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Motherhood in the Face of Trauma

Pathways Towards Healing and Growth

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Project BRIGHT: An Attachment-Based Intervention for Mothers with Substance Use Disorders and Their Young Children

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Abstract

In the context of increasing rates of opioid misuse, particularly by women of childbearing age with histories of trauma, this chapter describes the background, evidence base, conceptual framework, and practice parameters for an attachment-based evidence-informed dyadic intervention utilizing the principles of child-parent psychotherapy with mothers and infants impacted by substance use disorders (SUDs). A strong focus of this chapter is to elaborate on the emotional needs of mothers in early recovery as they enter into the parenting role and on the needs of substance-exposed newborns and their role in fragile infant-parent dyads. A case is presented at the end of the chapter so that readers are better able to conceptualize this novel application of dyadic psychotherapy.

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12.1 Introduction

Since 2002 rates of heroin and other opioid use among US women have doubled, and the increase is particularly apparent among non-Hispanic whites and those living in the Northeast (Jones et al. 2015). The Substance Abuse and Mental Health Services Administration (SAMHSA) reports that 5.4% of US pregnant women aged 15–44 in 2012–2013 used illicit substances during pregnancy (SAMHSA 2014). Publicly funded addiction treatment programs do not capture pregnancy status at intake, but data from 2014 estimate that 2% of enrollees in these programs were pregnant women. Although pregnancy is often thought of as a time when women are highly motivated for treatment, many do not report their substance use due to shame, stigma, lack of confidence, and fear of losing their infant to child welfare (Spielman et al. 2015). It is equally important to note that these women often have extensive histories of childhood and adult trauma and present with co-occurring mental health disorders (Kaltenbach 2013). Their infants are at risk for cognitive, social, and emotional difficulties due to in utero exposure and the quality of relationships with caregivers and caregiving practices (Nair et al. 2003; Salo and Flykt 2013). Even when women do seek treatment and commit to sobriety during pregnancy and early parenting, few interventions exist to address the complexities of their histories, current lives, and the parenting process they are about to embark on. In the following paragraphs, we first briefly review what is known about pregnant and parenting women with SUDs in terms of trauma history, mental health, child development, and mothering. Second, we describe the status of existing programs. Third, we provide a conceptual framework for our intervention. Finally, we offer details about Project BRIGHT (Building Resilience through Intervention: Growing Healthier Together), an attachment-based evidence-informed dyadic intervention for mothers in treatment for opioid addiction and their young children, including a composite case example.

12.2 Pregnant and Parenting Substance-Dependent Women: Trauma and Mental Health

Research suggests that pregnant and parenting women with SUDs are more likely to have family histories of substance misuse, high rates of complex trauma, and co-occurring mental health disorders. These factors alone, regardless of substance misuse, are correlated with suboptimal parenting (Kaltenbach 2013). Additionally, posttraumatic stress disorder (PTSD) and SUDs are often correlated. A review of 72 studies on parental PTSD symptoms and parent-child interactions found some support for the notion that these parents are less likely to be emotionally available and more likely to have negative perceptions of their children (however, some of the reviewed studies did not show these associations). In the affected dyads, children tended to be more easily dysregulated or distressed than children of parents without PTSD (van Ee et al. 2015).

12.3 Impact of Neonatal Exposure to Substances on Child Development

Approximately 60–80% of infants born exposed to opioids develop neonatal abstinence syndrome (NAS). NAS contributes to problematic infant neurobehavior and long term may impact hyperactivity, short attention span, and memory problems. Studies of neonatal opioid exposure also indicate increased risk of low birth weight, respiratory complications, and infant mortality (Behnke et al. 2013). Children who are substance-exposed are at increased risk for an insecure or disorganized attachment, likely due to parents' co-occurring mental health disorders and transactional effects between the parent and child (Salo and Flykt 2013). These findings suggest that interventions must focus on the parent-child relationship, as well as aspects of parental well-being, in order to augment protective factors in place for the child and the dyad (Salo and Flykt 2013). Although the full impact of prenatal opioid exposure on children's long-term development is not yet fully understood, given the risks associated with maternal opioid use and this fragile beginning, support for the mother during and after pregnancy is recommended in order to promote healthier dyadic outcomes (Logan et al. 2013).

12.4 Impact of Substance Use Disorders on Parenting: Importance of Attachment

Cause I used to think that being a parent… being a mother was just being the mother, just feed 'em, change 'em, and that's it. You know? I did not do any bonding with none of my other kids. I don't think I even read 'em a book once, BRIGHT participant reflecting on parenting relationships while using heroin.

The attachment relationship is essential to the infant's overall development, including trust, promoting what is referred to as the secure base. It is health promoting in parents as well, as the formation of an attachment relationship provides a sense of pleasure, connection, and competence for the primary caregiver (Slade 2005). From this trusting relationship, a child feels safe navigating potentially stressful situations. The pleasure and reward parents often feel during attachment are compromised when SUDs interrupt the healthy functioning of motivation and reward systems in the brain. As the substance-exposed newborn may have particular difficulties regulating his or her various states of sleep and hunger, the mother's responsive care is particularly essential, yet she is less able to read and respond to her baby's cues (Pajulo et al. 2012). Studies have also found greater levels of maternal intrusiveness, where a parent overrides the child's ongoing behavior and redirects to a parent-led activity (Hans et al. 1999). Given the centrality of the attachment relationship in young children's development, the mother's decreased responsiveness to her infant, intrusiveness, and the dysregulation of the mother-infant dyad are particularly detrimental.

12.5 Existing Interventions

Pregnancy and preparing for motherhood often motivate women with SUDs (particularly involving opioids) to consider treatment, given the fear and guilt regarding the impact of their substance misuse on their unborn child and the increasing rate of infants' removal by child welfare (Rutherford et al. 2013). This motivation provides an optimal treatment opportunity. Hence, treatment programs that simultaneously address women's recovery and parenting are well suited for this time. Historically, many programs intended to support mothers in recovery have been centered on didactic parental education that reduces problematic parenting with the goal of improving child behavior. Outcome intervention efficacy has been mixed, perhaps in part because they do not take into account the extensive parental trauma histories and neurobiological changes (Suchman et al. 2004). A shift in researchers' understanding of the centrality of parent-infant relationships in improving outcomes is slowly beginning to favor relational interventions grounded in attachment theory (Bromberg et al. 2010; Pajulo et al. 2006; Suchman et al. 2008). A 2015 review of 21 studies of treatments for SUDs and parenting recommended concurrent enrollment in treatment programs to address substance misuse and parenting, which represents a shift in the historic trend of focusing solely on the individual in early recovery. One important caveat is that the parenting intervention begins with a focus on psychological processes such as development of emotion regulation mechanisms, before fully addressing effective parenting strategies (Neger and Prinz 2015). Difficulties with emotion regulation are common in people who misuse opioids. Furthermore, emotion regulation skills are crucial as parents help shape their child's emotional experiences and they have a regulatory function within the parent-child relationship (Rutherford et al. 2013).

12.6 Conceptual Framework for Intervention

Given the challenges facing mothers with SUDs and subsequent risks to the parent-child relationship, interventions that foster trust and attachment provide a necessary support. Studies have validated attachment-based interventions which focus on addressing parental internal representations, those beliefs and expectations held about one's self and important others developed through transactions with primary caregivers and the environment (Fonagy et al. 2002). An additional specific focus of these interventions is reflective functioning (RF), or the capacity of the parent to understand her own and her child's feelings, needs, and motivations and link these inner states with external behavior (Slade 2005). "A mother's capacity to hold in her own mind a representation of her child as having feelings, desires, and intentions allows the child to discover his own internal experience via his mother's representation of it" (Slade 2005, p. 271). If a parent can hold in mind her child's mental states, she is more likely to behave in an optimal way toward that child, decreasing the likelihood of neglect or maltreatment. Even with histories of trauma, parents with high RF are more likely to have securely attached children; conversely, low RF

is associated with hostile and withdrawn parenting leading to decreased social competence in children (Grienenberger et al. 2005). An explicit focus on working at the representational level and building RF for mothers with SUDs and their children is supported by evidence from the work of Suchman (Pajulo et al. 2012; Suchman et al. 2010). An intervention approach that addresses attachment and RF is essential as many of these mothers yearn to parent their children but may have limited skill sets given their own histories of trauma and being poorly parented. Increasingly, their children are removed from their care at birth, leaving the mothers bereft and in need of an effective intervention that will support their recovery from opioid misuse, enhance the possibility of reunification with their child, and encourage optimal parenting practices.

12.7 Project BRIGHT: Overview

Project BRIGHT is an evidence-informed dyadic parenting intervention initially developed for the use in residential treatment programs for mothers with SUDs and their young children birth through five (2009–2012) and subsequently delivered in outpatient opioid treatment settings (2012–2016). BRIGHT is offered as an enhancement to substance use treatment and not as an addiction treatment on its own. Sessions can start in pregnancy, as the mother is beginning to anticipate the birth of her baby, soon after the infant is born or during the toddler or preschool years. Number of sessions can vary, but, optimally, the parent and child meet with the clinician for approximately 9–12 months, although progress has been noted with as few as 10–12 sessions. Early findings demonstrate that BRIGHT is associated with improvements in maternal mental health and parenting capacities (Paris et al. 2015).

BRIGHT is informed by principles and techniques of the evidence-based child-parent psychotherapy (CPP; Lieberman and Van Horn 2005; Toth et al. 2006) and strategies derived from infant mental health interventions for vulnerable parent-infant dyads (e.g., Slade et al. 2005) including parents with SUDs (Suchman et al. 2010). CPP is a dyadic intervention for parents and young children affected by trauma and mental health difficulties, firmly based in attachment theory. Like CPP, BRIGHT is a dyadic therapeutic model, using play and relationship-focused activities to improve parent-child interactions and overall development. Clinicians promote developmental progress through play, physical contact, and language; offer unstructured developmental guidance; help parents provide protective behavior; translate the meaning of children's feelings and actions for parents; provide emotional support and empathic communication; and provide concrete assistance with problems of daily living. Relying on current best practices for mothers and infants affected by parental addiction, BRIGHT clinicians work to build emotion regulation skills and reflective functioning as mechanisms for a parent to become attuned to her child's emotional and behavioral needs. Additionally, the clinician helps the dyad to regulate strong emotions that emerge in the parenting process and link past relationships to present parenting, promoting attunement and sensitivity to the child.

12.8 Balancing Dyadic Trauma Treatment with Early Recovery

Given that BRIGHT integrates the principles of CPP and infant mental health with research on the impact of addiction on parenting, one main tenet of the intervention is the importance of shifting among therapeutic stances emphasizing recovery, processing and integrating trauma, and attending to parenting and the mother-child relationship. We initially work to engage the dyad in treatment through listening to the parent and child's needs and narratives and demonstrating that we can tolerate difficult emotions. While we are not providing addiction treatment, we explore a parent's recovery from active addiction, question what has promoted and prevented healthy recovery in the past, and acknowledge that difficult affect can be a trigger to relapse. As we build initial rapport with mothers in early sessions, we explicitly state that we want to hear when their recovery is threatened or when they have had a relapse. Our main goals in BRIGHT treatment include (1) integrating of past and present parental internal representations, (2) supporting self-narratives of competence and confidence, (3) encouraging parental reflective functioning, (4) developing playful moments of pleasure and connection, and (5) promoting optimal protective behavior in parents. The following sections will provide details of the BRIGHT intervention including a composite case example.

12.9 Engagement and Assessment

Attending to Parent and Child Central to dyadic treatment is a balance of attention between the parent and young child. Simultaneously, trauma-informed care emphasizes the importance of asking clients early in treatment what they want and need in order to feel safe and supported. When meeting with dyads for the first time, we make extensive efforts to elicit from parents their desired gains from speaking with us and work to match our approach to their needs. We also attend to the child in the room, remaining mindful of implications of nonverbal communication for safety and caring. It is challenging to balance many messages at once, so we use different "channels" to communicate to each member of the dyad. For example, we might use words that encourage a mother's need to talk about distressing events while using a tone of voice and body language that convey calm containment, hoping to offer both mother and young child some regulatory support. When possible, at the beginning we meet with mothers alone at least once to gather important historical and developmental information and convey that sharing traumatic content in front of a child can be difficult for the child. An additional goal is to explain and discuss that we intend to focus on the mother's needs while also attending to the developmentally different partner (the child), who sometimes has competing ones.

Because we deliver a trauma-informed intervention, we are explicit with parents about collecting information about traumatic events in their lives and the lives of their children, as well as about their symptoms of distress and PTSD. We gather this information using standardized instruments and clinical interviews.

12.10 Beginning Treatment: Understanding the Individuals and the Dyad

Listening to Differing Narratives Often, in order to create a treatment frame that will address both parent's and child's needs, we begin with understanding the experience of the parent, her recovery, and the process of becoming a parent while working toward sobriety. Parents in recovery come to treatment with strong self-narratives influenced by their own and society's understanding of their substance misuse. We think of narratives as the stories we tell ourselves about ourselves and the systems with which we interact. They can affect our capacities for healthy future-oriented responses to current or future events. Reid and colleagues suggest that parents may identify as "bad," feel "thwarted" in their efforts to move fully into the parenting role, or experience themselves as "addicted" before experiencing themselves as parents (Reid et al. 2008). Overall, we aim to help mothers and young children experience a sense of forward movement and healing. Yet, we begin by tolerating complex and fraught narratives from the parents' past. Mothers in BRIGHT typically have experience with 12-step, self-help models of addiction treatment. It is essential for us to be familiar with the ideas that these groups emphasize. Being comfortable with the language and the stance used by recovery resources in our communities demonstrates our ability to view the parent as someone working toward recovery.

Tolerating Feelings An essential part of treatment is demonstrating a capacity to tolerate strong feelings as mothers address what it is like to immerse themselves simultaneously in parenthood and early recovery. For some parents, spending an hour in a therapy room with a child who may test limits is extremely evocative. We name the challenge and aim to support the different developmental needs of parent and child. Additionally, we describe the connection between exploring difficult emotions in therapy and the need to build affect regulation and self-soothing skills so that parents do not find themselves overwhelmed. Our research with women reflecting on their experiences of parenting in early recovery suggests that themes of guilt, shame, and fear permeate their narratives (Spielman et al. 2015). Each of these distressing feelings may shape the way parents present to us and interact with their children. We use reflection and supervision to tolerate these feelings and navigate among the strong pulls of guilt, often masquerading as rage, shame, camouflaged as loathing and doubt, and fear, coloring thoughts about the future and a parent's ability to trust.

Seeing the Baby We also take time in early sessions to understand the infant or young child. Most of the children have been exposed in utero to substances and also experienced very early traumatic events. Understanding children's regulatory capacities and their ability to explore and seek safety and find pleasure or connection is essential to formulating treatment goals. For example, a child who struggles to integrate environmental stimulation needs a very different physical treatment space than a child who seeks stimulation through objects.

12.11 Ongoing Treatment: Themes and Goals

Integrating Internal Representations We work toward the *first goal* of helping mothers tolerate and eventually integrate internal representations of their past and present selves. Often, parents' past representations are conflated with negative behaviors and traumatic experiences intertwined with distressing childhoods and active addiction. These painful self-representations affect parents' motivation, emotions, interactions, and representations of others, including their children. Parents work actively to shape new "clean" versions of themselves. We think that parents are best served by integrating these versions of themselves, not denying painful past moments. Optimal self-representations contain hopes for the future without risking the repetition of old mistakes and misjudgments. We strive to support parents as skillful and self-aware while recognizing that they are often newly exploring agency, self-determination, and trust in the world.

Parenting Confidence Evidence suggests that a sense of parenting confidence and competence can improve child outcomes (Sanders et al. 2002). Therefore, a *second related goal* is supporting a mother's confident self-narratives, outside of and within the parenting realm. In each session, we highlight and explore moments of both kinds of success—successes in arriving on time, getting a job, or completing a goal and successes in setting a limit with a child, offering comfort, or predicting a child's need. We support the mother's expertise in knowing her child, and when we think parents may benefit from developmental guidance, we offer it with a parent's permission. Because we recognize that our enthusiasm about a mother's success could just as easily activate her own self-doubt as it could buoy her, we are delicate with moments of praise. Typically we check in often regarding a parent's reaction and ask questions like "how does it feel to hear me say that?" in order to ensure that there is room for a parent to respond regarding how ready she is to see herself as competent.

A *third goal* of BRIGHT is enhancing a parent's reflective functioning by wondering about feelings and behaviors in the parent-child relationship. Interpreting and translating meaning is often a part of sessions, and clinicians see themselves as bidirectional translators, not only helping parents understand their children but also helping children to understand the sometimes strong affect of their parents. Additionally, the clinical approach includes making the clinician's relationship with the client explicit, talking about hurt and repair, mistakes, and wishes. This method is then used to promote a parallel understanding for the parent of what her relationship might be like with her child. If the mother is able, the clinician engages her in conversations about upset feelings that might occur in their interactions. She uses these moments to wonder with the parent what it might be like for her child to experience similar feelings. If the mother is unable, the clinician will note this difficulty in experiencing and discussing upset feelings and remain mindful that this might be similar in the mother's interactions with her child. This careful attention to all levels of relationship between clinician, parent, and child and the ability to discuss them openly are essential features of BRIGHT.

Pleasure and Play There are some aspects of CPP that we find particularly helpful in our work with mothers with SUDs and their children. The developers of CPP rightly emphasize the importance of parent-child representational play as a portal into understanding the child's experience and facilitating new pleasurable interactions. However, the BRIGHT dyads more often involve infants, as mothers are frequently motivated to enter treatment during pregnancy. BRIGHT attends to the needs of parent-infant dyads before representational play emerges. Therefore, for the *fourth goal*, we focus on "playful moments" of pleasure and connection, highlighting the times where infants imitate parents in gaze, gesture, or vocalization. This goal requires that clinicians recognize infant behavior such as protolanguage and mirroring gestures as relational attempts and point them out to parents. Also, many mothers lack their own experiences of pleasure and play in childhood and are challenged to relax and engage with the available toys and materials. Rather than focusing on "play" explicitly, we focus on "pleasure." When appropriate, we use sensory and physical modalities to promote touch, connection, and shared motor patterns to highlight somatic connections between mother and child. We talk explicitly about the role of pleasure in mothers' lives, in recovery, and in the ways that substances of misuse affect the pleasure centers in the brain. Clinicians point out when a parent's interaction with her infant promotes pleasure for both parties in the dyad.

Promoting Protective Behavior The *fifth goal* of promoting optimal protective behavior is also an important aspect of CPP. Mothers participating in BRIGHT have typically experienced about a dozen traumatic events in their lives and can have difficulties in assessing and ensuring their own safety, let alone that of their child. The parent may discuss past experiences of feeling unsafe and then wonder when the same might have been true for the child. Some mothers are able to tolerate this exploration and show us this by allowing appropriate affect to emerge, becoming tearful when they remember something scary or drawing their child close when they speak of moments they wish they had been able to protect their child. Others are less ready to tolerate this kind of exploration. For example, some mothers become defensive, insisting that their child has not been in harm's way or does not remember; others are overwhelmed by their own guilt and shame at failing to protect their child; and still others become hypervigilant and anxious. We understand from these reactions that in order to maintain the parent's psychological safety and sobriety, we need to support them in gaining some grounding skills and self-soothing strategies. In time, we work toward parents feeling that their own needs for safety and security in treatment are met, and we attempt anew to explore safety in the parent-child relationship. The clinician continues to empathize with how difficult it is be to parent in early recovery, when so much is expected.

Assistance with Problems of Daily Living Providing concrete assistance with problems of daily living and responding to crises are a part of CPP and typical throughout our work with mothers who are not being offered other case management services. Providing this type of assistance is experienced as supportive, helps to build trust, and makes space for a mother to consider other more reflective or affective needs.

Reflective Supervision We use reflective supervision as an essential part of BRIGHT. Working with strong feelings of guilt, shame, and fear, as well as balancing the needs of parents for support and possible mistakes, with the needs of infants for protection and safety, requires close examination of each case with a trusted infant mental health practitioner. Supervisors use parallel process to both model and create an environment of safety, trust, and self-exploration which match what we strive to create with parents. They model the same availability, consistency, and flexibility that we asked of clinicians and are transparent about the supervision process in order to promote exploration of relationships and feelings. Reflective supervision is a core piece of CPP that we find essential in our work with high-risk vulnerable families.

12.12 Termination

As with many clinicians who work with vulnerable populations, we find that our terminations are evenly split between those that are predictable and those that are not. When we are able to plan for a predicted termination, we see a tremendous opportunity to revisit treatment goals. We talk with mothers about the work they have done through treatment to build coherence between past and present and between a mother and child dyad with different developmental needs. We mark shared learning about children's unique developmental experiences as we reflect on the child's need for a supported "goodbye" session with the clinician. Moreover, we acknowledge what a mother has done to heal from her own difficult experiences as we talk about her wishes in a transition time. Often, BRIGHT termination coincides with terminations from other services as parents are moving, being given housing, switching level of care, or reuniting with family. We explicitly view termination as an opportunity to consider mother's and child's needs in other "goodbye" moments.

When terminations are unannounced, clinicians seek support to explore possible ways to enact a healthy "goodbye" with a family while tolerating their own sense of loss, anxiety, or confusion. Supervision is particularly detailed in this type of termination. When possible, we use mail, phone messages, texts, or notes to offer some pieces of what we might have wanted to offer in termination sessions to families who left unexpectedly. When appropriate, we acknowledge that this might be an upsetting or frightening time for the family, as when families are evicted or parents are incarcerated. We aim to send a message that people are held in mind whether they are present or not and, again, when appropriate draw parallels between holding our clients in mind and the ways the mothers, often separated from their infants for periods of time, hold their child in mind. We bring our own grief and anger to supervision to make psychological space for a new dyad without the weight of the missing family on our shoulders.

12.13 Case Example: Sarah and Olivia

Sarah was referred to Project BRIGHT when she was 5 months pregnant. At that time she indicated that everything was going well in her pregnancy and that she and her partner were very excited about the upcoming birth of their baby. She accepted

the referral from her counselor at the methadone clinic because she had questions about her developing baby, and she wanted to prepare herself for the birth and parenting.

At the time of referral, Sarah, a 30-year-old single Portuguese-American mother of two children, had recently been prescribed methadone for her opioid addiction. Her older son, age 13, was removed from her care at age 2 and adopted by his paternal grandmother. Sarah visited with him approximately every 6 months. Her middle daughter, age 6, was living with Sarah's mother and she saw her weekly.

Sarah herself was the oldest of three children. She grew up with hardworking parents who had high expectations and who she experienced as very critical. Sarah had strongly formed representations of herself in the context of her family relationships; she recalled her younger sister being the "favorite one," while Sarah could not do anything right. When the clinician explored Sarah's substance misuse, she noted that drugs helped her feel less anxious, more productive, and better able to meet her parent's high expectations, despite living a secret "double life." She knew that if or when her parents learned about her substance use, it would confirm their disappointment in her.

Yet, Sarah's parents had their own struggles. They were active alcohol users, and Sarah's father was physically and emotionally abusive toward her mother and occasionally struck Sarah as well. She recalled protecting her younger sisters from being hit and trying to shield her mother when her father became abusive. Sarah recounted her experience of sexual abuse by a paternal uncle from ages 8 to 12, and although she told her mother about the abuse, her mother did not believe her and did not take any protective action. When Sarah was 13 years old, she began to drink and smoke marijuana, progressively experimenting with various drugs to age 18 when she began using cocaine and heroin.

During the initial assessment phase of treatment, the clinician focused on the following areas: getting acquainted with Sarah and building a rapport; exploring whether Sarah was able to be reflective about her baby in utero; assessing her knowledge of newborn abstinence syndrome (NAS) and the withdrawal process, including how to recognize cues of distress and overstimulation; and holding in mind with Sarah her understandable anxiety that child welfare might place her baby into foster care. Additionally, standardized assessment measures confirmed the extent of Sarah's prior trauma, delineated symptoms of posttraumatic stress disorder including avoidance and irritability, and suggested difficulty with emotion regulation, mild depression, and anxiety.

The clinician's initial assessment of Sarah led her to decide that the following areas would be the foci of early treatment: expected development of the baby, assistance with Sarah's affect regulation, encouraging external supports, and discussion of trauma history.

(1) Expected infant development: Sarah indicated that she did not know what to expect in terms of her baby's experience of being born substance exposed and possibly going through withdrawal. She particularly wanted to understand more about how the baby might be overstimulated (common for newborns who are substance exposed) and how to soothe her baby if this occurred.

(2) Affect regulation: Given Sarah's extensive substance use history, likely indicating difficulties managing strong negative emotions, and the paucity of supportive and secure relationships in her life, the clinician wondered how Sarah coped with her own strong feelings and how she would manage her baby's negative affect.
(3) External supports: Sarah indicated limited familial support and that her baby's father was at times abusive. She was open to receiving services that could help strengthen her parenting, so the clinician referred her to a domestic violence support group and a home visitor through the Healthy Families program.
(4) Trauma history: Sarah shared her concerns regarding the physical and emotional abuse in her extended family and with her partner. She wanted to stop the cycle of abuse, but did not know how. The clinician also wondered how Sarah's early abusive experiences would impact her understanding of her child's inner world and how her own low self-esteem and ambivalence regarding relationships might affect her sense of competence and her support for her developing child. She planned to address these concerns in the clinical work with Sarah.

The clinician met with Sarah regularly during the latter part of her pregnancy. As the treatment continued and the baby's due date came closer, Sarah became increasingly anxious about what would happen when her baby was born and whether the baby would be taken into foster care. Sarah also reported sporadic experiences of interpersonal violence inflicted by her partner.

When the baby, Olivia, was born she began to show symptoms of withdrawal from opioids, so she was placed in an intensive care nursery for extra care. Sarah was allowed to visit and feed her every 3 h. During Olivia's stay in the hospital, the clinician visited her and Sarah during feeding time. She offered supportive comments such as how comfortable Sarah seemed caring for her baby. Sarah confidently swaddled Olivia and shared with the clinician a technique she had learned from the nurses of how to help Olivia suck better. While feeding Olivia she gently stroked and massaged her cheek. The clinician saw her role during this period of treatment as having three foci. First, she wanted to support Sarah in feeling confident as a mother to Olivia, which included thinking with Sarah about how the two communicated and responded to one another. Second, she wanted to recognize and bring to mind that this was a complicated yet precious time for the two of them. The mother and baby needed space to get to know one another, yet Sarah had strong feelings of shame and guilt about Olivia's withdrawal from opioids that the clinician thought might affect her emotions and interactions with the baby. Third, the clinician strove to hold in mind with and for Sarah the uncertainty of Olivia's custody and that she might not be allowed to go home with Sarah when she left the hospital.

During Olivia's 3-week stay in the nursery, Sarah visited her as often as she could while juggling various other appointments and getting back and forth to the methadone clinic and hospital on public transportation. Nevertheless, at the end of the 3 weeks in the hospital, due to Sarah's heroin use at three points during her pregnancy and the ongoing concerns about domestic violence and its impact on

Sarah, child welfare services sought custody so that Olivia would be placed in foster care when she was released from the hospital.

Sarah was devastated by the decision to place Olivia in someone else's care. In addition, she and the baby's father were arguing more frequently, and her housing situation was increasingly unstable. Sarah was considering moving into a homeless shelter. During the first few sessions after Olivia was placed in foster care, the clinician focused on Sarah's understandable sadness and anger while also supporting her with concrete needs such as food and housing. At times, therapy sessions took place in the car, when the clinician drove Sarah to the food pantry. The clinician understood that focusing on affect regulation and concrete assistance were essential to Sarah's ability to remain sober and to make space in her own mind for the needs of her daughter.

In the weeks after Olivia's placement, the clinician added to the treatment plan and concentrated on helping Sarah to hold Olivia in mind and through that process stay connected to her daughter. Together, the clinician and Sarah reflected on the weekly visits at the child welfare office between Sarah and Olivia and wondered about the baby's behavior, affect, and development. The clinician promoted Sarah's capacities for reflective function, asking Sarah questions such as what she had noticed about Olivia, what Olivia seemed to like and dislike, how Olivia responded when calmed by Sarah when she was upset, and how Sarah felt when she was with Olivia.

On a few occasions, the clinician accompanied Sarah on her visits with Olivia. During these visits, the clinician pointed out moments of pleasure between mother and baby, holding in mind the importance of shared instances of positive affect for the relationships between both mom and baby and mom and clinician. She commented on how Olivia adoringly looked at her mother, especially when Sarah was feeding her or the two of them were interacting in some pleasurable way. The clinician often asked Sarah how she thought about or understood Olivia's behavior or wondered with Sarah why Olivia responded in a certain way. This practice of observing Sarah with Olivia encouraged Sarah to ask additional questions about the changes she was noticing in Olivia's development. The technique helped to build a parental reflective stance in the mother, another goal of the treatment. Overall, the clinician hoped to foster the mother-baby relationship, support Sarah in knowing her daughter and trust in her developing knowledge, and assist her to regain custody of Olivia.

While the clinician was pointing out the strengths in Sarah and Olivia's relationship, she was also aware of building her own relationship with Sarah. Increasingly, Sarah discussed intimate details about herself and her childhood as she seemed to feel more connected and safe. In addition, she discussed everyday concerns and frustrations, such as dealing with Olivia's father, who at this point was incarcerated, or exploring deeper issues from her own childhood. Sarah wondered how her past was affecting her present, particularly with regard to how she parented Olivia and her other two children. For example, she recognized how sometimes she struggled to comfort her child when she was needy and cried. Upon reflection, she realized how her own mother had responded negatively to her when she needed reassurance and comfort.

As the time came closer for Sarah to reunify with Olivia after 1 year in foster care, the treatment shifted toward thinking about how Sarah would manage living with her daughter full-time. She discussed feeling both excited and terrified. These

mixed feelings regarding having full custody of Olivia made her feel guilty, especially given how hard she had worked to regain custody. Sarah wished she had a more supportive and happy extended family for Olivia. The clinician recognized how this deep yearning for family made Sarah susceptible to being back in contact with her partner when he was released from prison.

Following Sarah and Olivia's reunification, the clinician shifted more of the focus of the clinical work to the dyad. This included listening and wondering about each of them individually and together. Sarah often remarked on how she felt Olivia saved her life, believing that if it weren't for her daughter, she may not have made her recent life changes, particularly maintaining a sober lifestyle.

As the clinician concluded her work with Sarah and Olivia (now 14 months old), she reflected on how far Sarah had come personally and as a mother. Personally, Sarah was now separated from her partner with an active restraining order in place. She was prepared to contact the police if he attempted to violate the restraining order. From the clinician's perspective, this spoke to Sarah's growth in her ability to assess her own safety, to maintain clear boundaries, and to feel worthy of them. In terms of mothering, the clinician knew that Sarah would struggle with the normal stresses of parenthood and the realities of being a single mother in early recovery with limited income and supports. However, she also recognized how Sarah had worked to understand her early patterns of physical and sexual abuse within her family and how they had affected her self-esteem and view of relationships. Due to her history, she often viewed abusive behavior as loving, had difficulty tolerating and managing her emotions, and often did not know how to set appropriate boundaries. The clinician hoped Sarah would continue to work with an individual therapist on acknowledging her difficult emotions and acquiring a broader range of coping strategies to manage them, identifying and meeting her individual needs, and developing safe and reliable relationships.

At termination, the clinician saw many strengths between Sarah and Olivia. Despite being separated for the first year of Olivia's life, the two of them had a strong bond. Sarah was attentive and attuned to Olivia's needs. In the clinician's visits with the two of them, she witnessed much mutual joy and pleasure. Additionally, the clinician saw how Sarah made excellent use of external assistance (e.g., pediatrician, early intervention worker, and "mommy and me" play group) to better understand and support Olivia's emotional and physical needs.

Simultaneously, the clinician recognized that Olivia was on the cusp of becoming more independent; she was crawling and almost ready to walk, increasingly testing limits and fervently expressing her opinions and preferences. The clinician anticipated that Olivia's independence would present challenges for Sarah especially with regard to limit setting and the need to be an authority as a parent rather than just a nurturer. As Olivia grew and changed, developmental issues would emerge potentially triggering difficult memories for Sarah. The clinician believed that the therapeutic work done through BRIGHT along with Sarah's continued sobriety and involvement with recovery services offered a strong foundation for a loving healthy relationship that could break the cycles of trauma and substance misuse.

Conclusion

In this chapter, we briefly reviewed the research and theoretical literature on substance dependence, trauma, and parenting that provide the underpinnings for the BRIGHT attachment-based intervention. There are compelling arguments for the need to simultaneously provide an intervention focused on parenting and the parent-child relationship while a mother is involved in treatment for a SUD. We answered this need through the development of BRIGHT, relying strongly on the CPP approach to dyadic work along with best evidence-based infant mental health practices that address trauma and addiction. Our description of BRIGHT highlighted the importance of flexibility in the work given the need to shift among various domains such as supporting for the mothers' recovery, addressing trauma sequelae, encouraging optimal parenting practices, and scaffolding the parent-child dyad. The composite case example offered a close look at the flow and nuances of the intervention, demonstrating how a clinician addressed various developmental needs within one dyad. The intervention began with a pregnant woman in early recovery anticipating the birth of her child. Soon the clinician was working with a postpartum mother whose child was placed in foster care and needed to continue to maintain the hope of reunification and the reality of the relationship. Ultimately, the clinician was addressing the needs of a mother-child dyad newly reunified after being separated for 1 year. Given the increase in opioid use and SUDs and concomitant needs, along with growing research and clinical evidence regarding relational approaches to parenting interventions, we anticipate continuing to disseminate our specific work with these parents and their young children.

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