

MINDING THE BABY

Mentalization-based treatment in families with parental substance use disorder: Theoretical framework

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Abstract

The primary aim of this article is to give a theoretical and empirical background for clinical interventions in family-oriented treatment for substance use disorders. The article refers to an ongoing research project, which is based on the concepts of *mentalization* and *parental reflective functioning*. Theory of mentalization and attachment theory is explored as explanatory tools of both addictive problem and risk/resilience factors in offspring. Mentalization is defined as the competence to envision mental states in self and others and to understand behaviour in terms of mental states. Substance use is discussed as clinical expressions of impaired mentalizing skills and disorders of state- and affect regulation. Parental reflective function particularly refers to parents' competences to interpret the mind of their own infant or child. Parental reflective functioning, as 'minding the baby', promotes sensitive care, which again serves to protect the infant and the immature brain from potentially dangerous stress and physiological arousal. Substance use often makes the parent 'absent-minded' and thus imposes a risk of impaired interactions between caregivers and the extra vulnerable substance exposed child.

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Without a lifeline to the caregivers' mind, the development of self regulation and social competences is endangered. High-risk families need substantial support to break the burden of intergenerational transmission of internal representations of caregiving experiences, and to promote good enough care for the infant. The mentalization-based treatment programs (MBT) briefly outlined here, propose a long-term multidisciplinary treatment and follow-up.

Introduction

Substance abuse is a substantial problem with severe costs, in human, social and economical terms. Children of substance abusing parents are burdened in multiple ways. Some of them are exposed in uterus to harmful chemical substances resulting in a wide range of problems from severe mental retardation to more soft signs of regulatory problems (Moe & Slinning, 2002). These children are often born into social situations characterized by relational problems, unemployment, child protection issues and a relatively high incidence of parental mental illness (Pajulo et al., 2006). It is estimated that approximately two hundred thousand Norwegian children suffer under the harmful consequences of their caregivers' alcohol and drug habits (Solbakken & Lauritzen, 2006). A large number of these children present similar psychosocial problems in their own adult life. More than fifty percent of addicted parents are repeating the patterns from their own childhood, growing up with a parent with alcohol or drug problems (Lauritzen et al., 1997). Researchers, clinicians and health planners strive to understand and intervene into the presumed mechanisms and conditions involved in this non-genetic intergenerational transference of risk and resilience. Especially attachment patterns have been found to be reproduced through generations (Barrett, 2006) and in this transmission, parental reflective functioning seems to play a crucial role (Slade, Grienenberger et al., 2005).

Two recent reports describing the state of the art concerning children of substance abusing parents in Norway have concluded that there is a need for coordinated, long-term follow-up of these children (Solbakken & Lauritzen, 2006; Solbakken, Lauritzen & Ødegård, 2005). The reports propose that drug- and alcohol treatment must be more child-oriented in general, and the field is expected to develop and strengthen assessment, treatment strategies and adequate support systems for children and parents affected by harmful use of alcohol and drugs. The reports are in accordance with the scientific findings urging for better follow up on behalf of the children and more effective prevention and treatment strategies concerning both the addicted parent and the vulnerable child. The Norwegian directory of health and social services (Helsedirektoratet, 2007) states that one of the main challenges is to implement a family and systems perspective in drug treatment and early intervention.

Implementing a family perspective necessarily calls for an explanatory framework which includes hypotheses of intergenerational transference and theoretical assumptions regarding both the parents' addictive problem and the consequences for the child. Most treatment of addiction is mainly adult oriented. The role and needs of the child is often out of mind as the child generally is out of sight, and the parenting role, especially fathers' role of the addict may slip the attention of therapists and treatment agencies (McMahon et al., 2005; McMahon, Winkel & Rounsaville, 2008; Phares, 2002).

This article aims to outline a theoretical framework for a family-oriented treatment for substance use disorders. We build on research which describes a relative transgenerational stability of attachment patterns and the role of mentalization as a mediating mechanism. Thus, the key concepts used are mentalization, reflective functioning, affect regulation and caregiving competence. The article refers to an ongoing research project launched in 2007, in which *parental experience, mentalization and parental reflective functioning* in parents with addictive problems is being studied. The site of this project is a Norwegian inpatient treatment institution for pregnant women and parents with substance use disorder (SUD). Children follow their parents to treatment. This particular institution is in the process of building an attachment- and mentalization-based framework to strengthen the child- and family orientation in a treatment program called "Towards a secure base". Although the methodological examples stem from the research site, the main source of data is scientific texts on theory found to be relevant to the issue of substance dependency, parenthood and child care.

Mentalizing and reflective functioning

The concept of mentalization was introduced by French psychoanalysis in the late sixties (Nygren & Skårderud, 2008), and is used today e.g. in the studies of cognition and interpersonal understanding in autism and schizophrenia (Baron-Cohen, 1995). Peter Fonagy, Mary Target and colleagues (Fonagy et al., 1991; Target & Fonagy, 1996) have developed the concept referring to attachment theory, infant research and psychodynamic theory. They define mentalization as an individual's competence to envision mental states in self and others, and to understand behaviour in terms of mental states. The term mental state is used to describe all mental experience; thoughts, feelings, desires, beliefs and intentions. Mentalization thus implies a competence to identify mental states and to interpret one's own as well as others' inner states. The concept of 'reflective functioning' is usually used referring to the measurement of a mentalizing capacity (Fonagy et al., 1998). In this article these two concepts are used synonymously. For an

updated overview of the concept of mentalization, with emphasis on the Fonagy-tradition, we refer to Choi-Kain & Gunderson (2008).

Mentalizing is theoretically and empirically linked to *affect regulation*. Being able to think about one's own thoughts and feelings is necessary to understand, control and regulate both behaviour and emotional and physical arousal. Impaired mentalizing skills may also activate strong negative affects in the sense that misreading minds leads to misunderstandings, disruption and frustration in social communication.

Substance use and mentalizing

The aetiology of substance use disorders is undoubtedly multifactorial involving hereditary or constitutional factors, as well as personality and sociocultural factors. In this section we focus on personality characteristics that can be integrated into a conceptual model of mentalization. Fonagy and Target's concept of mentalization is developed from the conjunction of theory and knowledge from different disciplines such as infant research, attachment theory, neuroscience and psychodynamic theory (Fonagy & Target, 1996). Although the theory and its treatment implications received its clinical and scientific breakthrough when applied with good effect for borderline personality disorder (Bateman & Fonagy, 2004; Bateman & Fonagy, 2008), the concept's usage has expanded into an impressive array of clinical domains. This includes family therapy (Asen, in press), child psychotherapy (Baradon, 2005), treatment of professionals in crisis (Bleiberg, 2006), eating disorders (Skårderud & Fonagy, in press), school based communities to minimize violence (Twemlow & Fonagy, 2006), and with particular relevance for this article, high-risk parent-infant dyads (Slade, Sadler et al., 2005).

But hitherto, there is not much published literature applying the mentalization concept explicitly to substance use disorders. Allen, Fonagy & Bateman (2008) briefly describe the two-way process between substance abuse and mentalizing. On the one hand addiction and intoxication impairs mentalization, both in relation "to the self but also tend to be associated with obliviousness to the mental states of others, attachment figures not at least" (p. 299). And on the other hand, "impaired capacity to mentalize emotion contributes to the rigid reflex-like pathway from intense emotional arousal to substance abuse; that phenomenon provides an occasion to explain how mentalizing provides a needed "pause button" that potentially enhances the flexibility of coping responses" (p. 299). Furthermore, impaired mentalizing contributes to conflict in close relationships, and these interpersonal conflicts, in turn, generate distress that can lead to episodes of alcohol and drug abuse.

Due to the limited number of scientific texts discussing substance use disorders explicitly with reference to mentalizing, we approach the topic by referring to research and phenomenological descriptions using closely related concepts, with particular reference to disordered affect regulation. As will be further developed in detail about the mentalizing model, impaired affect regulation functions as a mediator between mentalizing and psychiatric symptoms and disorders (Fonagy et al., 2002). There is robust documentation of high levels of comorbidity between substance use disorders and disorders where affect regulation is seen as crucial traits in the aetiology and pathology, like eating disorders and borderline and antisocial personality disorders (Taylor, 1997).

There is a contemporary trend describing and understanding substance use disorders as a disorder of regulation. Not least does this open up for an integration of different explanatory and descriptive models in medicine and psychology. Advances in developmental psychology, affect theory, neurobiology, infant development research, trauma research, new concepts of personality development, and current concepts in psychoanalysis, have all contributed to the evolution of a new and distinct entity, that of self-regulation in general and of affect regulation in particular. Affect regulation as a concept represents a convergence zone between cognition and affect; it has both biological and developmental connotations; and it has further connotations that pertain to character style and to the aims of psychotherapeutic treatment itself (Jurist, 2005). The tradition around mentalizing is a prominent example of such integration of disciplines. In addition to individuals with such acquired deficits in affect regulation, however, there are individuals with inherited deficits in their neurobiological functions that may predispose them to affective dysregulation (Taylor, Bagby & Parker, 1997).

Affect regulation is a core feature of attachment theory. Other core features are the establishment of close relational ties and satisfaction of needs. Reading (2002) applies Bowlby's theory to investigate the psychology of addiction. He proposes that "the relationship between the drug user and the drug itself may be associated with experiences both of security and of the satisfaction of the needs as a result of its chemical and symbolic effects." (p. 15).

Kohout (1977) describes the problems leading in the direction of substance use and other addictive behaviour as a basic lack of self esteem or cohesion and problems in self comforting, leading to a search elsewhere for feelings of worth and comfort. In our opinion effective self comfort is to a large degree the result of sensitive care and internalized and symbolized soothing from care giver. An attachment-like relation to drugs may be exemplified by the following statement from one of the patients at the research site:

"Quitting was a really hard decision to take. It was like saying goodbye to the dearest I ever had, and I felt really sad to part with heroin. After all it had helped

me through all of my hard times for the last ten years. I was never let down; Heroin always gave what it promised."

Krystal and Raskin were among the first to describe how drug addicts experienced their affects mainly in an undifferentiated, global, primarily somatic way, and that they had great difficulty tolerating painful affects. These persons reported their subjective states in a vague and unspecific manner as though they were experiencing an undifferentiated form of common affect precursors, so that separate feelings of anxiety and depression could not be described (Krystal, 1962; Krystal & Raskin, 1970). The experiencing of emotions in a primitive sensorimotor form seemed to amplify the pain of withdrawal from a psychoactive drug, creating a dread of being overwhelmed by negative emotions and by an insatiable craving for the drug. According to Krystal (1982) being unable to verbalize affects adequately or use affects as signals to themselves, these patients tended to become preoccupied with the bodily sensations that accompany emotional arousal and with a compulsive need to block them through taking the drug.

Other important contributions to understanding the association between affect dysregulation and substance use have been offered by Wurmser (1984), who described a breakdown of affect defence in substance users as well as *hyposymbolization*. This latter term encompasses a cluster of characteristics that are virtually similar to some of those characteristic of impaired mentalizing, namely inability to articulate feelings, the experiencing of emotions as somatic sensations, a constricted fantasy life, and a tendency to acting out. In Wurmser's view, persons prone to substance use disorders have limited ability to experience their own affective world as well as the ability to empathize with the affect of others. Due to hyposymbolization affects may be experienced as "overwhelming, global, archaic, physically felt, and cannot be articulated in words" (Wurmser, 1978, p. 109). Based on such published reports and own observations Khantzian (1985) proposed a *self-medication hypothesis* that individuals are compelled to overuse and depend on alcohol or drugs to manage painful affective states and related psychiatric disorders.

Terms are used interchangeably to convey similar basic ideas, like the concept of alexithymia covers much of the same as described above; as it covers important aspects of mentalizing. Alexithymia literally means no-words-for-feelings, and was originally developed as a construct based on clinical observations of patients with classical psychosomatic disorders. It has later been refined theoretically (Taylor et al., 1997), and as it is presently defined it is composed of the following salient features: 1) difficulties identifying feelings and distinguishing between feelings and the bodily sensations of emotional arousal; 2) difficulty describing feelings to other people; 3) constricted imaginative processes, as evidenced by a paucity of fantasies; and 4) a stimulus-bound, externally orientated cognitive style.

Taylor (1997) reviews the rich empirical evidence for the association between alexithymia and substance use disorder.

This section illustrates that low levels of symbolization, disordered affect regulation, lack of words for feelings, and mentalization are highly overlapping phenomena which are all relevant in understanding the vulnerabilities for addiction. At the same time, substance use disorder produces problems in the same areas. We now turn to the developmental theory of mentalizing capacity and affect regulation.

Developing a mind and mindreading skills

The ability to understand other minds rests on the experience of having been understood as an individual with a mind. The child learns the dynamics and logic of the mind in safe and intimate interaction with caregivers, and the hoped for result is a well functioning interpersonal interpretive mechanism or mindreading, mentalizing competence. This has given rise to the subconcept 'parental reflective functioning'. We will return to this construct later in the article.

Fonagy (2001) suggests that "attachment in early infancy has the primary evolutionary function of generating a mind capable of inferring things about other people's minds, their thoughts and ideas, motivations and intentions" (p. 427.) Fonagy suggests that minding the mind of the baby is a necessary precondition for the development of the infants own self, affect regulation and interpersonal understanding. This is intuitively understood by most caregivers, as the early interaction with the infant to a large extent consists of face-to-face and mind-to-mind interactions.

Minding the baby

"Minding the baby" is the title of a mentalization-based treatment program developed to support young at-risk mothers to promote caregiving competence by helping them to keep their babies and themselves in mind (Slade, Sadler et al., 2005). We apply this expression here, to describe the parental looking after and creating a secure and nourishing environment in a physiological and psychological sense. It is close to Winnicott's (1960) notion of 'holding environment' but pinpoints more explicitly the importance of keeping the baby's mind in mind. The infant needs the caregiver's psychological and emotional availability as a mirror, as a regulator of state and affect, and as an anchor to the outside world from which s/he begins to organize an emerging sense of self and an emerging sense of self-other separateness. The sensitively responding caregiver helps the infant to gradually understand his/her own inner life, at the same time as a general

idea of how it feels to be with another person, and how others usually act and react in social encounters, builds up. This building up of patterns of expectations corresponds to Bowlby's attachment theory, and the notion of internal working models of a relationship (Bowlby, 1979).

In short, Bowlby's attachment theory describes how children develop patterns of expressing or suppressing cues depending on their caregiver's capacities to recognize and respond sensitively to such cues. The terms 'working model' and 'patterns of attachment' are used to explain how these early relational experiences influence the individual on a neurobiological and psychological level. Attachment patterns have been shown to influence mental health, school performance, resilience and peer and love relationships (Barrett, 2006). The internal working model of Bowlby, or Representations of Interaction Generalized (RIGs) as Stern (1985) names these psychological and neurological imprints of the early relationships, indicates a tendency to interpret interpersonal and social situations, and act upon them in a certain way. This suggests that attachment patterns are related to social competence as an interpersonal interpretive mechanism. Informed by recent findings in neurobiology, cognition, memory, and infant research, Fonagy et al. (2002) understand attachment patterns as a dynamic interpretive filter for social understanding and social behaviour. Attachment experiences influence the depth and complexity of processing one's own inner life and relational experiences.

From imitation to a theory of mind

The mindreading capacity develops from the initial simple imitation of facial expressions, gestures and vocalizations into a complex and dynamic understanding of minds, such as hidden motives, false beliefs, complex flirting behaviour, negotiations and problem solving. Infant research has described how the child develops through different phases where s/he first learns the more formal structure of social communication, such as turn taking, pauses, interactional disruption and repair, inviting for dialogue as well as rejecting and accepting invitations.

After the rules and structure of togetherness is established, the child discovers the content of social communication. S/he learns that inner states can be read, recognized or disregarded, and that there are possibilities of understandings and misunderstandings. Inner states can be influenced by interaction, both sorrow and happiness may be contagious; and the caregiver can even change her/his mind. The child also discovers that the mind of the caregiver is an important source for information about self, others and the outer world, and s/he starts looking into the face of the parent, searching for information on how to interpret different situations, so called 'social referring'. Around the age of three, words gradually take over as the main mode of explicit communication, while the preverbal mode of

being and understanding each other coexists throughout life as a most important source for interpersonal and social understanding.

As the psychological self develops, so does the understanding of self-other distinctions. According to Stern (1985), intersubjectivity lies in the core of self-development as the differentiated self is a product of intersubjectivity in the caregiving relationship. Intersubjectivity refers to a state of interaction when two people mutually modulate their interactions in relation to the other's inferred or perceived state of mind (Joyce, 2007). Theory of mind, in the tradition of autism research, focuses on understanding the cognition and logic behind human behaviour. In the mentalization tradition the affective and interpersonal dimensions are added to this mindreading capacity. As mentioned earlier, the role of mentalization in affect regulation is given paramount importance, and the concept of 'mentalized affectivity' is used by Fonagy et al. (2002, p. 435) to describe "how affects are experienced through the lens of self-reflexivity". Reading and understanding what lies behind human behaviour, is essential to social understanding as well as self-understanding. The child's ability to make sense of own affects is closely linked to the ability to regulate them.

Marked mirroring and affect regulation

By holding the child's mind in mind by looks, gestures, tone of voice and words in a *contingent* way, the inner life becomes real and available for the child. This supports the developing competences to represent and regulate feelings, desires and intentions. Contingency in interaction implies more than pure mirroring. The caregiver re-presents the emotional state of the child with slight differences from the child's expression, by softening or exaggerating or replying in a different modality, for example using tone of voice to mirror a movement or facial expression. The marking of the mirroring helps the child toward a distinction of self and other, and also clarifies the ownership of the internal state. The caregiver's marked mirroring is perceived as a representation of the child's inner states and thus forms the very beginning of a symbolic capacity (Fonagy et al., 2002).

Fonagy (2001, p. 438) links sensitive marked mirroring to the development of a social interpretive mechanism in this way: "At this level of human proximity, the other's subjective state is automatically referred to the self. In infancy the contingent responding of the attachment figure is thus far more than the provision of reassurance about a protective presence. It is the principal means by which infants acquire understanding of their own internal states, which is an intermediate step in the acquisition of an understanding of others as psychological entities."

Marked mirroring serves a crucial function of organizing and regulating the infant's affective states, and it is conceived as a necessary interactional attitude

and skill in the caregivers' role of being a self-regulatory other (Tronick, 1989). Marked mirroring may be seen as an early form of parental reflective functioning. It moves beyond the spontaneous mimic imitation present in the interaction from birth, and serves a confirmatory and regulatory function and supports the development of an interpersonal interpretive mechanism.

From this rather thorough description of the developmental process of affect regulation, symbolization of emotional and bodily experiences, and mentalizing, we focus on the concept of *parental reflective functioning*, which is found to be a mediating mechanism of intergenerational transmission of attachment patterns (Bernier & Dozier, 2003; Grienberger, Kelly & Slade, 2005; Slade, Grienberger et al., 2005). In a study of forty mother-child dyads Slade et al. (2005, p. 283) conclude: "The findings indicate that relations between adult attachment and parental reflective functioning are significant, as are relations between parental reflective functioning and infant attachment. A preliminary mediation analysis suggests that parental reflective functioning plays a crucial role in the intergenerational transmission of attachment".

Parental reflective functioning

The concept 'parental reflective functioning' is introduced by Arietta Slade and her colleagues (Slade, 2005; Slade, Grienberger et al., 2005). Derived from the theory of mentalization, it is defined as "parents' capacity to make sense of her/his child as a separate differentiated person with thoughts, feelings, and a mind of his own – to think reflectively about that child" (Slade, 2006, p. 640). The authors claim that 'reflective functioning' is central in sensitive caregiving, secure attachment patterns and mentalizing competence in the child. The caregiver's capacity to make sense of her own and her child's mental states plays a crucial role in helping the child to develop flexible and adaptive means of regulating itself, and to establish productive and sustaining relationships (Slade, Grienberger et al., 2005). Presumably, it is the parent's capacity to tolerate and regulate her/his own affective experiences that allows her/him to tolerate and regulate these experiences in the child.

The concepts of mentalization and parental reflective functioning have convinced several clinicians and researchers that the enhancement of parental reflective capacities are crucial to any successful treatment effort, and a potent catalyst for change in the parent-child relationship (Baradon, 2005; Slade, Sadler et al., 2005; Suchman et al., 2005).

Being a reflective parent means having a capacity to notice, to do reasonably precise interpretations and represent the inner state and intentions of the child. It means being able to recognize how the child feels, but at the same time manage

to take one step aside of the emotionality and to take whatever action is needed to support or regulate the child. At the same time the parent must be skilled in understanding own mental states in general and own feelings of parenthood specifically. The early experiences of being treated and understood as a person with an own inner life initiates the infant's development towards a 'theory of mind' and a mentalizing capacity.

Parent-child relationships at risk

Parental mind-mindedness and emotional availability is of major importance for the child's development of self and interpersonal competence. But what if the caregiver is 'absent-minded' or shut off, as often is the case when the mind is tormented by interpersonal trauma, psychiatric illness or caught in drug dependency? When the mind is occupied by drug dependency, the parent-child interaction is at risk suffering from emotional unavailability, incongruent mirroring and dyadic dysregulation. If the distorted mind of the parent systematically influences the patterns of interaction over a period of time, the child is handed over to its own incapacity to regulate own affects and to its own inability to make sense of own and other's minds. Hence, psychological and social development is endangered. Findings from neuroscience suggest that systematic failure in caregiver's sensitivity for the child endangers the child's neurobiological development. Normal brain development depends on sensitive care and protection from enduring stressful arousal to develop the prewired potential for an interpersonal interpretive mechanism (Allen & Fonagy, 2006).

When caregivers are not only absent-minded, but also exhibit weird, abusive and threatening behaviour as part of their interactional pattern, the consequences may be severe difficulties in both physiological and psychological regulation. It may lead to deficits in executive functions, such as planning skills, working memory, mental flexibility and inhibition of impulses (Schore, 2001). Teicher et al. (2003) suggest that stress and interpersonal trauma 'tailor' the brain to express anti-social behaviour. In an unpredictable and threatening world, there is more use for 'quick fight-and-flight' than slow empathy and interpersonal interpretation. The central nervous system prepares the organism for danger with physical arousal, whereas a mentalizing stance requires a basic sense of safety.

Measuring Parental reflective functioning

The notions of mentalizing and reflective functioning (RF) are based on assumptions that these capacities are distributed along a continuum from low to high. Slade and colleagues have construed an interview, the Parent Development

Interview (PDI), to measure parental reflective functioning in relation to a specific child (Slade et al., 2005). The PDI is assumed to pick up the parent's predominant stance towards the child as more or less an intentional being. The interview revolves around commonly experienced feelings, and it is expected to give a general idea of the nature of the parent-child relationship. Reflective functioning is measured on a scale ranging from -1, meaning a severely bizarre and disturbed mentalization, up to 9, signifying an exceptionally well-developed reflective functioning. A rating of 4 indicates a normal RF. A normal to high PDI-reflective functioning score is thought to describe a parental awareness of the child's inner experience and how minds work and interact in general. The Reflective Functioning scale was originally developed by Fonagy, Target, Steele & Steele (1998) to be used together with the Adult Attachment Interview.

Reflective functioning is generally low in substance abusing populations (Pajulo, 2007). Typical for low reflective functioning is a tendency to a behaviourally and personality oriented understanding of the child. I.e., the parent may describe the child without a deeper understanding of its emotional expressions. Denial of own mental states as a parent and distorted perceptions of the child are other characteristics.

A theoretical framework of addiction- and family interventions

We repeat our acknowledgment of substance use disorder as a complex and multicausal phenomenon, where our contribution is focused at the interpersonal and psychological level and to a certain degree on the resulting neurobiological traces of significant relational experiences. Although treatment always concretely takes place in the here-and-now, which is in the present family situation, our understanding is more precisely conceptualized as an intergenerational model which contains the dynamics within and between generations. Relational treatment during early parenthood is on site work directed towards both parent's own relational history and the evolving relation with the child as they are expressed in mental representations, narrative meaning and actual behaviour.

The vulnerabilities of addiction are relational, psychological and neurobiological. As mentioned earlier, Reading (2002) describes addiction as a relationship with drugs. From a neurobiological perspective, drug addiction influences the brain mechanism of the attachment system, meant to enhance interpersonal bonds and feelings of satisfaction and joy. Drugs prove to be effective regulators of physical state and emotional pain or imbalance, and substances can soon become best friend and comfort, the pill of peace and needle of love.

When the addictive person enters parenthood, substantial changes must occur

in order to provide good enough care for the baby and to prevent passing on the vulnerabilities behind the addiction as well as those resulting from it. One of the most urgent goals of family treatment is to restore the attachment system from the detrimental effects of drug addiction and redirect the liking-and-wanting mechanism of the brain towards natural stimuli. We propose that early parenthood is an especially productive moment to intervene in order to break the malign relationship with drugs. Stern (1998) describes pregnancy and early parenthood as a special psychological condition, “a unique organization of mental life appropriate for and adapted to the reality of having an infant to care for”. It is not simply a life crisis to be handled, potentially conducive of change; “Its cardinal function is to effect change, maturation, development, and growth” (Stern, 1998, p. 3).

According to Stern (1998), the points of entry in early parent-child intervention are many; at the behavioural level of the parent-child relationship, at the level of mental representations; of own parents, of the child, of relationship with therapist, and with drugs. Changes at the behavioural level may promote changes in the mental representations and vice versa. As addiction is partly understood as a regulating relationship with drugs or alcohol, specific attention must also be paid to this relationship, both in terms of mental representations and behaviour.

Mentalization-based parent-child treatment

Mentalization based treatment has already been applied in work with infant-families at risk.

The program “Minding the baby” is an interdisciplinary and community-based home-visiting program developed by Sadler, Slade and Mayes (2006), serving high-risk first-time parents living in urban poverty in USA. The aim of the program is to develop healthy and sustaining mother-child relationships. Although the authors say that the methods of the program “shares a variety of techniques with well established home visiting and infant health models”, they emphasize a “specific focus on the development of parental reflective functioning (RF) or mentalization, and on helping the parents keep their babies ‘in mind’ physically, emotionally, and developmentally” (Sadler, Slade & Mayes, 2006, p. 271).

The Finnish treatment project “Holding tight” (Hyytinen & Kuorelahti, 1998; Pajulo et al., 2006) has developed a mentalization-based parent-child treatment with the same objectives as “Minding the baby”, i.e. to enhance parenting skills, healthy child development and alcohol/drug abstinence. Pajulo et al. (2006) expect that a MBT-approach will even promote better drug treatment, and they suggest that “more persistent parental abstinence is achieved especially through intensive treatment focus on parent-child relationship rather than, or in addition to the converse, that abstinence facilitates more effective parenting” (p.460). This,

they say, is partly due to the relationship between central reward pathways in the brain and the capacity to invest in another person, as in parenting.

The treatment model focuses on helping the parents “invest in their child instead of substances, and to ‘reset’ the focus of the natural reward system by intensively facilitating and enhancing the mother’s satisfaction with positive interaction experiences with her baby and with being a parent” (Pajulo et al., 2006). In a way, this is an advanced neuroscientific and theoretical statement parallel to a substance abusing mother’s statement about her daughter: “No drug can ever make me feel better than Anna.”

Promoting parental reflective functioning

In today’s most popular parent-training programs like Webster-Stratton’s (2005) “The incredible years” and parent management training (PMT-Oregon) (Aasebøe, 2006), the focus of attention is placed largely on changes in the overt behavioural interactions, rather than the caregiver’s representations of those interactions. The principles advocated by Slade and others (Grienerberger et al., 2005; Slade, 2005) add the importance of mental representations and parental mind-mindedness to the behavioural aspects of sensitive caregiving. The general idea of promoting parental reflective functioning consists of helping the parent keep the child in mind in increasingly complex and sophisticated ways (Slade, 2006). The therapeutic strategy involves modelling reflectiveness, facilitating curiosity and eliciting affects alongside with efforts to understand as means to develop parental mentalization (Slade, 2006). The following are some examples from the treatment program “Towards a secure base” at the research site:

- Through a two year comprehensive training in the theory and practice of mentalization based treatment offered to the entire staff, including the non-clinical staff, all elements of the treatment program have been scrutinized and linked together with the explicit effort to promote mentalizing, in staff and patients. This has resulted in less emphasis on historical and narrative content and more focus on interactive and reflective processes in the here-and-now. However, narratives of past experiences are still explored in terms of how they may contribute to present emotional and relational functioning and especially how they may affect their parenting role and the relationship with their child/children. Additionally issues in the here-and-now are explored in relation to the past, specifically regarding attachment experiences.
- The heightened awareness of the importance of the parenting role and the necessity of minding the baby has led to more therapeutic activities investigating the perspective of the child. In therapeutic groups where the children

are not present, they are kept in mind by asking questions like: How do you think your child experienced this period/episode? How did your child tell you that she felt alone at that time? If your child could speak, what would he say about...?

- A parent-infant group is established to work with both the interaction within the families and the parental reflective functioning. Both parents are present together with the child. The facilitators establish a safe and predictable frame for the group. The aim is to promote a benign, curious and calm attitude in which the parent is engaged in trying to figure out what's going on in the mind of their child. At the same time the parents are urged to explore own childhood and adult experiences as well as bringing into the group issues of concern related to the child or the relationship. Talking about past relationship experiences in the context of the child often evokes strong emotional meeting points of past and present with therapeutic potential.
- Assessments of parent-child interaction are videotaped and replays are used as tool for promoting parental reflectivity. After one session of reflective video replay, a mother expressed:
"I used to think that my daughter didn't need me. When she turned away I just thought she had more interest in something else. But through investigating my own childhood experiences and looking at her in the video replay, I realized that I had left her alone, that she didn't expect any real contact from me. I remember how lonely I felt when I was little. If I could feel that way, then why shouldn't she experience the same?"

Discussion

The primary aim of this article has been to provide a theoretical framework for family-oriented treatment for substance use disorders. Terms are often used interchangeably to convey same basic ideas. The concept used here, mentalizing, spans a number of "conceptual cousins" such as *mind-blindness*, *emotional intelligence*, *insight*, *theory of mind* and *social cognition* (Allen, Fonagy & Bateman, 2008). Such concepts are to some extent overlapping. Hence, concerning the interest in the concept of mentalizing the last years it has been asked whether this is the well-known "old wine in new bottles". We would argue that it is not. Rather the novelty and utility of mentalizing may represent a new paradigm. As such it combines clinical observations with findings in neuropsychology, traces its role in both human evolution and developmental psychology, links development of mentalizing competences to intersubjectivity and attachment experiences, and clinically connects mentalizing to affect regulation and clinical symptoms. Mentalizing as a concept represents conceptual and empirical bonds between brain and mind.

And different from other psychodynamic traditions the mentalizing tradition aims to combine psychodynamic hermeneutics with evidence-based medicine. And not at least, as mentioned in this article, there have been developed empirical measurements of mentalizing through instruments covering reflective functioning in general and parental reflective functioning specifically. Therefore, we do find the paradigm of mentalizing representing new developments in theory, clinical work and research, to be more than the old wine in new bottles.

As a global concept referring to the development of a human interpretative skill crucial to mental health and social competence, it is highly relevant in prevention – e.g. the children of substance users – as in psychotherapeutic work – e.g. the substance using parents. Substance dependency influences caregiving in a number of ways, and for these vulnerable infants, even minor dysfunctions in the patterns of interaction may lead to developmental and psychological disturbances. We have illustrated how parental reflective functioning promotes sensitive care, which again serves to protect the infant and the immature brain from potentially dangerous stress and physiological arousal. Without a lifeline to the caregivers' mind, the development of self regulation and social competence is endangered.

The mentalization-based framework and the treatment programs briefly outlined here, suggest a long-term multidisciplinary intervention and follow-up. Some of the central risk factors for prolonged addictive problems in the parent and developmental hazards for the child are embedded in the deep structures of human life. High-risk families need substantial support to break the burden of intergenerational transmission of internal representations of caregiving experiences, and to promote good enough care for the infant. Mentalization, parental reflective functioning and the importance of "how the interpersonal world is remembered, abstracted and lived" (Stern, 1991) should therefore be at the centre of our attention in work with parent-infant relationships at risk.

Mentalization-based therapy (MBT) evokes interest in both academic and clinical settings and has been applied with success to different adult patient populations. MBT programs such as "Minding the baby" (Slade, Sadler et al., 2005), the Finnish model "Holding tight" (Hyytinen & Kuorelahti, 1998; Pajulo et al., 2006) and the Norwegian program "Towards a secure base" bring this promising theory and clinical methods back to promoting well being of babies at developmental risk.

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