Disrupted Parenting: Repairing the Wounds

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Agenda

- Substance Use (SU) and Trauma
- Substance Use (SU) and Parenting
- Principles of Infant Mental Health
- In Practice: Case Presentations
- Questions and Discussion

Substance Use and Trauma

- Traumatic Experiences are central to the development of Substance Use Disorders (SUD).
- Mothers with SUD are more likely to have experienced child maltreatment or other childhood traumas.
- Women with more Adverse Childhood Experiences (ACES) are more likely to develop a SUD.

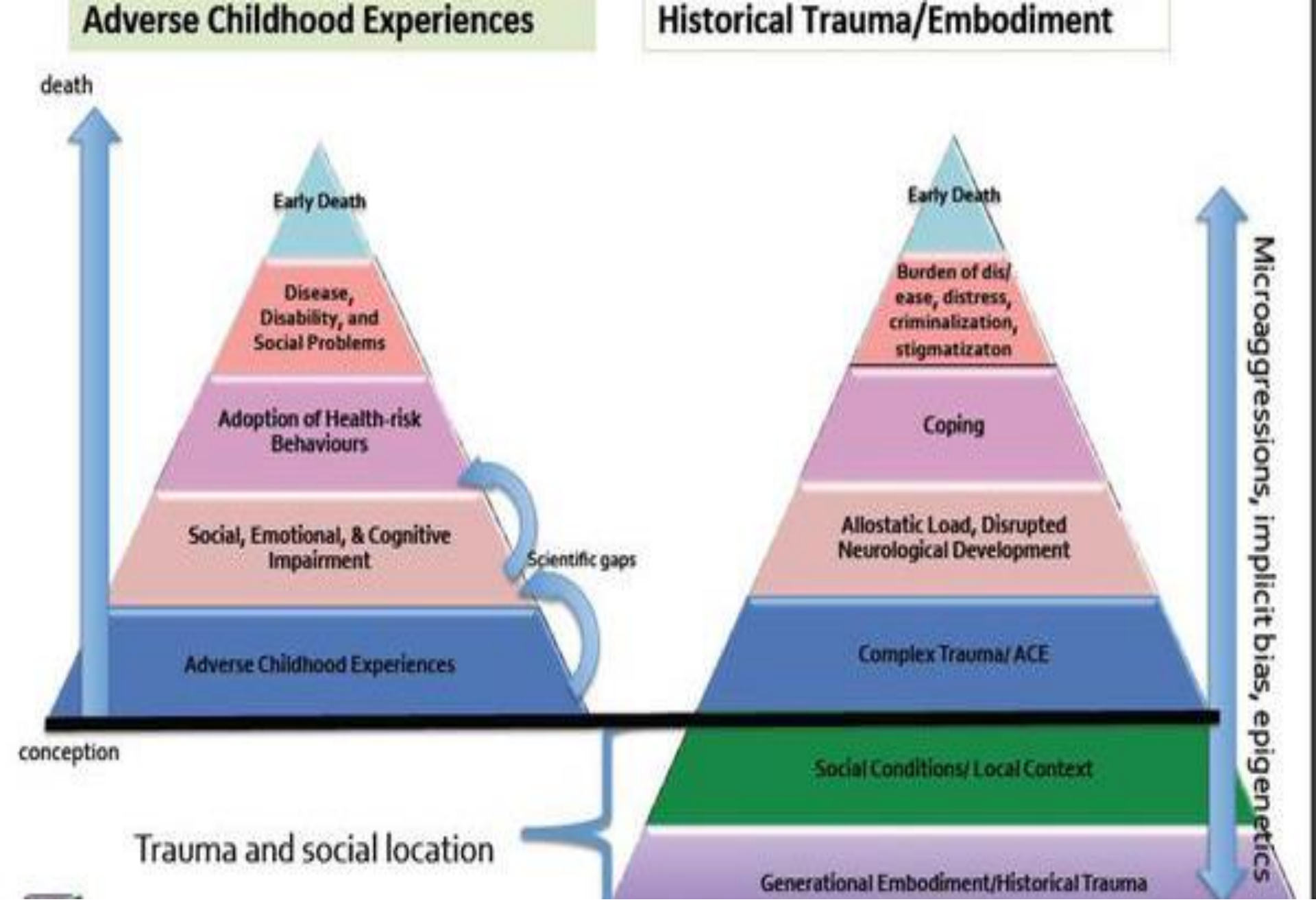


Figure from RYSE Center, 2015

Relationship Between SUD and Trauma

- People with early trauma(s), often have trouble managing difficult emotions and negative internal states.
- SU becomes a coping strategy, offering relief from pain related to early trauma(s).
- Because it offers relief, SU becomes reinforcing—leading to the development of a SUD.

SUD, Trauma, and Mental Health

- Women with SUD are also more likely to have co-occurring mental health disorders.
- A range of mental health disorders are connected to the impact of early childhood adversity.
- Trauma, particularly early childhood trauma, is the common link between SUD and other mental health disorders.

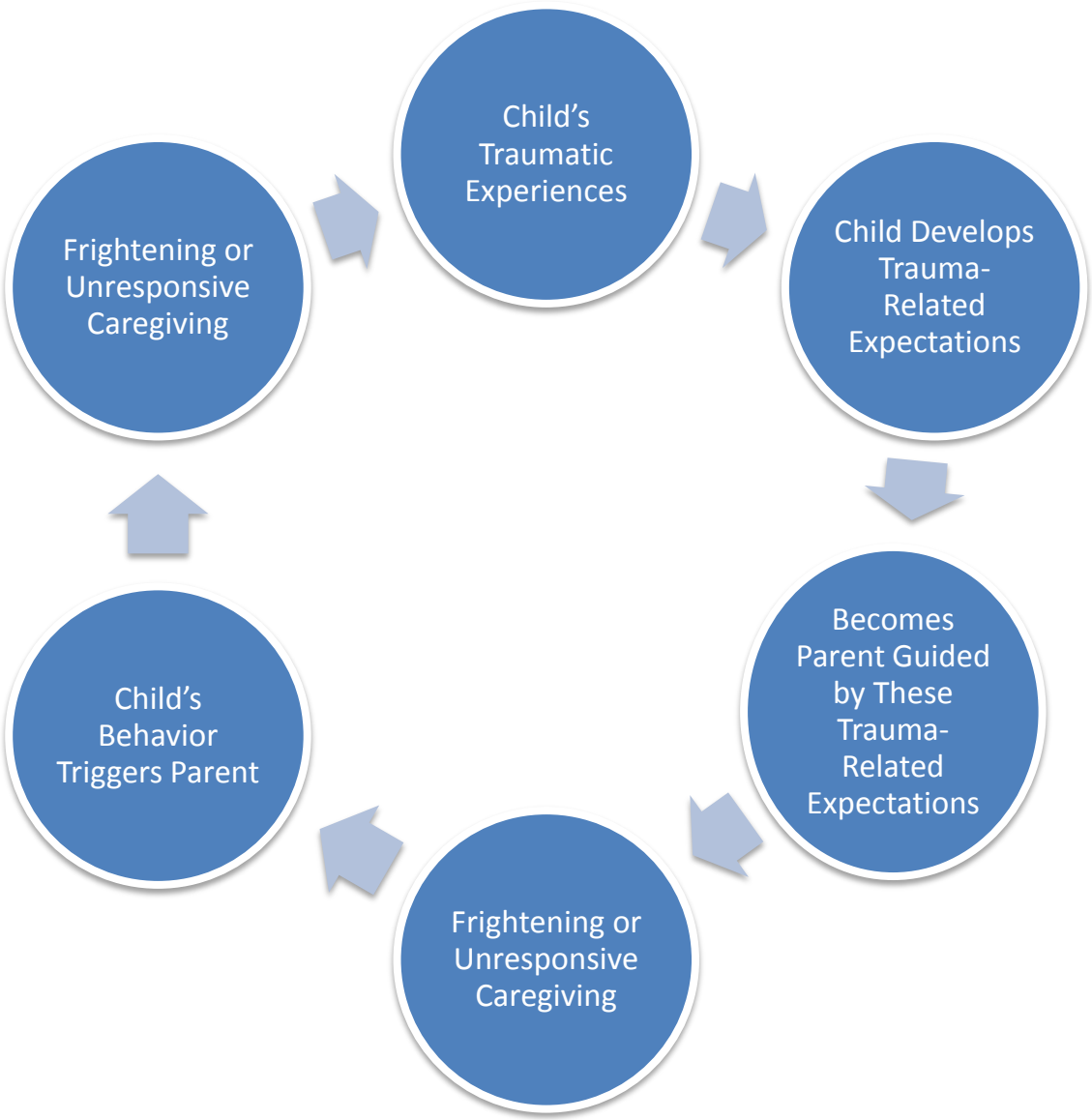
Trauma, SUD, and Parenting

- Caregiving challenges reflect challenges related to addiction as well as challenges that do not directly stem from their addiction.
- Parents with SUD likely did not have a nurturing caregiver who modeled positive parenting behaviors.
- SUD itself is also associated with problematic parenting behaviors.

How Early Experiences Impact Our Understanding of the World

- Our early relationships with our primary caregivers form a blueprint for how relationships work and what to expect from them.
- Optimal growth and development occurs in the context of safe, supportive, nurturing, relationships.
- Disconnected, unresponsive, or frightening caregiving can disrupt typical development.

Intergenerational Transmission of Trauma



Mothers with SUD often Experience:

- Guilt and Shame
- Powerlessness
- Hopelessness
- Despair
- Believe themselves to be Failures
- Feel Unworthy of Help
- Worry about Losing Children
- Anger

Caregiving Challenges for Parents with SUD

- Decreased Sensitivity and Empathy
- Decreased Responsiveness
- Decreased Emotional Availability
- Lack of Structure
- Lack of Flexibility
- Decreased Involvement
- Difficulties with Affect Regulation
- Lack of Reflective Functioning
- Inappropriate Expectations of Children

Adapted from Institute for Health and Recovery, 2017

Caregiver SUD Impact on Children

- Children living with caregivers with a SUD often experience poor outcomes:
  - Developmental delays
  - Cognitive, social, psychological, and health problems related to prenatal exposure
  - May have basic needs met but not emotional ones
  - Emotional withdraw in infants and young children whose bids for interaction are inconsistently met

Challenges Related to SUD and Parenting are Interactional

- Caregivers with SUD are **less equipped** to handle **parentin**g, more likely to have **higher needs infant** and child.

- Infants **exposed to substances prenatally** can have a wide range of **behavioral difficulties:**
  - Increased negative affect
  - Greater distancing and disengaging with parents
  - Cues can be harder to distinguish

- **Child Characteristics Impact Caregiving:**
  - More difficult to soothe children
  - Parents feel ineffective
  - Harder to establish a strong, early attachment

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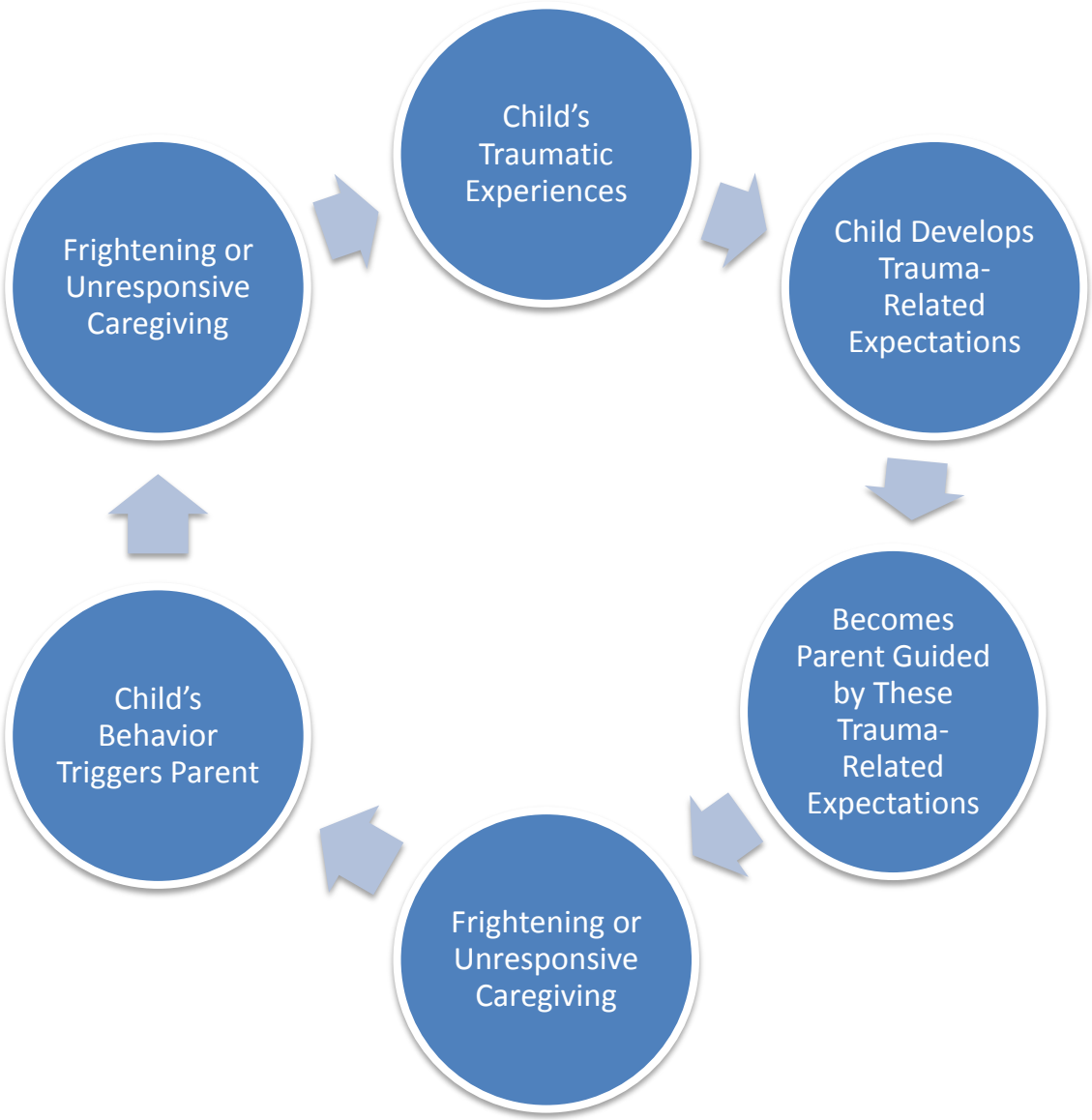

System Challenges in Addressing Trauma and Early Relationships

- Separation from infant
  - DCF
  - For Treatment
- Limited visitation
- Little social or emotional support
- Interactions are shaming/guilt producing
- Placement disruptions (children)
- Separation from siblings (children)

Parenting as Motivator to Treatment

- For some caregivers with SUD, motivation to parent is a powerful opportunity for treatment.

- Pleasure of bonding with a baby and satisfaction of providing competent care can reinforce abstinence.

Parenting as Barrier to Recovery

- Parenting is also a barrier to accessing treatment due to lack of treatment facilities that allow children to reside with parent.

- Once in recovery, everyday stresses of parenting create another risk for relapse.

Trauma and Parenting: The Missing Link in SUD Treatment

- Despite the centrality of trauma in the presence of SUD, treatment that integrates trauma and SUD is rare.
- SUD treatment programs generally do not integrate parenting or address needs of parents with SUD.
- Instead, SUD programs tend to focus on detox, gaining sobriety and then maintaining it.

Holding the Parent and Child in Mind

- “Trauma in the first years of life needs to be assessed and treated within the context of the child’s primary attachments.”

(Lieberman, 2004)

Parent Infant Mental Health

- Develops the capacity of an infant and parent to:
  - Understand How Past Experiences Impact Current Caregiving
  - Experience, Regulate, and Express Emotions
  - Experience Pleasure in Each Other
  - Form Close and Secure Interpersonal Relationships

Parent Infant Mental Health Offers:

- Perinatal Intervention
- Concrete Assistance
- Emotional Support
- Developmental Guidance
- Caregiver Skill Building
- Early Relationship Assessment & Support
- Advocacy
- Infant-Parent Psychotherapy

What Does This Mean in Practice?

Trauma-Informed PIMH

- **Realize** the impact of trauma on young children and their parents.
- **Recognize** the signs and symptoms of trauma in children 0-3 in the context of their relationship with their caregiver.
- **Respond** by fully integrating knowledge about trauma into practice, advocating for appropriate policy.
- **Reflect** with supervisor to actively resist re-traumatization.

Megan Smith, 2017

CASE EXAMPLES: Translating theory into Practice

CGE: Our SUD Program

Adult Residential Program for pregnant and/or parenting women with substance use disorders

- Eight beds
- Length of stay is 6-9 months
- Funded by the state as part of the Women's Set Aside funds
  - Priority admission given to referrals by NJ Dept of Child Protection and Permanency (DCP&P)
  - Priority admission given to pregnant women
- We accept women on methadone or buprenorphine
  - 75% of our residential clients have opioid use disorder; most are on medication assisted treatment
- Facilitation of reunifications with children (age 0-5) removed from mother's custody

Our Treatment Approach

- All programs operate under the principles of trauma informed care
- Attachment theory at the core of our philosophy and interventions
- Implementing ARC Framework as part of a NCTSN grant

Trauma informed substance abuse treatment

The Center for Great Expectations
Embracing change. Empowering futures.

Our approach to substance abuse treatment is embedded in **trauma informed principles**

- The foundational treatment strategy is **emotional regulation**
  - Clients engage in daily practice of a variety of emotional regulation strategies
  - We train all staff (residential and clinical) how to regulate their own emotional state so that they are able to respond to difficult clients behaviors in a calm and therapeutic manner
- We understand that substance abuse, for our population, is a **maladaptive coping strategy** for adverse childhood experiences
- We provide a safe environment where a woman can receive treatment for both trauma and addiction

We utilize **evidence based addiction treatment** strategies

- Life in Balance (Hazelden)
- Seeking Safety (Najavits)
- Trauma Recovery Empowerment Model
- Medication assisted treatment (Methadone and Buprenorphrine)

Parent Infant Mental Health at CGE

- Relationship-Based Approach
- Use video taped play session as part of the assessment and clinical intervention
  - KIPS: Keys to Interactive Parenting
- We design interventions that strengthen the mother-child relationship
  - Individual sessions
  - Dyad sessions
  - Group sessions
- We intervene strategically when the mother is triggered by her child
  - We coach, model and “speak for the child” in the environment milieu

Trauma Informed Reunifications

Each mother-child dyad has a Parent Infant Mental Health (PIMH) clinician working with them, and offers expertise to DCP&P on the reunification plan

- PIMH clinician will observe visits that prepare mother and child for reunification
- PIMH will, if possible, put in place strategies to ease the child's transition from foster care to mom
  - Blankets that have foster mother's scent
  - Recorded stories by mom that are sent to foster home
  - Education and preparation of mom for the inevitable difficult behaviors that children exhibit once reunified

Case Presentation: Margaret

- **Margaret, 36 year old, seeking reunification with 18 month old son, Ben**
- **Second time in treatment at CGE, relapse intertwined with parenting**
- **Intergenerational substance use disorder**
- **Intergenerational patterns of insecure attachment**

Treatment Focus

- **Attachment**
  - Interactions with child unearth attachment patterns linked to SUD, create opportunities for change
  - Understanding intersection of attachment, substance use, and parenting
  - Building reflective functioning skills
  - In-the-moment coaching: attuning to child, regulating emotion, effective response
  - Identifying impact of unmet needs on attachment with child: breaking cycle of intergenerational trauma

- **Regulation**

  - Therapeutic visitation: In the moment support in identifying alarm response
  - Co-regulating

- **Competency**
  - Margaret's perception of being manipulated by child creates opportunity to build a cohesive sense of self and see progress reflected in relationship with child
  - Being manipulated is factor in abusive relationships and SUD. Parenting provides an opportunity to work with the issue in real time.

Case Presentation: Gina

- Gina, 32 year old African American arrived at CGE pregnant with 3rd child
- Identity of self-in-relation
- Intergenerational SUD and insecure attachment
- Separation from two older children
- Insecure attachment with prenate during pregnancy
- Trauma experienced while pregnant

Treatment Focus

- Attachment
- PIMH provides opportunity to access manifestations of patterns of intergenerational trauma
- Opportunities for connection with child while separated
- Addiction/parenting timeline
- Increased attunement, reflective functioning, and effective response
- Trauma-informed birth experience and physiological bonding during immediate postpartum
- Repairing attachment disruptions due to substance use and periods of absence

- Regulation
- Increased ability to understand affect in self and others
- Integrate emotional, cognitive, and behavioral experiences
- Ability to separate the emotions of others from her own emotions
- Recognizing how adaptive behaviors are often used to regulate self
- Increase internal and external coping strategies

- Competency
- Identity of self and self-in-relation have been adapted for survival
- Address difficulty identifying and prioritizing own needs in context of parenting and as trigger for relapse

Integration of PIMH Into SUD Treatment

- Treatment team are caregivers; our relationships with client are blueprints for new attachment patterns
- To separate PIMH from SUD treatment disintegrates coherent identity as mother; children are separate from the rest of life experience
- To separate mother and child during treatment is traumatizing to mother, child, and creates rupture in attachment
- PIMH creates an opening into attachment patterns and relational trauma which are integral to recovery

Methods for Integration

- Treatment Team meetings: Issues critical to recovery are uncovered in PIMH treatment, providing insight to treatment
- Milieu: Understanding client's attachment patterns assists RA and clinical staff in responding effectively to clients in residential setting
- Assisting Clinical and residential staff in understanding challenging parent-child interactions as adaptive behaviors