Rethinking parenting interventions for drug-dependent mothers: From behavior management to fostering emotional bonds

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Abstract

Mothers who are physically and/or psychologically dependent upon alcohol and illicit drugs are at risk for a wide range of parenting deficits beginning when their children are infants and continuing as their children move through school-age and adolescent years. Behavioral parent training programs for drug-dependent mothers have had limited success in improving parent-child relationships or children’s psychological adjustment. One reason behavioral parenting programs may have had limited success is the lack of attention to the emotional quality of the parent-child relationship. Research on attachment suggests that the emotional quality of mother-child relationships is an important predictor of children’s psychological development through school-age and adolescent years. In this paper, we present a rationale and approach for developing attachment-based parenting interventions for drug-dependent mothers and report preliminary data on the feasibility of offering an attachment-based parenting intervention in an outpatient drug treatment program for women. © 2004 Elsevier Inc. All rights reserved.

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1. Introduction

Mothers who are physically and/or psychologically dependent upon alcohol and illicit drugs (i.e., heroin, cocaine, marijuana) are at risk for a wide range of parenting deficits beginning when their children are infants and continuing as their children move through school-age and adolescent years (for a review, see Mayes & Truman, 2002). As a group, drug-dependent mothers fare worse than non drug-dependent mothers on a wide range of parenting indices and more frequently lose their children to foster care than non drug-dependent mothers (Chaffin, Kelleher, and Hollenberg, 1996; Mayes & Bornstein, 1996). Observations of mother-infant dyads have shown patterns of mothers’ poor sensitivity and responsiveness to children’s emotional cues juxtaposed with heightened physical activity, provocation, and intrusiveness (Burns, Chethik, Burns, & Clark, 1997; Hans, Bernstein, & Henson, 1999; Rodning, Beckwith, & Howard, 1991). Studies reporting perspectives of substance-abusing mothers about parenting have indicated a lack of understanding about basic child development issues, ambivalent feelings about having and keeping children, and lower capacities to reflect upon their children’s emotional and cognitive experience (Levy, Truman, & Mayes, 2001; Mayes & Truman, 2002; Murphy & Rosenbaum, 1999). Self-reported behaviors among drug-dependent mothers have also revealed harsh, threatening, overly-involved, authoritarian parenting styles juxtaposed with permissiveness, neglect, poor involvement, low tolerance of child demands and misbehavior, and parent-child role reversals.
(Harmer, Sanderson, & Mertin, 1999; Mayes & Truman, 2002; Suchman & Luthar, 2000).

1.1. Previous clinical trials involving parent skills training

Several parenting skills training studies involving drug-dependent parents have been reported to date, including two randomized clinical trials. Generally, the objectives of these parent training programs have been to reduce maladaptive parenting practices (e.g., harsh punishment), improve positive parenting skills (e.g., behavior management through rewards and punishment) and thereby reduce problematic child behaviors (e.g., externalizing and drug abuse). Although some of these programs (see Ashery, Robertson, & Kumpfer, 1998) have demonstrated success at changing parenting practices and reducing children’s conflict-producing behaviors, generally, parent skills training programs have not led to lasting improvement in the quality of the parent-child relationship or fostered improvement in children’s psychological functioning. For example, in a randomized clinical trial, Catalano, Gainey, Fleming, Haggerty, and Johnson (1999) tested the efficacy of a parent training program combining 16 weeks of parent skills training and 9 months of home-based case management for 144 methadone maintained parents of children ages 4–16. The program provided training in relapse prevention, anger management, and parenting skills. At the 12-month followup, parents who received parent training showed greater ability in management, and parenting skills. At the 12-month followup, of 11 child adjustment indices measured (e.g., physical punishment. In a NIDA Monograph report, Kumpfer (1998) examined the efficacy of the Strengthening Families Program (SFP), a 14-week drug abuse prevention program targeting children ages 6–10 reared in families with drug-dependent parents. The authors used an experimental dismantling design to test the efficacy of parent skills training alone vs. the addition of social skills training for children and behavioral family therapy. The parent training component of SFP was designed to decrease parents’ drug use, improve positive parenting skills (e.g., discipline, rewards, and punishment), and reduce physical punishment. In a NIDA Monograph report, Kumpfer (1998) reported that the parenting program improved the parents’ ability to reduce negative, acting-out behaviors in children and improve child compliance with parental requests. However, the parent training program alone did not improve children’s pro-social skills (i.e., communication, problem solving, peer resistance, and goal setting). Moreover, the authors reported that family relationships actually deteriorated when the parent training program was implemented alone. Children reported at posttest that they did not believe their parents loved them as much as before the parenting program started. It is possible that, without strengthening emotional bonds between parents and children, children experience more stringent behavior management as punitive and uncaring.

Taken together, findings from these well-designed clinical trials of parent training programs indicate that, whereas they may have some short-term efficacy for increasing parents’ behavior management strategies aimed at reducing children’s conflict-producing behaviors, they do not lead to long-term improvement in the quality of parent-child relationships or children’s psychological adjustment.

1.2. Why parent training programs may not work

One reason parent skills training programs may fail to bring about generalized changes in parent-child relationships and children’s psychological development is their exclusive focus on procedures of overt behavior management skills (e.g., rewards, punishment, discipline), and relatively little attention to helping parents understand the emotional needs driving their children’s behavior. In parent skills training, parents learn to apply behavior management techniques that immediately reduce children’s conflict-producing behavior. Less attention is given to the emotional needs underlying children’s problematic behaviors, such as needs to experience physical safety, emotional reassurance, and acceptance/encouragement of autonomy, that occur within the context of the parent-child relationship (Speltz, 1990).

Parent training programs also pay less attention to fostering parents’ emotional availability and responsiveness to children, or the capacity to respond to children’s emotional cues in an emotionally open and flexible manner. It has been well documented that parents who are at high risk for maladaptive patterns of relating to their children (e.g., drug-dependent parents) often have their own long-standing relational difficulties that make it difficult to respond to children in an emotionally available way (e.g., with empathy, warmth, and acceptance toward the child’s emotional needs). The failure of parent training programs to bring about changes in relationship quality and children’s psychological well-being may be due not only to their lack of attention to children’s emotional needs, but also to their lack to attention to more deeply engrained limitations in parents’ emotional experiences and responses in the parenting role (Egeland, Winfield, Bosquet, & Cheng, 2000; van IJzendoorn, Juffer, & Duyvesteyn, 1995).

1.3. An attachment-based perspective on parenting interventions for drug-dependent mothers

1.3.1. The importance of the emotional quality of the mother-child relationship

Originating with the ideas of John Bowlby (1982), attachment research over the past 30 years has shown that
emotional aspects of the parent-child relationship (i.e., the capacity of a parent to recognize children’s emotional needs and respond to them in an emotionally available way) are important predictors of children’s psychological development. In general, attachment research has shown that, when parents are able to accurately perceive and sensitively respond to their children’s emotional needs (e.g., for comfort, security, autonomy) during infancy and toddler years, children are more likely to be psychologically well adjusted (e.g., socially competent with absence of behavior problems) in their school-aged and adolescent years (see Egeland, Weinfeld, Bosquet, & Cheng, 2000; Sroufe, Carlson, Levy, & Egeland, 1999 for a review of longitudinal studies). Likewise, when parents misperceive or respond insensitively to children’s emotional cues during infancy and toddler years, children are more likely to show signs of emotional disturbance, problems in social competence, and behavior problems during their school-aged and adolescent years. Even when children’s individual temperament has been taken into account in attachment studies, maternal sensitivity to children’s emotional cues and emotional availability appear to be protective factors for children’s psychological development.

1.3.2. Mechanisms by which mothers develop the capacities for maternal sensitivity and emotional availability in the mother-child relationship

1.3.2.1. Internal working models of the care-giving relationship. According to attachment theory, in the early care-giving relationship, when primary caregivers accurately perceive and sensitively respond to children’s emotional needs in a consistent manner over multiple instances, their children have the repeated experience of the caregiver as emotionally sensitive, available, and responsive during episodes of emotional distress and of being effectively soothed by the caregiver’s efforts. According to attachment theory, over time, children develop an internal mental representation of the care-giving relationship (what Bowlby referred to as an “internal working model”) based on the multiple interactions that transpired with the caregiver during instances of emotional distress. Children whose early caregivers were able to recognize their signals of emotional distress, and respond in an emotionally sensitive and flexible manner are thought to develop mental representations of the care-giving relationship that are emotionally balanced (i.e., include both positive and negative emotions), realistic and coherent (i.e., memories of specific instances that help characterize the relationship are imminently accessible), and non-defensive (i.e., no distortion or denial of painful emotional aspects of the relationship). Children whose early care givers misperceived their signals of distress or responded in rigid, controlling, chaotic, or frightening ways to children’s emotional distress, are thought to develop mental representations of the care-giving relationship that are emotionally imbalanced (i.e., excessively positive, negative, or neutral), unrealistic and incoherent (i.e., memories of specific instances that help characterize the relationship are either inaccessible or distorted), and defensive (i.e., painful emotional aspects are either denied or distorted).

1.3.2.2. Internal working models as prototypes for care-giving relationships in the next generation. Internal working models are thought to serve as prototypes for all subsequent relationships in adulthood including the next generation of care-giving relationships (Sroufe et al., 1999). Attachment researchers have generally found that mothers who reported feeling secure in their relationships with their own parents have more flexible relational styles as parents that allow them to perceive their children’s emotional cues and be emotionally available and responsive to their children’s emotional needs. Likewise, their children are more likely to express feelings and needs directly and openly without fearing a loss of security (Slade & Cohen, 1996). These mothers are thought to have mental representations of the care-giving relationship that are accessible, coherent, balanced in terms of positive and negative affect, and realistic (e.g., undistorted). This balanced representation of the care-giving relationship is thought to allow mothers to perceive children’s emotional cues (without defensive denial or distortion) and respond to children’s emotional cues in emotionally available and flexible ways. Mothers who did not feel secure in relationships with their own parents are thought to have internalized mental representations of the care-giving relationship that are characterized by exclusion or distortion of painful affect that causes them to either deny or be overwhelmed by (and distort) their children’s emotional needs (Solomon & George, 1996).

1.3.2.3. Reflective functioning: the metacognitive capacity to monitor thoughts and emotions and their influence on behavior. In order for a mother to become more sensitized to her child’s emotional cues, she must also have the capacity to monitor her child’s cognitive and affective experiences and be able to recognize that these experiences influence behavior. For example, in order for a mother to understand that her 2-year-old son’s crying upon her departure is a cue that he is struggling with emotions about separation, she must have the capacity to recognize her child’s mental experience (e.g., fear) and also have the capacity to recognize that the child’s mental experience (e.g., fear) is influencing the child’s behavior (e.g., crying). Recognition of a child’s mental states and their influence on behavior also involves recognition of one’s own mental states and their influence on behavior; otherwise, distinction between the mothers’ and children’s mental experiences is not possible. During the past 5 years, Fonagy and colleagues (Fonagy et al., 1995; Fonagy, Gergely, Jurist, & Target, 2002; Fonagy & Target, 1997) have been examining this metacognitive capacity for “reflective functioning” and have found in both low- and high-risk samples of mothers that
maternal capacity for “reflective functioning” is associated with maternal ways of thinking about the care-giving relationship, with maternal behaviors in mother-child interactions (e.g., flexibility and sensitivity), and with children’s felt security (Grienenberger, Kelly, & Slade, 2001; Slade, Grienenberger, Bernbach, Levy, & Locker, 2001). Importantly, low levels of reflective functioning have been associated with insensitive and emotionally unresponsive maternal behaviors (e.g., withdrawal, hostility, intrusiveness, and distorted perceptions of affective communication). Maternal capacity for reflective functioning has also been found to mediate associations between maternal substance abuse and children’s psychosocial development (e.g., attention, social skills, and withdrawal; Levy and Truman, 2002). Thus, the maternal capacity to monitor her own and her child’s thoughts and feelings (i.e., mental representations) about her relationship with her child is thought to be more accessible and amenable to change (Slade & Cohen, 1996). Change in the mother’s mental representations of her relationship with her child are thought to occur through (a) a secure relationship with a caring clinician that allows her to (b) explore previously denied or distorted affect about the care-giving relationship and its impact on her own parenting behavior and her child’s emotional experience (Pawl & Lieberman, 1997). Studies of short-term attachment-based parenting interventions with high-risk mothers have shown that mothers’ mental representations of care-giving can change in response to intervention (Cramer et al., 1990; Robert-Tissot et al., 1996).

1.4. Can intervention foster improvement in maternal sensitivity and emotional availability in at-risk mothers?

1.4.1. Maternal sensitivity

A number of researchers have evaluated the preliminary efficacy of attachment-based parenting interventions with high-risk mothers (for reviews see Bakermans-Kranenburg, van IJzendoorn, & Juffer, 2003; Egeland et al., 2000; van IJzendoorn et al., 1995). These studies have shown that maternal sensitivity (mothers’ ability to accurately perceive children’s emotional cues and understand them within a developmental context) can be improved through short-term intervention. Specifically, providing developmental guidance to mothers about their children’s emotional needs and their behavioral manifestations at different ages has helped at-risk mothers become more accurate and sensitive perceivers of their children’s emotional cues. However, improvements in maternal sensitivity alone have not corresponded with improvement in the emotional quality of the mother-child relationship. Particularly in the case of at-risk mothers, other maternal factors, including emotional availability and concomitant psychosocial problems, are thought to play important roles in the quality of the mother-child relationship and children’s psychological development.

1.4.2. Maternal emotional availability

Attachment-based clinicians have generally thought that, for a mother to become more emotionally available and responsive to her child, her thoughts and feelings (i.e., mental representations) about her relationship with her child must first change. Although mental representations of the mother’s early care-giving relationship are ordinarily difficult to access, within the context of current, newly formed relationships with children, the mother’s forming mental representation of her relationship with her own child is thought to be more accessible and amenable to change (Slade & Cohen, 1996). Change in the mother’s mental representations of her relationship with her child are thought to occur through (a) a secure relationship with a caring clinician that allows her to (b) explore previously denied or distorted affect about the care-giving relationship and its impact on her own parenting behavior and her child’s emotional experience (Pawl & Lieberman, 1997). Studies of short-term attachment-based parenting interventions with high-risk mothers have shown that mothers’ mental representations of care-giving can change in response to intervention (Cramer et al., 1990; Robert-Tissot et al., 1996).

1.5. Implications for therapeutic intervention model

Together, the mechanisms outlined above point to the need for therapeutic parenting interventions that aim to foster maternal sensitivity and emotional responsiveness to children’s emotional needs and capacities at different ages within a clinical setting where comprehensive services are available, including treatment for drug dependence, psychiatric illness, and problems of everyday living.

1.5.1. Maternal sensitivity

In order to foster improvement in maternal sensitivity, or the mother’s capacity to recognize her children’s emotional needs (e.g., safety, security, autonomy) and their behavioral manifestations (e.g., crying, clinging, fighting, defiance), parenting interventions will need to focus on expanding mothers’ knowledge of children’s emotional needs and abilities at different ages as well as their capacity to make reasonable inferences about the emotional states underlying their children’s behavior. Therapeutic strategies related to this objective include providing timely developmental guidance about children’s emotional needs and psychosocial capacities at different ages and how they are behaviorally expressed, and providing opportunities to observe and
explore mother-child interactions with mothers to assist in the development of their capacities to make accurate inferences about the thoughts and feelings underlying their children’s behavior. Timely developmental guidance involves imparting developmental information about children’s emotional needs and psychosocial capacities and about relational dynamics in the care-giving relationship. It also involves imparting knowledge about how these capacities and dynamics will evolve over time. For instance, providing mothers of toddlers with basic information about their limited capacities to remember instructions, visualize the caregiver in her absence, or regulate impulses and affective distress can support changes in the mother’s sensitivity to the child’s needs and abilities. Providing basic information to mothers about their toddlers’ needs for them (the mothers) to serve as a secure emotional base from which the child can feel safe to explore can also help mothers interact more sensitively when their children express needs for proximity and autonomy (rather than experiencing these bids as intrusions or rejections). The timing of such interventions is critical, such that the mother must perceive the information as relevant and useful rather than as unwelcome advice or criticism.

1.5.2. Emotional availability

Attachment theory suggests that emotional availability, the mother’s capacity to tolerate her child’s emotional needs and respond to them in a flexible and emotionally open manner, is driven by her internal working model of the care-giving relationship. It follows then, that improvement in maternal emotional availability is not possible without change in the mother’s internal representations of the care-giving relationship. Therapeutically, changes in maternal representations of the child and the care-giving relationship are thought to occur within the context of a secure relationship with a caring adult (e.g., a therapist) in which previously distorted or denied thoughts and feelings about the child and care-giving relationship can be recognized and resolved (i.e., attributed to their original sources).

Therapeutic strategies related to this objective include fostering a therapeutic alliance and exploring maternal cognitions and affect in the parenting relationship. In order for a mother to talk openly about these negative experiences as a parent, she needs to experience the therapist as being “with her,” interested in and accepting of aberrant views and affective reactions to parenting (Fraiberg, Adelson, & Shapiro, 1987; Pawl & Lieberman, 1997). The therapeutic alliance can be fostered by providing a balance of genuine interest and concern, acceptance of wide-ranging concerns and beliefs about parenting, empathy for emotional distress, clear and direct communication about the limitations of the therapeutic relationship (e.g., avoiding false promises about therapist availability or custody outcomes), and taking direct action to protect children in harm’s way.

Previously distorted or denied affect toward the child in the care-giving relationship can be identified and redirected to original sources by exploring mothers’ affective distress in the parenting role and the sources of her emotional distress other than her child. Preoccupations with interpersonal loss and trauma, feelings of shame, defiance, and neediness are readily and repeatedly activated by children’s everyday emotional demands (Solomon & George, 1996) and thus become accessible to the mother and therapist who can then work together to identify original sources and replace distorted representations of children with more balanced and accurate ‘working models’ of the child and the care-giving relationship.

1.5.3. The clinical setting

The drug treatment clinic where drug-dependent mothers are often referred by child welfare for treatment for problems with drug abuse and psychiatric disturbance is, in many ways, an ideal setting for providing therapeutic parenting interventions for mothers who are overwhelmed in their roles as parents. The drug treatment clinic provides a structured program for focusing on abstinence and relapse prevention, ready access to medical and psychiatric care and individual assistance with problems of daily living, and a potential social network of peers focusing on the common issues of parenting and recovery. The addition of a therapeutic parenting intervention to an intact, comprehensive treatment delivery program can permit a coordinated effort to simultaneously address parenting deficits and other acute psychosocial problems.

1.5.4. Intervention format

The theoretical framework and therapeutic objectives outlined above are most likely to be effectively addressed in an individual therapy format that maximizes a strong, positive therapeutic alliance and flexibility in tailoring the intervention to the specific needs of the mother-child dyad. There are reasons to suggest that targeting parenting interventions to mothers of toddlers (e.g., ages 18 to 36 months) would yield the greatest benefit: First, from an attachment perspective, a mother’s capacity to foster children’s sense of security and autonomy during this period through sensitive, emotionally open interactions is critical to children’s subsequent psychosocial development (e.g., social competence, adaptive behavior, success in school). Second, in our clinical work with drug-dependent mothers we have observed that children’s natural autonomous forays and expressions of defiance beginning at 18 months often mark the onset of acute distress in the mother-child dyad, strong negative affect toward the child, and harsh, punitive parenting practices, and that this acute distress is characterized by mothers’ confusion and distortion about children’s intentions, abilities, and needs at this stage of development. Third, mothers’ representations of the relationship with toddlers/preschoolers vs. school-aged/adolescent children are relatively new and more amenable to change. Fourth, during school-age and adolescent years, a mother’s influence in child development is diffused by the
increased influence of peers and other adults. Fifth, focusing on a broader age span compromises the depth of the intervention’s developmental sensitivity and specificity to any particular age.

2. Materials and methods

2.1. Feasibility data from a pre-pilot study

The authors recently piloted a parenting intervention based on the rationale and approach outlined above with 25 mothers referred by child welfare for treatment to an outpatient drug treatment program for women in New Haven, CT. In this pre-pilot study, we compared 25 mothers enrolled in the adjunct parenting intervention with 23 mothers who received standard treatment alone on indices of treatment attendance, retention, compliance, and drug use at discharge. The adjunct parenting intervention took place for 1.5 h per week for 12 weeks in addition to standard treatment and was conducted by the principal author, N.S., and two M.S.W. therapists who were trained by the authors. Standard treatment for women at the clinic involved one of two tracks: a 12-week outpatient treatment program where women attended two groups per week (e.g., a supportive group therapy intervention and a group relapse prevention intervention) or a 12-week an intensive outpatient program that women attend 3 days per week for 3 hours of group therapy each day (groups focused on women’s issues, trauma, relapse prevention, and time management).

Using chart reviews, we compared the 25 mothers who enrolled in the parenting intervention with 23 mothers who received standard treatment at the clinic during the same year on indices of treatment attendance, compliance, retention, completion, and abstinence from drug use at the time they were discharged from the program. Intervention mothers attended an average of eight sessions and were retained an average of 10 weeks, compared with an average of six sessions and 8 weeks retention in the standard treatment group. Both these differences were marginally significant ($p < .06$) but had moderate effect sizes of .52 and .54, respectively. Mothers in the parenting intervention were also more compliant in following clinical advice than mothers enrolled in standard treatment alone ($\chi^2 = 12.13, p = .001$). Group differences in treatment completion ($\chi^2 = 2.45, p = .145$) were not significant, although a small effect size ($d = .22$) favored mothers who received the parenting intervention. Group differences in abstinence from drug and alcohol use at discharge were not significant ($\chi^2 = .25, p = .748$).

3. Discussion

Over the past decade, although several randomized clinical trials testing behavioral parenting interventions have shown some improvement in parents’ implementation of behavioral management strategies and reduction in children’s conflict-producing behaviors, intervention efforts have shown little success in improving the emotional quality of parent-child relationships or fostering children’s psychosocial development. To interrupt pervasive patterns of physical and emotional neglect across generations in families affected by maternal drug-dependence, it may be necessary for parenting interventions to take into account the emotional quality of the parent-child relationship as well as the behavior management skills of parents. Attachment theory and research offers much in the way of a clear conceptual model and a multifaceted intervention approach that may hold greater promise for strengthening emotional bonds, maximizing children’s chances for optimal psychosocial development, and interrupting the transmission of maladaptive parenting practices across generations. In this report we presented the rationale, therapeutic objectives, and preliminary feasibility data for an attachment-based parenting intervention for drug-dependent mothers that aims to improve maternal sensitivity and emotional availability in the care-giving relationship.

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