow
  - Clinics recommend treatment from 6 months to years/indefinite length
  - Group modalities a large part of clinic focus
Core Concepts in Project BRIGHT: CPP with Adaptations

1. Facilitating shared experiences of pleasure and connection
2. Exploration of relationships
3. Linking past and present
4. Containing/regulating strong affect
5. Building parental reflective function
In Practice: Facilitating Connection

- The importance of routine and consistency in the clinical encounter so that parents and children are “ready to play”
- Identify with both parent and child’s needs and seeking moments in which both parent and child can feel understood by each other
- Find and amplify moments of pleasure, physical connection, joy, and developmental success
With three people in the room, there are at least three relationships to attend to:
- The parent-child relationship is always primary
- Parent must feel safe and accepted
- Child must feel safe and understood

The concept of “rupture and repair” in relationships:
- Past experience of parents include being parented; past experience of child may induce guilt & shame
- Exploring past relationships impacting the present with “Ghosts” and “Angels”
Parents’ affect throughout the treatment process is understood as a possible response to prior experiences.

Affect is explored in the content parents bring to each session, their interactions with their children, and their interactions with the clinician.

Moment-to-moment interactions in the parent-child relationship are monitored so that parent’s arousal does not become too much for the child to tolerate; clinician sees herself as a source of calming containment for the parent and offers concrete coping strategies.
RF refers to the ability to understand behavior in terms of the thoughts, feelings, and intentions of another.

- Behavior has meaning and can be wondered about, especially when we consider another’s possible thoughts, feelings.
- Parents can consider the meaning behind their own behavior and the interplay between their feelings and their responses to their child.
- Parents can wonder about the possible meaning behind their child’s behavior and the many meanings behavior may have.
Case Vignette

“Shakira & Shakira”
Courtesy of Amy Sommer, LICSW
What Were the Lessons Learned in BRIGHT I?
Project BRIGHT I: Evaluation

Design: Quasi Experimental - Treatment and comparison group*

Baseline
• Treatment Group: n=82
• Comparison Group: n=45

Post-test
• Treatment Group: n=67
• Comparison Group: n=26

Evaluation Tools:
• Self-report questionnaires
• Observer rated instrument
• Qualitative post-treatment interview with clients and staff
• Administrative data from the MA Department of Public Health

*women only
Measures

Substance Use
- Enterprise Service Management (ESM, MA Department of Public Health)

Parenting
- Adult Adolescent Parenting Inventory (AAPI, Bavolek, 2001)
- Parental Reflective Functioning Questionnaire – 1 (PM, CM, IC) (PRFQ – 1, Luyten, Mayes, et al., 2009)

Trauma
- Life Stressors Checklist – Revised (LSCR, Wolfe & Kimerling, 1997)
- Traumatic Events Screening Inventory (children) (TESI, Ippen et. al, 2002)

Adult Psychological Distress
- Brief Symptom Inventory (BSI, Derogatis, 1975)

Social-Emotional Development
Project BRIGHT Participants

- **Mean Age:**
  - Mother: 29 years
  - Child: 1.9 years (Range 3 wks - 4.9y)

- **Non-Hispanic white:** 79%

- **HS diploma/GED or more:** 63%

- **Unemployed:** 98.5%

- **Substance of choice:** heroin, crack, cocaine, other opiates

- **Trauma history:**
  - Mother (LSCR): 13 events
  - Child (TESI): 4 events

- **Psych distress (BSI):**
  - Mother: M=0.9 (Range 0.08-2.6)
  - Community: M=0.3

- **Social/emotional development (ASQ-SE):** Child: 34% at-risk

- **Child maltreatment (AAPI):** Approx 20% at high risk

- **Reflective Functioning (PRFQ):**
  - Pre Mentalizing: M=1.8 (Range 1 - 5.3)
  - Interest and Curiosity: M=6.1 (Range 3.7 - 7)
  - Certainty of Mental States: M=3.2 (Range 1.2 - 6.3)

- **Parent-child relationship:** Majority rated distressed or disordered (PIR-GAS, DC 0-3R)

- **BRIGHT sessions:** M=13
Trauma Exposure: Parent (LSC-R)

- Family member(s) substance use caused worry or upset 92%
- Abused physically, attacked or harshly punished by someone you knew 76%
- Separated from your child against your will 76%
- Someone close to you died 76%
- Abortion, miscarriage, or still birth 76%
- Emotionally abused or neglected 72%
- Seen violence between family members before age sixteen 68%
- Someone close to you died unexpectedly 64%
- Close family member sent to jail 60%
- Been touched or made to touch in a sexual way/forced sex 60%
- Had to leave place where living because could not afford it 56%
- Been sent to jail 52%
Trauma Exposure: Index Child (TESI)

- Separated from parent or someone close to them: 84%
- Seen or heard physical fighting within the family: 44%
- Seen or heard family threaten to harm each other: 28%
- Seen or heard people outside family fighting: 28%
- Seen or known family member was arrested or jailed: 24%
- Undergone medical procedures: 24%
- Experienced illness of someone close to them: 20%
- Attempted suicide or to harm self: 20%
- Lacked appropriate care: 16%
- All children exposed to parent(s) using heroin, cocaine, or other opiates
Was participation in Project BRIGHT I associated with improvements in participants’ psychological health, parenting and parent-child relationships?
Post-Treatment Quantitative Findings

1. Mothers in most psychologically distressed group (top third) improved significantly after BRIGHT.
2. These same mothers improved in Reflective Functioning (IC).
3. Their children in top third group were seen by mothers as less at risk (social/emotional) after participation in BRIGHT.
4. However, clinicians rated the less distressed mothers (bottom and middle group) as significantly improved in their parent-child relationship.
5. No changes in BSI, RF, or ASQ-SE in comparison group.
Client Post – Treatment Qualitative Interviews: Select Findings

- 41 client interviews

- Select themes:
  - Changes in parenting practices
  - Developmental understanding of children
  - Reflective functioning
“'Cause I used to think that being a parent... being a mother was just being the mother, just feed ‘em, change ‘em, and that’s it, you know?... I did not do any bonding with none of my other kids. I don’t think I even read ‘em a book once. The playing... that was a low too... With this baby, I just had changed a lot, my way of thinking.”
“At first, you know I was concerned because he was almost 3 weeks early. I was concerned that he wasn’t meeting his milestones. But she [clinician] helped me to remember that, you know, because he was 3 weeks early, that... he may be a little bit behind, but, you know, he will meet his milestones, and he has... That was my biggest concern... she [clinician] helped to... take care of my fears with that.”
Putting myself into their shoes and figuring out, you know, what they thought about it and how they felt. Everything from them first moving their heads to, you know, emotions. How frustrating it is that they can’t move their heads, and they can’t tell me what they want. You know, she [clinician] made me realize that babies have it tough.”
Summary/Conclusions

• **Short –term intervention (M=13 sessions):** Small but important improvements were noted for many highest risk participants in mental health, parental RF, and social/emotional risk for children; clients themselves perceived change in knowledge, understanding and in relationships with their children

• **Strengths:** Real-world setting involving community agencies /academic partnership; Enhancement of existing substance abuse treatment program with an evidence-based trauma-focused attachment intervention
What are the Questions to Address in Evaluation of BRIGHT II?

- Short-term intervention in residential treatment achieved small changes. What happens if we are able to work with parents and children for a longer time?

- BRIGHT I was feasible and effective in Residential treatment. How will BRIGHT II function in methadone programs where children and parenting issues are less visible? What are the necessary adaptations?
Quantitative Measures

Child Focused Measures
- Devereux Early Childhood Assessment
- Child Behavior Checklist
- Traumatic Events Screening Inventory for Children

Parenting Capacities
- Parenting Sense of Competence
- Parental Reflective Functioning Questionnaire
- Parenting Stress Index

Parental Mental Health
- Brief Symptom Inventory
- Difficulties in Emotion Regulation Scale
- Life Stressor Checklist Revised
- PTSD Symptom Scale
- Addiction Severity Index

Parent-Child Relationship
Parent-child videos coded with CIB

* New measures for BRIGHT II in italics
Qualitative Interview with Clients

- **Parent’s Story**
  - History as a parent: Pre-BRIGHT Participation
    - Separation from their child
    - Experience using substances while parenting
    - Interactions and relationship with their child
    - Challenges to parenting and support systems

- **Experiences with Project BRIGHT II**
  - Relationship with clinician
  - Helpfulness of the program
  - Understanding child’s needs and behaviors
  - Parenting style, child development, and scary situations
  - Most important things learned
  - Suggestions for how we can improve
# Participant Demographics

<table>
<thead>
<tr>
<th>Variable</th>
<th>N=57</th>
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<tbody>
<tr>
<td>Mom’s Age</td>
<td>34 years</td>
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<tr>
<td>Child’s Age</td>
<td>30 months</td>
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| Marital Status           | 68% - Never married  
                          | 14% - Married      
                          | 18% - Separated/Divorced |
| Number of Children       | 11% - 0/Pregnant  
                          | 49% - 1 child      
                          | 12% - 2 children   
                          | 28% - 3 or more children |
| Employment               | 72% - Unemployed  
                          | 16% - Part time employment  
                          | 11% - Full time employment |

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<tr>
<th>Variable</th>
<th>N=57</th>
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<tr>
<td>Highest Level of Education</td>
<td>35% - H.S diploma/equivalent</td>
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<tr>
<td></td>
<td>32% - Some college or bachelor’s degree</td>
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<td></td>
<td>19% - Voc/tech program</td>
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<td></td>
<td>14% - Some high school</td>
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<tr>
<td>Child Welfare Involvement</td>
<td>78% have been involved</td>
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<tr>
<td>Race/Ethnicity</td>
<td>98% - White; 3.5% Hispanic</td>
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<tr>
<td>Substance major problem</td>
<td>58% - Heroin</td>
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<td></td>
<td>12% - Other opiates</td>
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<td>27% - Polydrug</td>
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## Baseline Measures

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<tr>
<th>Measure</th>
<th>Mean Score</th>
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<tr>
<td><strong>Adult Trauma (n=57)</strong></td>
<td>M=11.6 episodes</td>
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<tr>
<td><strong>PTSD Cutoff (n=57)</strong></td>
<td>66.7% meet cutoff</td>
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<tr>
<td><strong>Psychological Distress (n=57)</strong></td>
<td>M=1.04</td>
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<tr>
<td><strong>Emotion Regulation (n=57)</strong></td>
<td>M=81</td>
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<tr>
<td>Nonclinical Sample &lt;80; 81-95 = Mean for Tx-seeking substance users</td>
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<tr>
<td><strong>Parenting Sense of Competence (n=45)</strong></td>
<td>75% - High parental confidence; 22% - Moderate; 2% - Low</td>
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<tr>
<td><strong>Parental Stress (n=45)</strong></td>
<td>22% - High stress; 29% - At Risk; 47% - Below risk</td>
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<tr>
<th>Measure</th>
<th>Mean Score</th>
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<tr>
<td><strong>Child Trauma (n=45)</strong></td>
<td>M=3.8 episodes</td>
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<tr>
<td><strong>Parental Reflective Functioning (n=45)</strong></td>
<td>Pre-Mentalizing – 1.6</td>
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<tr>
<td><strong>CERTainty of Mental States – 3.8</strong></td>
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<td><strong>Interest and Curiosity – 6.3</strong></td>
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<td><strong>DECA (n=42)</strong></td>
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<td>Strength = 60-72; Typical = 41-59; Area of Need = 28-40</td>
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<tr>
<td><strong>Attachment – 50.7 (12% Need)</strong></td>
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<td><strong>Initiative – 52.7 (10% Need)</strong></td>
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<tr>
<td><strong>Total Score – 50.6 (14% Need)</strong></td>
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<tr>
<td><strong>CBCL (n=27)</strong></td>
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<tr>
<td>Total score – Clinically referred children sample = 58.8; Non-referred = 33.4</td>
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<td><strong>Internalizing – 12.3 (referred 17.5)</strong></td>
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<tr>
<td><strong>Externalizing – 18.4 (referred 19)</strong></td>
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<tr>
<td><strong>Total Score – 47.5</strong></td>
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Relationships Among Substance Use, Parenting and Trauma in BRIGHT II at Baseline

- Longer use of heroin and greater child’s trauma exposure significantly predict more parenting stress.
- However, mother’s greater ability to regulate her emotions mediated the impact of child trauma and heroin use on parenting stress.
- Longer use of heroin was also associated with less parenting competence.
- More specifically, mothers who had greater posttraumatic stress symptoms felt less competent as parents and PTSS overrode the impact of substance misuse.

What does this tell us?
For mothers in recovery, by addressing emotion regulation and PTSS we may be able to improve parenting stress and parenting competence ultimately impacting the parent-child relationship.
What do BRIGHT II Participants Say About the Intervention?

Regarding working with her BRIGHT II clinician…

□ “She takes the time to like come to the [DCF] visits with us to see the interaction and she’ll videotape us, that way we can both sit back and watch like “oh, look how you do this with him and look how he reacts back to you”, and it shows me what I’m doing good and then it also shows me like “well we could do this different.” ... She tries to help me if I’m struggling with a part that I’m supposed to be doing… And mainly I think the bond with the baby has been a lot better since me and her have been working and since she’s been going to the visits, and being able to watch the visits after and what I’m doing good with.”
Regarding flexibility of the BRIGHT II clinician…

- “She’s been great. Also, … we used to meet here [OTP] a lot, but because it’s kinda hard for me to take two kids here … she’s been very good as far as ‘Oh, I’ll meet you at your home’, or she will meet us at the library. Which I think is huge. Like, she doesn’t have to do that … So, I give her a lot of credit. You know I’m very thankful for that.”

Regarding helpfulness with understanding her son…

- “I think there were some issues that I had that I thought were concerning with my son. But I think, (the clinician) was very honest with me with certain things that she didn’t feel really was anything to do with my son, it was more to do with myself and how I was brought up. And that was just like a huge, it was like an epiphany…”
Regarding substance misuse and parenting...

“I definitely think that (the clinician) has shown me that he’s the most important thing in my life one hundred percent. ... I knew that from the beginning when I had him but, my priorities weren’t a hundred percent on him because I was so worried about you know getting high, getting my drugs, like he wasn’t in my care a hundred percent. But once I finally started to see ... my body needs drugs but my child needs me way more than my body needs drugs ... he can’t even feed himself without me ...she definitely changed my opinion on ... the importance of things in my life ...”
Summary and Conclusion

- **Viability** of enhancing substance abuse treatment (residential and outpatient methadone programs) with trauma-informed attachment-focused parenting intervention for mothers and children.

- **Significant impact** of intervention tailored to this population on parental distress, attitudes, behaviors & reflective capacities and parent-child relationship.

- **Potential impact on child welfare involvement** given parent’s greater sensitivity to child’s needs and improved parenting can work in tandem with DCF.

- **Evaluation-Clinical partnership** shaped and guided the intervention, and enabled us to demonstrate important aggregate findings.

- **Sustainability** of the work by community partners (ongoing DPH funding; grant renewal) and by promoting the core treatment concepts that have lead to important clinical changes.
Questions
Thank You!

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