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HHS Public Access

Author manuscript

Int J Birth Parent Educ. Author manuscript; available in PMC 2016 November 10.

Published in final edited form as:

Int J Birth Parent Educ. 2016 July ; 3(4): 19–24.

Mothering from the Inside Out:

A mentalization-based therapy for mothers in treatment for drug addiction

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Abstract

Not all mothers with histories of substance use struggle as parents, but many of them do. Research has shown that, although quality of caregiving varies widely, as a group, mothers with histories of chronic substance use are at greater risk than mothers with no substance use history for losing custody of their young children (Grant et al., 2011; Choi & Ryan, 2006; Department of Health and Human Services, 1999). In observational studies, mothers with substance use disorders have demonstrated lower levels of sensitivity and responsiveness to their young children's emotional cues and marked oscillation between intrusive, over-controlling behavior and passive withdrawal (Hans et al., 1999; Burns et al., 1997). Recent developments in the neuroscience of addiction and parenting may help to explain the marked absence of sensitivity and the dramatic juxtaposition of parenting behaviors.

Keywords

substance abuse; parenting; attachment; mentalization; intervention

Chronic substance use often leads to changes in neural circuitry to accommodate excessive availability of dopamine in the brain (Volkow et al., 2016; Volkow et al., 2003). Dopamine and other neurotransmitters play an important role in rewarding human behaviors that are essential for survival (e.g., caring for offspring, obtaining food, engaging in sexual activity). When chronic substance use co-opts the neural reward system, activities such as caring for offspring are often experienced as less rewarding and more stressful, and motivation to care for young children may decline. The experience of stress during caregiving may even function as a trigger for relapse to substance use (Rutherford et al., 2013; Rutherford et al., 2011).

Emerging evidence from neuro-imaging studies (e.g. Landi et al., 2011) supports the notion that mothers with histories of chronic substance use experience less neural reward in response to caring for their young children. Managing emotional distress in the parenting role (the parent's and the child's) is therefore a critical capacity to monitor while mothers are in recovery from drug addiction.

MENTALIZATION OR REFLECTIVE FUNCTIONING

From an attachment perspective, the management of emotional distress in the parent-child dyad is critical to optimal development in young children (Sroufe et al., 2005; Sroufe, 1995).

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Managing emotional distress in the dyad may also promote a mother's successful recovery from addiction and her capacity to experience reward and delight in her parenting role earlier in her recovery (Suchman et al., in press). One way to promote a parent's capacity to manage emotional distress (her own and her child's) that is gaining recognition in psychotherapy (e.g. Gabbard, 2010) and developmental research (see Katznelson, 2014) is the capacity for mentalization or reflective functioning.

Several decades ago, Fonagy and colleagues (1998; 1991) coined the term mentalization to indicate the process by which parents transmit secure attachment to the next generation. Reflective functioning (RF) is simply the 'observed manifestation' of the capacity to mentalize, although the terms are often used interchangeably.

When we observe another person crying, we automatically (and often unconsciously) infer that person's sadness and experience empathy, which might lead us to offer comfort. In fact, we are probably mentalizing much more frequently than our awareness indicates and we probably use this capacity to function in many interpersonal and autonomous situations on a daily basis (see Allen et al., 2008, for further elaboration).

A parent's capacity to mentalize for a young child is thought to be critical for promoting the child's growing capacities for emotional regulation, self-organization, and social competence (see Slade et al., 2005; Fonagy et al., 2002). Several studies have now shown evidence that a parent's capacity to mentalize about their own and their children's behavior predicts their children's attachment security (e.g. Grienenberg et al., 2005; Slade et al., 2005).

Mentalizing enables a parent to make sense of a child's behavior in terms of underlying mental states and to make decisions about how to manage or respond to the child's behavior. For example, a parent who can make sense of her toddler's sudden tantrum as a signal that the child is frustrated and angry may be more likely to respond to the behavior in a way that helps the toddler better manage the strong feelings (rather than punishing the child for the behavior).

Importantly, mentalizing also enables the parent to make sense of his or her own behavior in terms of underlying mental states. So, for example, a parent who can think about the anger rising up inside him or herself as a child begins to tantrum may be able to trace the anger back to its original source (e.g. an argument with a friend, unpaid bills, or sleep deprivation) rather than automatically directing it toward the dysregulated child.

Mentalizing capacities in vulnerable populations of parents (e.g. parents with psychiatric or substance use disorders) tend to be more compromised than in the general population (for a review, see Katznelson, 2014). The self-mentalizing capacity of these vulnerable parents can be particularly relevant to their parenting (see Suchman et al., 2010) when heightened emotional distress and limited coping skills cause emotional dysregulation, symptom exacerbation and/or relapse to substance use.

Fonagy and colleagues (2012; 2002) have suggested that impairment of the automatic mentalizing capacity often occurs under conditions of high emotional arousal, particularly

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under circumstances where an individual's attachment needs are activated (e.g. fears about abandonment, loss, closeness and/or intimacy). In the absence of the capacity to mentalize, an individual is more likely to confuse internal and external reality (e.g. believe that their worst fears are real), rely on external sources for self-regulation (e.g. escape to drugs), and/or resort to excessive control (e.g. manipulation or force) in an effort to self-regulate (Fonagy et al., 2002).

Impaired mentalizing occurs under conditions of high emotional arousal

Mentalization-based therapies generally involve therapists supporting their patients to engage in conscious and explicit efforts to mentalize, during therapy sessions, about moments of emotional arousal when the mentalizing capacity was momentarily suspended. This process involves slowing down and considering both the events and the individual's mental and emotional reactions that precipitated the state of emotional arousal and loss of reflective functioning. Engaging in this process repeatedly during therapy is thought to assist patients, over time, to use it independently and automatically when their emotional arousal become activated in their day to day lives (Allen et al., 2008).

Mentalization-based therapy with parents of young children involves therapists supporting the parent to engage in conscious and explicit efforts to mentalize about the child, the parent-child relationship, and the parent's own strong reactions to parenting situations.

'MOTHERING FROM THE INSIDE OUT' (MIO)

'Mothering from the Inside Out' (MIO) is an individual, manualized (Suchman & Bers, 2015), psychotherapeutic intervention designed to promote parental RF in mothers who are in treatment for drug addiction and/or mental illness.

MIO is founded on the Mentalization-Based Therapy (MBT) model developed by Allen and colleagues (2008) which emphasizes restoration of mentalizing capacities under conditions of emotional arousal. In the case of drug addiction, MIO explicitly targets parental RF so that mothers in addiction recovery can better manage emotional distress in the absence of neural reward that is common following chronic substance use episodes and during the process of early recovery.

THE MIO APPROACH

The MIO approach involves fostering a process rather than delivering a specific content. The first and most important objective in this process is to form and maintain a therapeutic alliance. Without the therapeutic alliance, other intervention strategies will likely fail.

The second and next most important objective is to foster the mother's capacity to mentalize for herself. The therapist listens for moments when the mother has become emotionally aroused and has experienced a limited capacity to think about her own internal mental states. The therapist pauses the conversation and helps the mother uncover and make sense of the thoughts, wishes, emotions and intentions – along with the events – that led up to her emotionally-aroused state.

The third most important objective is to foster the mother's capacity to mentalize for her child. Once the therapist has helped the mother restore her capacity to mentalize for herself, she pauses the conversation again and encourages the mother to imagine the thoughts, wishes, intentions and emotions that her child might be experiencing during the stressful interaction.

The therapist maintains an inquisitive, curious, not-knowing stance toward the mother's experiences and in exploring what the mother imagines the child's experiences to be. Therapeutic alliance notwithstanding, maintaining the mentalizing stance is probably the most important – and most difficult – component to implement and maintain (see Allen et al., 2008). For a variety of reasons, including the therapist's own customary approach and the patient's psychological make-up, MIO therapists can, at times, feel compelled to become more directive, active, instructional, advice-giving and coach-like during therapy sessions with parents. Under circumstances where a child's physical or emotional safety is at risk, these approaches are usually most appropriate. However, when safety is not an imminent concern, it's important for the therapist to convey that the mother's own thoughts and experiences are genuinely valued and important and that what the mother imagines her child to experience is critically important as well. Likewise, it's important for the therapist to create room in the session for the mother to engage in mentalizing and avoid doing the mentalizing work for the mother – which can interfere with the mother's own mentalizing process.

The mother determines the focus of the discussion

During each MIO session, the mother determines the focus of the discussion. If the child is not the immediate topic, the therapist will bring the child into mind when the timing seems appropriate. When the focus is on what is on the mother's mind, it is more likely to lead directly to sources of emotional arousal where mentalizing is lost. Stressful situations—particularly those where the mother's capacity for reflective functioning is challenged—are considered in detail. The therapist is careful not to shift the focus to the child too early.

When the therapist asks the mother to mentalize and the mother is unable to, the therapist can be transparent about her own thoughts and model her own mentalizing process. For example, if a mother who reports spanking her toddler for running into the street is unable to respond to her therapist's inquiry about mental states at that moment, the therapist might say, 'Well, I was wondering if you might have been frightened that your child would get injured. What do you think about that?'

Developmental guidance about the child's emerging cognitive, language, motor and social capacities can be provided when the mother's expectations for the child appear to be unrealistic. Strategies for promoting a secure attachment (e.g. managing transitions and separations) can also be provided when the mother expresses uncertainty about what to do or how to interact with her child in specific situations. When developmental guidance and parenting strategies are offered, the therapist is careful to return to the mentalizing process so that this developing capacity in the mother can continue to flourish. When the child's or mother's safety is at stake, a more directive approach is used until the unsafe situation is resolved. All mothers are enrolled in wrap-around services provided by the substance use

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treatment clinic where they are enrolled. MIO also provides additional case management to assist mothers in meeting basic needs (e.g. food, clothing, shelter, and transportation).

RESEARCH FINDINGS TO DATE

MIO is now considered 'evidence-based' for mothers in treatment for drug addiction because it has demonstrated efficacy in two randomized controlled clinical trials. Below is a summary of major findings.

MENTALIZATION

In two randomized trials with mothers enrolled in treatment for drug addiction, MIO was compared with Parent Education (PE), an active comparison intervention designed to control for treatment 'dose' and alliance. PE is a twelve-session individual psycho-educational program where mothers review pamphlets of their choice with an individual counsellor. Pamphlet topics included common parenting challenges (e.g. bedtime, power struggles) and pamphlet content provides developmental guidance and parenting strategies. In the first trial with 47 mothers caring for children aged birth to 36 months (see Suchman et al., 2011), those who received MIO demonstrated a better capacity for mentalizing at the end of 12 sessions and this benefit was sustained at a six week follow up. In the second trial with 87 mothers caring for children aged 12 to 60 months (see Suchman et al., in press), those who received MIO demonstrated a better capacity for mentalizing at the end of 12 sessions and this benefit was sustained at a 12 week follow-up visit.

In another study (Suchman et al., 2010) we identified two robust components of RF, including self-focused mentalizing (the mother's capacity to mentalize her own strong emotions and their impact on her child) and child-focused mentalizing (the mother's capacity to mentalize about her child's strong emotions and their impact on herself). Surprisingly, self-focused RF was most strongly related to the mother's capacity to be sensitive and responsive in the caregiving role.

In a third pilot study testing MIO with 17 mothers involved with mental health services (Suchman et al., under review), mentalizing capacity increased at the end of 12 sessions.

MOTHER-CHILD INTERACTIONS

In the first randomized trial, mothers who received MIO demonstrated more sensitive and responsive caregiving behavior with their children at the end of treatment and these benefits were sustained at the six week follow-up. In the second trial, where mothers reported more severe addiction histories (e.g. began using drugs earlier; a larger percentage reporting family histories of substance abuse), maternal caregiving behavior and dyadic reciprocity demonstrated improvement at a one year follow-up visit. In the second trial, mothers with more severe addiction showed much greater benefit when they were assigned to MIO.

SUBSTANCE ABUSE

In the second randomized trial, mothers who were enrolled in MIO showed a medium decline in their heroin use across the six months they were enrolled in the study, whereas mothers enrolled in psycho-education showed a medium increase.

MECHANISMS OF CHANGE

In both clinical trials with mothers in addiction treatment, and in the third pilot study with mothers involved with mental health services, evidence was found supporting proposed mechanisms of change. That is, therapist adherence to the MIO treatment approach predicted improvement in maternal RF which, in turn, predicted improvement in mother-child interactions (Suchman et al., under review; Suchman et al., 2012).

SUMMARY

Mothers who are in treatment for drug addiction while caring for young children are especially vulnerable to maladaptive parenting that is likely triggered, in part, by the changes in the neural stress and reward system during chronic drug use. 'Mothering from the Inside Out' is one approach to enhancing addiction treatment that has helped mothers in recovery recognize and manage the emotional stress related to parenting young children. MIO emphasizes the mother's capacity to mentalize or make sense of her own emotional stress and to consider her child's emotional needs during stressful parenting situations. Evidence from two randomized clinical trials indicates the potential promise of mentalization-based approaches to parenting intervention with high risk parents caring for young children.

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Mentalization

Mentalization is the capacity to make sense of behavior, in oneself and others, in terms of underlying thoughts, emotions, wishes, and intentions.

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Goals for 'Mothering from the Inside Out'

The short-term goals for MIO:

- Provide a positive experience in a therapeutic relationship in which the mother's thoughts and emotions are taken seriously so that she can feel supported and understood
- Begin a process of helping the mother make sense of her own and her child's underlying affective experiences and think about how these experiences are related to individual need, behavior and development.

The long term goals of MIO are to:

- Support the mother's developing capacity for emotional regulation
- Restore the mother's own capacity to engage in human attachment (e.g. replace attachment to a substance with attachment to the child)
- Promote the mother's capacity to engage with and enjoy her child, tolerate her child's emotional distress, understand her child's emotional needs and support her child's developing regulatory capacities.

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An MIO vignette

This vignette provides a brief snapshot of how a typical mid-treatment MIO session might begin. Although the mother and child are fictitious, the mother's presenting concerns and the therapeutic process are meant to illustrate typical issues and processes that arise during MIO sessions with mothers in addiction recovery. In the vignette, the mother, Theresa, has arrived for her fourth session with her MIO therapist. Her daughter Anna is a very active 2½ years old girl. Theresa is enrolled in methadone maintenance for her opiate use and must travel to the clinic daily to receive her methadone dose. She has no help with child care and must bring Anna to the clinic with her each morning and must comply with strictly-held medication hours.

> My Anna! She's getting an attitude. She just doesn't listen to me. This morning I had to get to the clinic before they closed. I tried to dress her but she wouldn't have it. She wanted to play with her dolls. So I said, 'Anna, you're going to get a spanking if you keep this up!' I know she's doing this to annoy me.

The therapist begins with a focus on the mother, expressing interest and curiosity in the mother's own mental and emotional states that preceded her threat of a spanking, with the aim of helping the mother to better recognize and understand how her own thoughts and emotions led to her highly aroused state of mind. The therapist begins with an open inquiry about the mother's sensations and thoughts and confirms her understanding of the mother's experience before moving on.

> So I'm wondering what was going through your mind when you were trying to get Anna dressed this morning…
>
> If I don't get medicated, my body starts to ache and I begin to sweat! And I don't want to pick up using again.
>
> So you were worried that if you didn't make the medication hours, you'd begin going into withdrawal which would make you think about using. Do I have that right?
>
> Yes, they don't let you in the door if you're one minute late. They're very strict about it.

Next, the therapist asks the mother to consider her own emotional state during the moment of arousal. When the mother is unable to respond, the therapist transparently and tentatively shares what she imagines the mother might be thinking and feeling (but is unable to express in words at the moment) and then confirms with the mother if what she imagined or guessed matches the mother's experience.

> Oh, I see. What was it like for you to be thinking about that possibility of going into withdrawal?
>
> If I don't get medicated, my body starts to ache and I begin to sweat! And I don't want to pick up using again.
>
> So in your body you feel incredible discomfort. How about emotions. Does anything come to mind?

> No, I just feel sick!
>
> I'm wondering if you might have felt scared – and maybe a little bit mad with Anna? Could that be?
>
> Well, no, I wasn't scared, but I was very worried and nervous. I wasn't mad at Anna but I guess I was more than a little annoyed. (Sighs, takes a sip of her coffee).

Once Theresa's own mental states leading up to the event have been taken seriously and explored, and she appears more contained, the focus shifts to mentalizing for the child. Developmental guidance may be provided along with parenting strategies. But the greatest emphasis is placed on helping the mother consider and imagine what her child is experiencing and how these experiences influence the child's behavior.

> That's very understandable. I'm glad you were able to help me understand how you felt. That's very important to me. It sounds like you really wanted Anna to cooperate and understand what was worrying you. Do I have that right?
>
> Yeah, it's always a struggle. She's so stubborn.
>
> What do you suppose was going through her mind this morning when you were trying to get her dressed and out the door?
>
> I don't know. She's just two years old. I never really thought about what she thinks. I guess she just wanted to play. Maybe she doesn't understand.
>
> Can you say more about that? What do you think she doesn't understand? And why do you think playing is so meaningful to her right now?

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