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Help and Healing During Withdrawal

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HELP AND HEALING DURING WITHDRAWAL

The University of New Mexico School of Medicine was awarded a federal grant through the Abandoned Infants Assistance Project called Los Pasos. The grant, which began in 1990, was designed to decrease the physical and emotional abandonment of children due to alcohol and other drug use.

- I. A multi-dimensional approach helps to heal the active and ongoing withdrawal of the newborn. The family environment in a drug-using culture is often chaotic, disruptive and disorganized. The lives of families are marked by overstimulation and fragmentation colored by violence and poverty. The infant enters into a sub-culture which is preoccupied with addiction. Families are often unable to respond with consistent and predictable behaviors. The support parents seek can be scattered throughout broken homes and divided into complicated social systems. Philosophical approaches to this issue may vary among hospital systems and agencies. The common threads that help to interweave healing during an infant's withdrawal and recovery is what service providers seek to identify and supply.

A. Setting the tone

Setting the tone occurs best during the period after birth and is built upon throughout the relationship with the family. How we can set the tone is as follows:

1. Establish trust and communication with families and include them as part of the team.
2. Refrain from judgment. Deal with the baby and family with open minds and hearts. The families may already feel guilty, ashamed and paranoid.
3. Support families by providing specific guidelines and expectations. For example, during the baby's hospitalization provide instruction to the parents regarding the baby's care. Include parents in decision-making and planning.
4. Be honest rather than suspicious. Ask direct questions, and speak your truth.
5. Focus on the positive but be realistic about the obstacles. Keep a balance between both perspectives throughout your interactions.
6. Establish boundaries for yourself and the family.
7. Take one day at a time. Allow the relationship to build and grow. Each contact with families offers different experiences and provides opportunities to learn in a natural and holistic manner.
8. Encourage families and staff to take care of themselves throughout the sometimes stressful situations that occur.
9. Listen to what the family has to say.

B. Nourish the Environment

During a baby's withdrawal, environmental considerations are crucial to diminish overstimulation and maintain calm. A quiet and peaceful setting where parents can feel welcomed is essential. Babies need to receive the message that they are safe, warm, protected, and comforted in a predictable and stable environment. Ideally this setting would extend from the hospital to the home environment. Key factors to consider include:

1. Noise reduction: encourage both staff and family to talk softly and positively. Avoid loud startling noises. Offer soft music to create an ambiance of tranquillity (i.e. heartbeat or nature sounds). Cover open isolette to muffle sound.
2. Reduce light; when possible use individual bedside lighting and optimize natural outdoor light in the nursery. Keep lights dimmed especially at night to provide a day/night cycle. Shield babies from bright light when feeding and handling.
3. Rhythmic movement: baby equipment such as a 'snoozle', swing and rocking chair can be helpful. Discriminate appropriate time, place and rhythm. Vary frequency and duration of use of equipment. Holding and swaddling are vital. Human contact, including opportunities for frequent holding with swaddling, is essential.
4. Warm baths followed by massage provide relaxation during painful withdrawal.
5. Provide a home-like environment: use furnishings that are comfortable for the baby and parent. This may help to optimize parent involvement and interaction. Ideally the nursery should provide comfortable chairs (a rocker and folding beds). An overnight space needs to be created for parents to allow 24-hour visitation and caregiving.

II. Interrelations of the Newborn and Family and Staff

A. The newborn exposed to drugs is a baby first and drug exposed second.

1. Identify and understand individual drug side effects.
2. Read and respond to the baby as an individual.
3. Understand the baby in the context of their family and the nursery environment. This is not a static process but interactional in nature.
4. Be aware of the family dynamics related to team interaction. Recognize and work with the baby in context of the family. This requires extensive time, energy and coordination.
5. Work with the family as a team.

B. The family is unique and varied in composition.

1. Identify key members of the family.
2. Acknowledge the culture of the family. How culture shapes a family's values and beliefs must be respected.
3. Invite and encourage early participation in the baby's care.
4. Identify the various barriers that keep families away from relating to and caring for their newborn. Assist families in overcoming this obstacle.

C. The staff includes nurses, physicians, social workers and therapists.

1. The newborn and family needs care coordination with a team that is knowledgeable, willing, and invested in providing support and a multi-faceted approach.
2. The staff needs to have time for: specialized training, planning, care conferences, teaming and peer support.

3. The overall goal is to provide complete care in a nurturing environment which incorporates the family in the care of their baby.

III. Formal and informal assessment is utilized from the time of birth until discharge. Assessment may vary from days to months, especially if an infant is preterm, is experiencing a difficult detoxification, has genetic anomalies or has known handicapping conditions.

A. Preterm infants are those born prior to 37 weeks gestation and as early as 24 weeks gestation. Typically, preterm birth requires the infant to be in a newborn intensive care unit (NICU).

1. Evaluation of the preterm, drug-exposed infant in the NICU initially involves observation. The naturalistic observation of newborn behavior is utilized by nurses and developmental specialists. The baby is observed before, during and after medical care. The assessment looks at the infant's behavior after which a plan of care can be developed.
2. Neuromotor assessment: This includes evaluating muscle tone, reflexes, body symmetry, movement and oral motor skills.
3. State assessment: State is defined by Brazelton as a range of activities from deep sleep to crying. State fluctuation and lability are important components to assess in an infant exposed to Alcohol or Other Drugs AOD. A baby in active withdrawal will often go from a sleep state to crying unable to maintain an alert period. (Refer to the handout Infant States...)
4. Orientation: Orientation to auditory and visual stimuli is best assessed when the infant reaches 32 weeks gestation. Initially, the assessment determines if these systems are intact (can the baby see and hear). The ability to see and hear inanimate and animate objects is explored. For this portion of the assessment it is ideal to have family members involved since an infant responds best to the voice and face of the parents.
5. Environment: Continuous monitoring of an infant's response to his or her environment occurs during the formal and informal assessment. Observation of light, sound, movement, touch, positioning and handling effect an infant differently, potentially causing shut down or over stimulation.

B. The term infant exposed to AOD may experience a stronger and more prolonged detoxification. When born full term, the AOD infant is exposed to teratogens for a greater period of time compared to a preterm infant born one to three months early.

1. Scoring an infant for withdrawal using a scale such as the one developed by Loretta Finnegan can help provide some objectivity to assessing the infants detoxification. Current use of medication such as methadone or Phenobarbitalis used to assist the infant through the withdrawal process. Treatment protocols vary from hospital to hospital.
2. Use of therapeutic positioning and handling and monitoring of the environment can assist an infant through withdrawal.
3. Optimizing the environment to include family accessibility including 24-hour visitation with facilities for overnight stay is part of the assessment plan and the infant's total care.

4. The Neonatal Behavioral Assessment Scale (Brazelton, 1983) is the most widely used tool to assess infant behavior. It allows assessment of the infant's skills in the following areas:

- Habituation: infant's ability to accommodate to light and sound, initially responding then tuning out the stimuli.
- State: infant's ability to exhibit and transition through a variety of states smoothly and predictably.
- Motor: muscle tone, reflexes, quality of movement and symmetry.
- Physiologic: color and respiration.
- Orientation: infant's ability to visually track animate and inanimate objects; and locate sound.

* The NBAS also identifies an infant's optimal learning style and ideal ways to console the baby.

IV. Reading and responding to the infant's cues is an essential part of the informal evaluation and training provided to staff and families. Teaching staff and families to read and respond to the infant's cues will assist both the critically ill preterm infant and the infant in active withdrawal as follows:

- Helping the infant to become better organized and self-regulated. It also helps the infant to become more medically stable and alert and better able to calm him or herself. This is particularly important during the withdrawal period.
- Helping to identify the infant's individual style of communicating and learning. In an attempt to optimize the infant's development, one can begin early in life by identifying the key approach and avoidance cues the infant provides (refer to the handout Infant States...).
- Helping the infant become more organized and self-regulated. This may increase the family's success and ability to calm and interact with their baby.
- Helping to achieve a balance in the autonomic, motor and state interaction systems. This allows service providers and families to shape the physical and social environment and to assist the infant to become more organized and self-regulated. (Refer to the handout, Calming and Comforting...)

V. Nurturing touch and movement have been found to be two of the most essential human necessities. This can best be described as a synchronized dance between the caregiver and baby and includes the following:

- Positioning** of the preterm or term baby who is drug exposed occurs most effectively through mimicking the womb. Positioning includes: nesting, swaddling, facilitating hands to mouth and face, providing trunk and extremity flexion and placing prone and/or sidelying. (Refer to the handout, Positioning and Handling...)
- Handling** incorporates the use of containment during care. This is both an active and passive process. (Refer to the handout, Positioning and Handling...)
 - Passive containment allows one to contain baby's arms and legs. This provides the infant with support and boundaries which may not yet have been developed internally. This becomes crucial when working with the critically ill, preterm baby.

2. Active containment involves the same principals, though the caretaker must move the infant while still containing arm's and legs.
- C. **Nurturing holds** may often be the first touch tolerated by a baby in active withdrawal or when critically ill. Specific holds to key parts of the body can help calm the baby and assists them in touch desensitization. It can also help to enhance the alert state, to become better organized and to discriminate between painful and pleasant touch.
- D. **Massage** of the infant best occurs when the infant is medically stable. Massage allows touch acceptance.
 1. The massage is adapted to the special needs of the infant.
 2. A sequential approach is used emphasizing reading the infants cues.
 3. Begin with simple, steady, hands on to key body parts.
 4. Stroking: the traditional order of the massage including frequency and duration of strokes may need to be altered and modified as the baby is recovering from illness and/or withdrawal.
 5. The parent or primary caregiver provides the massage with guidance from the therapist. This has been found to be an optimal way of enhancing early parent-infant attachment. The benefits and contra-indications are listed on handouts entitled Benefits of Massage and Contra-indications).
- E. **Movement** needs to be incorporated into the infant's environment.
 1. Movement is important to all infants influencing the vestibular mechanism of the brain. Throughout pregnancy, natural movement occurs. Post-birth movement may have to be provided externally. Individualizing the infant's source of movement using both human and mechanical forms may be beneficial. Close monitoring of rate, rhythm, frequency and duration can not be over emphasized.
 2. Traditional use of holding and rocking.
 3. Mechanical ways to provide movement include waterbeds, hammocks, swings or a snoozle (an infant seat that is motorized to provide motion) are incorporated (refer to the handout, Calming and Comforting...).

In summary, the process of help and healing during infant's withdrawal begins within the hospital setting. It involves a team approach with a family focus. Hopefully, the baby and family are discharged with a continuity care plan that can be expanded upon in the community.

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DEVELOPMENTAL SEQUELAE RELATED TO SPECIFIC DRUG EXPOSURE

There are some specific neurodevelopmental characteristics related to specific drugs. Though the literature clearly has found that most infants are poly-drug exposed, being aware of specific drug effects can be helpful. Below is an overview of the developmental sequelae of infants exposed to drugs in-utero.

HEROINE/METHADONE/OPIATES

The typical characteristics of an infant in active withdrawal includes: increased muscle tone, jitteriness, hyperactive startle, frantic sucking, and feeding difficulties. Initially, the baby may show poor oral motor coordination followed by frantic sucking and overeating. The infant may demonstrate rapid state transition moving from sleep to agitation. Other physiologic characteristics include: sneezing, vomiting, color change, increased respiration. Overall the baby may be difficult to calm and console.

COCAINE

The greatest difficulty infants exposed to cocaine have is difficulty with habituation. Other areas of concern may include state maintenance and orientation. More specifically, they may have difficulty with arousing, awakening and sleeping deeply. They are readily overstimulated and focused orientation to people and objects can be difficult. Asymmetries may be evident but not routinely found.

MARIJUANA

The most obvious characteristic of infants marijuana-exposed is marked jitteriness in extremities, especially arms. This jitteriness can persist for months. At four months, intention tremors may be observed as an infant tries to reach for objects. With continued exposure throughout nursing an infant may continue to be exposed. They may become more sleepy with limited focused alert periods.

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