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Research article

Adverse and adaptive childhood experiences are associated with parental reflective functioning in mothers with substance use disorder

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ABSTRACT

Mothers with a substance use disorder (SUD) are at risk for maladaptive parenting practices, and have heightened likelihood of having experienced childhood adversity themselves. In addition, parental reflective functioning (PRF), a capacity underlying sensitive caregiving, is often low in mothers with SUD. This study examines the relationship between PRF and aversive (emotional, physical, sexual abuse and neglect) and adaptive (safety and competence) experiences, in different developmental phases (early childhood, latency, and adolescence) in mothers with a SUD. A sample of 43 mothers with small children were interviewed with the Parental Developmental Interview to assess PRF, and they completed the Traumatic Antecedents Questionnaire regarding aversive and adaptive experiences. In addition, we used the Hopkins Symptoms Checklist-10 to control for mental health status and a battery of neuropsychological tests to control for executive functions. Results indicated that adaptive experiences in early childhood were positively related to PRF, and that experience of emotional abuse was negatively related to PRF. When separating the group of mothers in two sub-groups based on PRF level, results showed that mothers with negative to low PRF had significantly more experiences of adversities in early childhood and latency, and significantly less adaptive experiences in early childhood, latency and adolescence, compared to mothers with moderate to high PRF. In addition, mothers with adequate to high PRF reported experiencing significantly more types of adaptive experiences, and significantly less adversities compared to mothers with negative to low PRF. Results are discussed in relation to developmental trauma, resilience, epistemic trust and mistrust.

1. Introduction

Adverse interpersonal traumatic experiences in childhood and adolescence are shown to negatively affect somatic health as well as heighten the risk for adult psychopathology (Heleniak, Jenness, Vander Stoep, McCauley, & McLaughlin, 2016; Shonkoff et al., 2012; Teicher & Samson, 2016). Although experiences of early adversity might lead to post-traumatic stress disorder (PTSD) for some

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individuals, others might develop other forms of psychopathological symptoms such as depression, anxiety or a substance use disorder (SUD), and some individuals may not develop any symptoms (Dube et al., 2003, 2006; Ozer, Best, Lipsey, & Weiss, 2003; Strine et al., 2012). In numerous studies, results suggest that there is a high co-occurrence between SUD and the likelihood of having experienced childhood adversity (Felitti et al., 1998; Green et al., 2010; Jansson & Velez, 2011; Norman et al., 2012; Vachon, Krueger, Rogosch, & Cicchetti, 2015). Furthermore, it has been suggested that substance abuse might be conceptualized as a form of coping behaviour, where substances might function as a strategy to manage challenging emotions associated with previous traumatic exposure (Berking & Wupperman, 2012; Haller & Chassin, 2014; Leeies, Pagura, Sareen, & Bolton, 2010; Sheerin et al., 2016).

Trauma is defined as a response to an event that threatens a person's life, physical or psychological integrity whether experienced directly, witnessed or heard about (American Psychological Association, 2013; Rothschild, 2011). Early, recurrent and severe interpersonal trauma has been termed developmental trauma (Ford et al., 2013). Developmental trauma suggests that a primary caregiver is involved in the adversity, and therefore the experience could affect core developmental capacities in the child. Specifically early caregiving relationships are thought to provide the relational context in which children develop the earliest psychological representations of self, others, and self in relation to others (Fonagy, Gergely, & Jurist, 2004). These working models form a developmental foundation of a child's sense of safety, emotion regulation capacity, distress tolerance and a sense of agency, and together these processes influence the experience of controlling one's own actions and having competence to handle events in the outside world (Haggard & Chambon, 2012; Sokol, Hammond, Kuebli, & Sweetman, 2015). When the child-caregiver relationship is the source of adversity, the attachment relationship may be severely compromised (Allen, 2012; Cook et al., 2005; Van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). For instance, when a caregiver is too preoccupied, distant, unpredictable, punitive or distressed to be reliably responsive, children can become distressed easily (Cook et al., 2017; Shonkoff et al., 2012). Different forms of adversity frequently co-occur, and exposure to a higher number of adversities predicts greater psychological and somatic symptom severity in childhood through to adulthood (Cecil, Viding, Fearon, Glaser, & McCrory, 2017; Finkelhor, Ormrod, & Turner, 2007; Finkelhor, Ormrod, & Turner, 2009). Furthermore, there is an increasing risk when victimization in childhood is followed by further traumatization in adolescence and in adulthood (Briere, Kaltman, & Green, 2008; Van der Kolk et al., 2005). Exposure to adversity during sensitive periods, such as early childhood and adolescence are particularly harmful for the developing child, and may compromise core self-regulatory capacities in childhood (Kolk & Fisler, 1994; Manly, Kim, Rogosch, & Cicchetti, 2001; Meaney & Ferguson-Smith, 2010). In addition, individuals exposed to adversity in childhood may be particularly sensitive to stressful experiences and prone for later psychological distress in adolescence and adulthood (Althoff, Verhulst, Rettew, Hudziak, & van der Ende, 2010; Dougherty, Klein, & Davila, 2004; Fonzo et al., 2016; McLaughlin, Sheridan, Alves, & Mendes, 2014).

Transition to parenthood is considered a period of reorganization of the self, that may trigger memories and experiences associated with childhood adversity (Fraiberg, Adelson, & Shapiro, 1975; Lieberman & Van Horn, 2011). Repeated adversities may disrupt the development of appropriate emotion regulation capacities and interpersonal skills needed for parenting, making the cues and demands from the child potentially overwhelming for the parent (Burns, Jackson, & Harding, 2010; Cicchetti & Rogosch, 2009). Indeed, adults with developmental trauma are shown to be at risk for impaired parenting capacities (Belsky & Pluess, 2013; DiLillo & Damashek, 2003; Fuchs, Möhler, Resch, & Kaess, 2015; Gonzalez, 2015). Consequences of adverse childhood experiences may as such extend into the next generation.

Adaptive experiences in childhood and adolescence such as safe relationships, adequate coping mechanisms, and a sense of competence and agency may contribute to resilience in adulthood (Belsky & Pluess, 2009; Block & Block, 1980; Cook et al., 2017; McGloin & Widom, 2001). Resilience is defined as the ability to maintain equilibrium in the face of stressful life events (Bonanno, 2005), or a pattern of positive adaptation in the context of significant risk or adversity (Rutter, 2012). A good enough, safe attachment relationship with the caregiver, in addition to having effective coping capacities have been found to be protective factors when growing up with adversity (Luthar, 2006, 2003; Schofield, Conger, & Neppl, 2014). Adults with SUD exposed to developmental trauma often report low levels of such protective adult relationships in childhood (Brown & Shillington, 2017).

Early adversity is associated with disturbances in mentalizing abilities in individuals with SUD (Allen, Lemma, & Fonagy, 2012). Mentalizing is a developmentally acquired skill that enables an understanding of mental states (e.g. feelings, wishes, thoughts) in others and oneself as underlying behavioural expressions (Fonagy, Steele, Steele, Moran, & Higgitt, 1991; Fonagy et al., 2004). Development of adequate mentalizing capacities may be a protective factor against emergence of psychopathology in the face of childhood adversity by creating a coherent narrative around the adversity (Fonagy, Steele, Steele, Higgitt, & Target, 1994). Reflective functioning (RF) is the manifestation of mentalizing, and is suggested to first develop in an attachment relationship with a sensitive and responsive caregiver (Bouchard et al., 2008; Fonagy & Target, 1997; Fonagy & Target, 2002; Sharp & Fonagy, 2008). Parental RF (PRF) is the capacity to mentalize in the context of the caregiving relationship (Slade, 2005), and is considered a prerequisite of parental sensitivity (Pajulo et al., 2012). The level of PRF also influences the development of child RF, for instance moderate to high PRF has been associated with moderate child RF (Ensink & Mayes, 2010; Sharp & Fonagy, 2008; Slade, 2005). However, as the child develops, peers, teachers and the sociocultural context increasingly influence RF capacity (Luyten, Nijssens, Fonagy, & Mayes, 2017). Indeed, although RF is not directly associated with parenting, RF and PRF are separate but related capacities that capture different aspects of mentalizing (Luyten, Fonagy, Lowyck, & Vermote, 2012; Luyten, van Houdenhove, Lemma, Target, & Fonagy, 2012; Luyten et al., 2017; Steele et al., 2008). Both RF and PRF are considered dynamic capacities as they are influenced by particular contexts (e.g. developmental trauma) and specific relationships (e.g. being a parent). Fonagy et al. (1991, 1995) suggested that PRF has a mediating effect between maternal childhood adversity and the development of attachment security in the child. As such, PRF has been considered an intergenerational resilience factor. Previous studies have identified negative associations between PRF and emotional abuse (Bottos & Nilsen, 2014; Burns et al., 2010; Hart, Binggeli, & Brassard, 1997) and between PRF and neglect (San Cristobal, Santelices, & Fuenzalida, 2017), indicating that different forms of adversity might affect PRF differently (Teicher, Samson,