

Substance dependent women becoming mothers – breaking the intergenerational transference of substance use disorders.

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Scientific environment

This research was carried out within the institutional framework of the PhD programme at the Norwegian Centre for Addiction Research, University of Oslo, Norway.

During this period I have been employed at a regional resource centre in the addiction field, Kompetansesenter rus – region sør, Skien, Norge.

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- Edle Ravndal, Norwegian Centre for Addiction Research, University of Oslo, Norway.

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Acknowledgements

My employment at a resource centre in the addiction field disclosed a need to further develop knowledge and skills to improve support and help for pregnant women and parents with substance use disorders. Wishing to improve clinical practice, I in 2011 started a research study based on substance dependent parents with infant children submitted to inpatient family -treatment at a drug clinic. The research has been a part time position and was completed in 2017.

I would like to thank all participants who voluntarily accepted to be interviewed. This access to important individual stories has been the essential part of this research. First and foremost I would like to thank the 9 powerful and forthcoming mothers and their significant others, and secondly I would like to say thanks to the practitioners who have contributed.

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The article from the third sub-study has been revised and published after submission of this thesis. The reference is:

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Eli Marie Wiig

Abbreviations

The ACE-studyThe Adverse Childhood Experiences Study is a research study completed by the American Health Organization Kaiser Permanente and Centers for Disease Control and Prevention. 17000 participants were recruited to the study between 1995 and 1997 and have been followed up longitudinally for health outcomes. The study has shown associations between adverse childhood experiences and health and social difficulties as an adult. More than 50 scientific articles have been published as a result of the ACE-study. The study is considered a landmark in epidemiological research.

ICD-10	International Classification of Diseases, 2010, World Health Organisation
IPA	Interpretative phenomenological analysis
LAR	Medically assisted rehabilitation
PDI	Parent Development Interview
SERAF	Norwegian Centre for Addiction Research, University of Oslo, Norway
TA	Thematic analysis

Abstract

Background: Children born to substance-dependent mothers who themselves have had an upbringing disturbed by parental substance-abuse, are expected to be at high risk of adverse childhood experiences, dysfunctional family life, and to develop psychological problems, including substance dependence. The mothers in this study represent a highly vulnerable group, often difficult for researchers and support systems to access, because substance use disorders generally, and substance-dependent mothers especially is linked to shame and stigmatization. We need to extend our knowledge on pregnant women and families with substance-dependence, especially when the mothers themselves have had an upbringing disturbed by parental substance-abuse problems. Norway has established units in drug –institutions with dual treatment tailored for substance –dependent pregnant women and families with small children. Systematized knowledge on high -risk families with generationally transferred substance –dependence, including what kind of help these families may benefit from, is needed.

Aims: I) To explore how substance-dependent mothers understand their challenges and how they describe the association between their childhood experiences with substance-abusing parents and their own role as caregivers. II) To explore the social support available for these mothers, helping them stay abstinent and create safe family environments for themselves and their children. III) To explore how professionals at a family –ward describe the aims, therapeutic roles and interventions in the treatment for parents with substance use disorders (SUD) and their children.

Methods: Using purposeful sampling, we approached mothers with self-reported upbringing disturbed by parental substance-abuse problems, admitted for one year to a family-ward at a substance abuse clinic. Through in-depth, qualitative interviews, nine substance-dependent mothers described their lives in the form of present, past and future tense. The mothers' significant others were then in-depth interviewed and the characteristics of the social support available for the mothers were investigated. Finally, three focus-group interviews were conducted, comprising 15 professionals, including both ward staff and therapists. Data were analysed using systematic text condensation and thematic analysis.

Findings: The substance-dependent women in this study, faced several major challenges when they became mothers. Some described having lived their whole lives on 'the edge of society'. This made their rehabilitation process complex. All mothers struggled to abstain from substances, process traumatic experiences and integrate their family into society. They needed help to extend their supportive social networks and to establish a safe and predictable family environment for themselves and their children. The significant others had

limited financial and social resources and were themselves exposed to adverse experiences and cumulative psychosocial and socioeconomic risk factors. Their relationships with the mothers were, nevertheless, close, consistent and reliable. Supporting the existing social network should be an integrated part of the work of family welfare services aiming to help substance-dependent mothers from families with parental substance abuse to rehabilitate and to integrate successfully into local communities.

Combining treatment of SUD, interventions to improve parenting roles and practice, and at the same time looking after the developmental needs of the children, seemed to be a complex and challenging task for the professionals. In the therapeutic efforts some professionals seemed to concentrate their attention on the parent with SUD, while others mainly focused on the well-being of the child. The professionals emphasised to establish therapeutic alliances with the parents and to use present-moment situations with the families in their everyday activities at the ward therapeutically. The SUD parents were experienced as unpredictable and challenging, with some professionals having problems staying emotionally balanced during sessions. Consequently they needed to focus also on their own emotion regulation, and they expressed tensions between groups of professionals.

Publications:

Wiig, E.M., Haugland, B.S.M., Halså, A. & Myhra, S.M. (2014). Substance-dependent women becoming mothers: breaking the cycle of adverse childhood experiences. *Child & Family Social Work*. DOI: 10.1111/cfs. 12190.

Wiig, E.M., Halså, A. & Haugland, B.S.M. (2016). Social support available for substance-dependent mothers from families with parental substance abuse. *Child & Family Social Work*. DOI: 10.1111/cfs. 12341.

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Table of contents

Substance dependent women becoming mothers – breaking the intergenerational transference of substance use disorders.....	1
Scientific environment	2
Acknowledgements.....	3
Abbreviations.....	5
Abstract.....	6
Publications:.....	8
Table of contents	9
1.0. Introduction	11
2.0. Background	13
2.1. Clarification of concepts	14
2.2. The risk of intergenerational transmission of substance abuse from mothers to their children	15
2.2.1. Genetic risk and effect on the foetus.....	15
2.2.2. Risks associated with the childhood environment	16
2.3. Protective factors for children of SUD parents.....	19
2.4. SUD mothers’ understanding of parenting.....	20
2.4.1. Parenting style	21
2.5. The importance of social support	22
2.6. Prevention of intergenerational transmission of SUD-related problems between parents and their children: A treatment perspective	24
2.6.1. Interaction training	25
2.6.2. The therapists’ perspective.....	26
2.7. Summary	26
3.0 Research questions	28
4.0 Method	30
4.1. Choice of method.....	30
4.2. Theoretical framework	30
4.3. Preparation for the study.....	33
4.4. Selection criteria	33
4.4.1. The mothers	33
4.4.2. Support people.....	35
4.4.3. The staff	36
4.5. Interview guides.....	36

4.5.1.	Interviews with mothers	36
4.5.2.	Interviews with support people	37
4.5.3.	Focus group interviews with staff	37
4.6.	Implementation and the researcher's position	37
4.7.	Analysis	40
4.7.1.	The first sub-study	40
4.7.2.	The second sub-study	41
4.7.3.	The third sub-study	42
4.8.	Ethical considerations	43
5.0	Results	45
5.1.	The first sub-study	45
5.2.	The second sub-study	46
5.3.	The third sub-study	47
6.0.	General discussion	49
6.1.	Methodological and ethical considerations	49
6.1.1.	Internal validity	49
6.1.2.	External validity	53
6.1.3.	Reflexivity	54
6.1.4.	Ethical considerations	55
6.2.	Discussion of findings	56
6.2.1.	Summary of the main findings:	56
6.2.2.	A marginalised existence	56
6.2.2.	Traumatic experiences	58
6.2.3.	Life after the SUD facility	59
6.2.4.	A long and close relationship with the support person	60
6.2.5.	Three types of relationship	60
6.2.6.	A limited, vulnerable network	61
6.2.7.	Different treatment approaches	61
6.2.8.	Making therapeutic use of everyday situations	64
6.2.9.	Cooperation and tension between staff	65
7.0	Conclusions	67
8.0.	References	69

1.0. Introduction

The overall theme of this research project is the intergenerational transmission of substance abuse problems. Substance dependence is one of the most hereditary conditions known (Kendler, Aggen, Tambs & Reichborn-Kjennerud, 2006; Mayfield, Harris, & Schuckit, 2008). In addition to genetic factors, environmental factors are believed to have a significant impact on the transmission of substance abuse between generations (Kendler, Prescott, Myers, & Neale, 2003). It is therefore crucial to gain knowledge of how this intergenerational transference can be prevented.

Mothers with substance use disorders (SUD), who themselves have grown up in families with SUD, and their children, are thought to be difficult to access for health and social services and for researchers. This is probably because these mothers experience barriers to seeking help. This may involve a risk of stigma, shame or fear of losing custody of one's children (Trulsson, 2003). Isolation and lack of openness about SUD problems may explain why children of addicted mothers are among the most vulnerable groups in society, especially when substance abuse has been present for several generations. The same barriers that prevent mothers from seeking help can also make them difficult to research. We therefore have limited research knowledge about these mothers and their children, and insufficient knowledge of the kind and extent of help these families need.

Mothers with SUD have low status in society (Green, Polen, Dickinson, Lynch & Bennett, 2002). SUD mothers who themselves had one or both parents with SUD are thought to be particularly vulnerable. In order to improve help for these women and their children, we need more knowledge about their life situation, challenges and resources. This will form a basis for helping them to establish a life without substance abuse and, when circumstances allow, to take care of their children.

My choice of research field was based on my work at a centre of substance abuse expertise, in addition to a personal interest in enabling children in difficulties to receive the best possible help. My work consisted of providing instruction and guidance to personnel in primary and specialised health care on substance abuse prevention, detection of children at risk and support for families with substance abuse problems. At the same time, sections on health professionals with special responsibility for children were introduced into the Specialised Health Services Act and the Health Personnel Act (IS-5/2010, Helsedirektoratet). Sections on "children as relatives" deal with children of parents with substance abuse or mental health challenges. The aim of these legislative changes was to focus on and address the needs of children in both primary and specialised health care. To increase my knowledge of children in SUD families, I needed to study the literature in the field. It gradually became apparent that there was limited knowledge of challenges and help available for SUD families with young children where the addiction had been transmitted over several generations. This prompted the need to study these families more closely. Children's lives are dependent

on parental functioning. The whole family needs support to improve children's well-being. On this basis, I and my researchers wanted to investigate how SUD mothers who had grown up in SUD families understand parenting. What everyday challenges do they face in giving their children a good upbringing?

The research questions of the first sub-study were: What understanding do SUD mothers have of the concept of a good mother? Following inpatient SUD treatment, what challenges must be solved by mothers in families with intergenerational transmission in order to live as "normal" families in the local community? This sub-study included interviews with nine mothers admitted to a Norwegian family SUD facility with their infants (0-12 months). All the mothers had experience of parental substance abuse in their own childhood. The interviews focused on the mothers' understanding of their current parental role, reflections on childhood experiences related to their own parents' SUD, and their future plans for themselves and their children. The interviews were analysed using systematic text condensation (Malterud, 2012), which is a cross-cutting phenomenological-hermeneutic method of analysis inspired by Giorgi (2012).

Sub-study 2 focused on the extent, content and type of social support available to mothers and children after discharge from an SUD treatment centre. In interviews, the mothers stated whom they considered to be their main support person; this was either their partner, older sister, mother or grandparents. The nine support people were then interviewed about their relationship with the mothers, the support they provided and whether other social support was available to the family. Their responses were then compared with the mothers' statements about perceived social support. The data from sub-study 2 were also analysed using systematic text condensation (Malterud, 2012).

The third sub-study was devoted to the perspectives of staff working in the SUD facility where the mothers had been admitted. The staff took part in focus group interviews on how they understood their role, tasks and goals in their work with the mothers and infants. There were three focus group interviews with a total of 15 staff, two with ward staff and one with therapists. The interviews were analysed using the phenomenological-hermeneutic method of thematic analysis (Braun & Clarke, 2006).

Inpatient treatment of addicted mothers with infants is extensive and costly but may be a profitable investment, since the children are in their very early years and the parents are in early adulthood with the potential for a long and independent life. If the parents manage to establish themselves in an addiction-free life and learn to be sensitive, loving and predictable parents, both they and their children will avoid many subsequent problems and society will save considerable sums on health care, social benefits and/or crime prevention and rehabilitation.

2.0. Background

The present study builds on knowledge from different research traditions and concepts from different theoretical approaches. Substance abuse in a family and generational perspective is the common theme of the three sub-studies. Further key background areas to this thesis are marginalisation, addiction, neglect, social support and risk and protective factors for developmental problems in children.

It is estimated that 8.3% of Norwegian children under 18 live with parents with alcohol addiction (Torvik & Rognmo, 2011). We also know that an unspecified number of children in Norway have parents who abuse illegal or prescription drugs. The number of children who grow up with parental abuse of any substance is therefore likely to be higher than the above estimate.

The literature shows that children of parents with SUD have increased likelihood of biological, psychological and social problems (Belsky, Conger & Capaldi, 2009; Christoffersen & Sothill, 2003). This makes these children vulnerable to mental health problems in general, in addition to the development of their own substance abuse problems. Children of SUD mothers have a greater risk of physical, academic and socio-emotional problems (Conners et al., 2004). Such problems may in turn increase the risk of developing addiction (Galea, Nandi & Vlahov, 2004).

The Adverse Childhood Experiences (ACE) study shows a correlation between negative childhood experiences and the development of SUD (Dube et al., 2001; Anda et al., 2006; Perry, 2010). Population studies show that genetic vulnerability, negative influence of family and environment, psychosocial challenges and lower socioeconomic status are risk factors for the development of substance abuse problems (Galea, Nandi & Vlahov, 2004). Children of SUD parents also have an increased risk of developing relationship problems and insecure attachment style (VanIjzendoorn, 1995). Risk factors in families with SUD parents are child neglect, violence and family conflicts (Boris, 2009; Christoffersen & Sothill, 2003; Lindgaard, 2011).

In spite of considerable research on problems and environmental risks in children of addicted parents, there have been few studies focusing on the children's own perspective and on the challenges they face when becoming parents themselves. Although some studies have examined parenting from the perspective of addicted mothers, these do not have the inclusion criterion that the mothers themselves have had SUD parents (Trulsson, 2003; Powis, Gossop, Bury, Payne, & Griffiths, 2000; Banwell & Bammer, 2006).

In order to meet the needs of SUD families, it is important to know what the parents themselves find challenging and what strategies they use to create a loving and predictable environment for themselves and their children. Against this background, the present study is rooted in the framework of a phenomenological-hermeneutic approach, which aims to gain insight into the perspectives and understandings of the interviewees.

A phenomenological-hermeneutic approach was also applied when studying the mothers' support people and the staff of the SUD facility. The grounds for the choice of theoretical framework were the need for an exploratory approach to a little researched field and the desire for a close examination of the personal experiences, understandings and descriptions of the interviewees.

2.1. Clarification of concepts

This research project is concerned with SUD mothers whose own childhood was marked by parental substance abuse. SUD mothers in this context are those with a diagnosable disorder according to ICD 10, F10-F19 (mental disorders and behavioural disorders related to the use of psychoactive substances) and who care for children from 0 to 5 years. Addiction involves behavioural, cognitive and physiological disorders that occur after repeated intake of the substance. Addicted people commonly feel such a powerful need for a substance that they are unable to control their use despite the harmful consequences involved. They also experience increased tolerance of the substance and often a physical withdrawal condition that results in higher priority for substance intake than other activities and obligations (World Health Organisation, 2010).

The focus of this study is on mothers and their perspectives. This is because SUD fathers are considerably less involved in the care of their children (Roberts & Leonard, 1997) and also because fathers were a minority in the SUD facility for parents with young children where the interviewees were recruited.

In this study, a childhood marked by parental substance abuse implies that the mothers report having had parents with problematic substance use. We had no available diagnostic or other independent information about the parents' substance use. The diagnostic criteria indicate harmful use or addiction. However, they only include use that is harmful to the user, with no information about the effect on family members. Further, it is not only diagnosable substance abuse that can cause problems in a family. A diagnosed SUD does not predict parenting ability (Benjet, Azar & Kuersten-Hogan, 2003). Family functioning, including parenting, can thus be disturbed by the substance use of a family member, even though this person does not fulfil the diagnostic criteria (Hansen, 1990). On this basis, it was considered adequate for the research purpose that problematic parental substance use was defined by the mothers' perceptions of their parents' use, not by whether the parents fulfilled the relevant diagnostic criteria.

Intergenerational transmission of SUD means that children of parents with problematic substance use develop similar problems to their parents and that this continues for at least two generations. Substance addiction is a hereditary condition (Kendler et al., 2006; Mayfield et al., 2008). The transmission between generations appears to be due to both genetic and environmental factors (Kendler et al., 2006).

Risk and protective factors affect the likelihood of children of SUD parents developing SUD themselves. Risk factors are features of the childhood environment or the individual that increase the probability of a disorder (Psychology Dictionary, 2013). Protective factors are those that reduce the likelihood that children exposed to risk will develop problems (Masten & Coatsworth, 1998). Genetic disposition and gender are examples of static risk factors that cannot be influenced by society. Dynamic risk factors, on the other hand, can be influenced by societal interventions, such as foster homes, support in the home, improved social networks or enhanced socioeconomic status. Some risk factors are closely linked to the development of certain disorders, while others are more general and can be associated with a variety of problems. Persistent risk factors or prolonged stress harm children more than a limited number of negative episodes. Several risk factors that co-occur are referred to as cumulative risk (Christoffersen & Soothill, 2003). There is greatest cause for concern when several serious risk factors co-occur in early life (Kvello, 2013).

2.2. The risk of intergenerational transmission of substance abuse from mothers to their children

Parental addiction is associated with a risk of the children developing addiction (Christoffersen & Soothill, 2003; Lauritzen et al., 1997). Lauritzen et al., in a study of addicts in treatment in Norway, found that over half had grown up with parental alcohol problems. Fuller et al. (2003) examined alcohol addicts and their sons over three generations with regard to the transmission of aggression and alcohol dependence. They found an increased risk of developing alcohol dependence, but concluded that this was more related to the aggressive behaviour and parenting style of the fathers than the fathers' use of alcohol in isolation.

In a metastudy, Zucker, Donovan, Masten, Mattson and Moss (2007) examined the association between early childhood development and the risk of alcohol problems in adulthood. They found strong evidence that the risk of later alcohol problems is linked to early childhood risk factors and characteristics of the family environment. This led them to argue for a greater focus on risk factors for alcohol abuse in early childhood than on those associated with adolescence. This was followed by Boris (2009), who showed how parental substance abuse affects children. According to Boris, this effect involves three different mechanisms: i) effect on the foetus, ii) genetic susceptibility and iii) environmental factors.

2.2.1. Genetic risk and effect on the foetus

A metastudy of studies of twins and adoption by Verhulst, Neale and Kendler (2015) revealed that about 50% of alcohol abuse was due to hereditary factors. The majority of these involved genetics, but shared environmental factors also had a significant impact on the development of addiction. In a population-based survey of Norwegian twins, Kendler et al. (2006) found that genetic factors also play a significant role in intergenerational transfer of abuse of illicit drugs. A genetic predisposition may be perceived as a deterministic and

negative factor, suggesting that the disorder was predetermined and that prevention is therefore of little benefit. However, knowledge of high genetic heritability can facilitate the detection of vulnerable individuals, thus enabling early intervention to prevent the development of SUD (Mayfield et al., 2008).

A research team from the University of Oslo followed SUD mothers and their children from pregnancy to pre-school age (Moe & Slinning, 2001; Moe, 2002; Slinning, 2003). Moe and Slinning (2001) studied newborns exposed to opiates and other drugs during pregnancy and found that 78% of them had neonatal abstinence syndrome (NAS), with a particular susceptibility to NAS in boys. Slinning (2003) showed that these infants had attention and self-regulation problems in the newborn period. Of the infants exposed to prenatal drug abuse, 88% were placed in foster homes or adopted before the age of one. Moe (2002) studied the children again at the age of 4½ and showed that the sum of the biomedical risk factors associated with the effect of drugs in pregnancy can lead to later developmental problems, even if the child receives good care after birth. When the children were 4½ years old, they tended to perform worse than average in perceptual development, even though they had grown up in foster homes (Moe, 2002; Slinning, 2003). This indicates congenital susceptibility that can lead to cognitive developmental difficulties, and may also be related to later substance abuse problems.

Biological vulnerability due to genetics and/or prenatal substance exposure are given factors at birth. The present study concentrates on environmental factors in early childhood. A child's genetic and biological risk factors will naturally form part of the overall picture to enhance understanding of the parents, child and their interaction, especially if the child has particular challenges that make parenting more demanding.

2.2.2. Risks associated with the childhood environment

Mayes and Suchman (2006) have described developmental pathways leading to early substance abuse. In addition to genetic vulnerability, they point out the importance of the person's circle of friends, the availability of substances, and the attitude of the social environment to substance use. They show that adolescents that start substance use early have a greater risk of developing addiction, dropping out of school, becoming socially isolated and engaging in crime. Connors et al. (2004) found that environmental risk factors had a greater impact on psychosocial development in children of addicted mothers than prenatal substance exposure.

A number of studies have shown that parental addiction can lead to child neglect (Dube et al., 2001; Young, Boles, & Otero, 2007). A tendency towards high levels of conflict and domestic violence are other challenges associated with parental addiction (Lindgaard, 2011), especially when the mothers are addicted (Boris, 2009). Furthermore, neglect and violence in families with alcohol-abusing parents are linked to poor protection of children and their potential exposure to violence and abuse (Christoffersen & Soothill, 2003).

Similarly, Keller, Cummings, Davies, and Mitchell (2008) found correlations between parental problem drinking, poor family functioning and poor adjustment in children.

Child neglect increases the risk of psychological distress and subsequent addiction. From the early 2000s, articles were published from the comprehensive ACE study of children who had experienced adverse experiences in their childhood environment. The ACE study examined the relationship between a difficult childhood and subsequent health problems. It showed that childhood challenges, including parental substance abuse, negatively affect a child's normal development (Perry, 2010; Anda et al., 2006). Dube et al. (2001) demonstrated that a childhood with parents who drink excessively is clearly linked to abuse, neglect and various forms of family malfunctioning. Dube et al. (2003) also demonstrated a relationship between growing up in SUD families and an increased risk of using illegal drugs. Longitudinal studies show that negative childhood experiences such as violence and abuse predict both neurobiological development and general morbidity in adulthood (Anda et al., 2006). Chapman, Dube and Anda (2007) show that adverse childhood experiences also increase the risk of developing mental problems or disorders. Similarly, Felitti and Anda (2010) have shown a correlation between negative childhood experiences and adult functioning, including well-being, social functioning, use of healthcare services and the development of one's own substance abuse problems. It has also been found that persistent traumatic experiences in early life are particularly harmful in terms of developing post-traumatic stress disorder (PTSD) (Courtois & Ford, 2009).

There is a clear relationship between mental health disorders and addiction in adult patients (Lauritzen et al., 1997; Kessler et al., 2005). Addicted parents will therefore also commonly have other mental health disorders. Parental mental health problems are also a risk factor for poor parent-child interaction (Ostler, 2010). Other known risk factors of children of substance-abusing parents are the family's poor social network, low socioeconomic status, and unpredictability in everyday life (Haugland, 2003; Lindgaard, 2011). In families involved with child welfare services, it has also been shown that addicted parents are more likely to have additional problems, such as mental health disorders, and that these families are often socially vulnerable (Forrester & Harwin, 2006).

2.2.2.1. Increased risk when the addicted parent is the mother

Children of SUD mothers are more likely to develop problems than those of SUD fathers (Christoffersen & Soothill, 2003; Conners et al., 2004). An extensive Danish longitudinal register study demonstrated a higher risk of negative life events in children of alcohol-dependent mothers. Compared to children of alcohol-dependent fathers, these children were more exposed to neglect and abuse, more likely to exhibit violent behaviour and more likely to have children as teenagers (Christoffersen & Soothill, 2003). Conners et al. (2004) focused particularly on the risks for children of mothers with severe substance abuse problems. They found a higher than average risk of physical, academic and socio-emotional problems. A decisive factor for these children's functioning was greater exposure to cumulative risk.

Greater risk for children of addicted mothers than for those of addicted fathers may be explained by a number of factors, including women's important role as caregiver in families. Haugland (2003) found that families with addicted parents have high levels of unpredictability and conflicts. In families where the father is addicted, the mother, if she does not have her own substance-related problems, can act as a stable compensatory carer for the children, by maintaining daily routines and predictability in their lives (Haugland, 2005). It is presumably less common that a father would act as a compensatory carer when the mother abuses substances, partly because addicted women tend to have a partner who is also addicted (Roberts & Leonard, 1997). In society at large, women and men have different perceptions of what a mother and father, respectively, can and should do. It is still women who are mainly responsible for children and who view caring for their children as their primary responsibility (Wærness, 2002; Ellingsæther, 2006).

Addicted women appear to bear a greater burden than addicted men in many respects. According to Green et al. (2002), only 1/3 of patients in substance abuse treatment are women. Women seem to be more reluctant to seek help for SUD, despite the fact that treatment outcomes are equally good for both genders (Green et al., 2002). Women also have a greater consumption of addictive medications than men (Vandeskog & Skutle, 1996). Women's substance abuse problems develop more quickly and they become more rapidly addicted, in comparison with men (Grella, 1996). Women experience health problems after less consumption and less time than men (Greenfield, 2002). Addicted women are more likely to meet with disapproval and have inferior networks and less social support (Green et al., 2002). This gives cause for concern, since women may be more dependent on social support for their mental health than men are (Kendler, Myers & Prescott, 2005). There is also a greater proportion of women than men in treatment who are dependent on state benefits (Vandeskog & Skutle, 1996). SUD women more often suffer from anxiety, depression, guilt and shame (Rosenbaum, 1979). A correlation has also been shown between addiction in women and sexual or physical abuse (Green et al., 2002). Further, mothers addicted to alcohol are more likely to attempt suicide (Christoffersen & Soothill, 2003).

The childhood environment is affected by the mother's general state of health. Kahila, Gissler, Sarkola, Autti-Rämö and Halmesmäki (2010) found that the mother's health is at risk when she abuses alcohol or other substances. The researchers followed Finnish women with alcohol and/or other substance abuse receiving special treatment in pregnancy. The mothers were studied for at least six years after the birth, and compared to a control group of mothers without addiction. The addicted mothers had a greater risk of mental disorders, various infectious diseases, skin disorders, injuries and poisoning. They also had more frequent outpatient treatment, longer hospital stays and greater likelihood of receiving disability and social security benefits. Kahila et al. (2010) concluded that it is important to provide both adequate follow-up care after birth and treatment for the substance abuse.

Nair, Schuler, Black, Kettinger and Harrington (2003) studied addicted mothers caring for their children 18 months after giving birth. Mothers with at least five risk factors in addition to substance abuse (such as depression, domestic and non-domestic violence, family size, imprisonment, single mother, negative life events, mental health problems, homelessness and severe substance abuse) were more likely to experience stress in parenting, and also to ill-treat their children.

Powis et al. (2000) have described a number of challenges for mothers who use heroin or other opiates. They have both social and psychological problems in addition to their specific substance abuse challenges. Powis et al. (2000) describe the mothers as ambivalent towards seeking help, despite their great need for help. The mothers with the most serious addiction, of both alcohol and heroin, reported feeling that they ought to seek substance abuse treatment to avoid losing custody of their children. However, they were also afraid that seeking treatment would increase the risk of losing custody (Powis et al., 2009). This is supported by Rhodes, Bernays and Houmoller (2010) who reported that addicted women do not dare to talk to health and social services about being addicted and a mother, even though they strive to balance their need for substances (risk behaviour) with their desire to take care of their children (harm reduction).

Trulsson (2003) has shown that SUD mothers develop a particular choreography for meetings with social services and others in authority. In qualitative interviews with SUD mothers, she found that they are afraid to lose custody of their children, and therefore view social services as their greatest threat, even though these are the main services to assist substance abusers. If they contact the social services and therefore reveal that they need help, they are afraid that the social services will consider removing the children from their home. Further, Beard et al. (2010) show that addicted women who are also prostitutes are reluctant to turn to social services for fear of losing their children. SUD mothers often have low income and are socially isolated; they therefore have a great need for professional help and support (Banwell & Bammer, 2006). In spite of this, SUD mothers receive less financial and other help from public services than other mothers with low income and poor social networks (Banwell & Bammer, 2006).

2.3. Protective factors for children of SUD parents

Longitudinal studies of children of addicted mothers show that their symptoms and functioning can greatly improve or deteriorate during childhood and adolescence (Moe, 2002; Sundfær, 2009). It is therefore important that professionals and significant others are constantly aware of the stress involved in living in an SUD family and of protective factors in and around the family and the child. Identifying the factors that protect such children from developing problems will enable us to devise more effective measures for children at risk (Borge, 2003). Protective factors are defined as factors which enable successful adaptation despite negative circumstances and which increase the ability to cope with later problems

(Masten & Coatsworth, 1998). In a longitudinal study from Hawaii (Werner & Smith, 2001), the researchers followed a group of children who, in addition to other risk factors, such as poverty or a chaotic care situation, also had parents with alcohol problems. The study showed that about 60% of the children were able to cope without developing problems despite the environmental stress factors.

Risk factors associated with substance abuse in the family may have less impact if the children have an even temperament, self-confidence, self-esteem, intellectual capacity, problem-solving ability and/or good social support in their environment (Cobb, 1976; Werner & Smith, 2001). Key characteristics of families whose children adapt successfully despite environmental risk are, according to Werner and Smith (2001), rules and structure in the child's home. The importance of maintaining routines and structure at home also concurs with a Norwegian study that shows that families with parental alcohol abuse function better and the children adapt better if the family maintains its rituals and routines through different phases of the drinking cycle (Haugland, 2005).

Mayes and Suchman showed that, despite parental addiction, children who felt in control of their lives and had stable and caring friends or adults were protected from developing their own addiction. Luthar (2006) found that good relationships with other people protected children from psychological problems, including addiction, particularly in early childhood; however, this research did not specifically apply to children of substance abusers. Luthar also pointed out that poor finances and serious illness are elements that make it difficult to maintain the protective factors. SUD families tend to be relatively poor and often experience broken relationships, which can weaken the protective factors.

Skinner, Haggerty, Fleming and Catalano (2010) studied young adults who had grown up with opiate-addicted parents in methadone treatment. They found that early interventions to prevent and reduce children's internalising and externalising problems could protect them and enhance their adaptation in young adulthood. This shows the importance of strengthening protective factors in and around SUD families through early intervention, preferably before the children develop their own problems.

2.4. SUD mothers' understanding of parenting

Interventions to protect children of SUD mothers from maladaptation will often focus on parenting. During childhood, it is assumed that the child develops an internal working model of parenting (Kanami, Hiromi, Atsuko, & Masae, 2002). A child who grows up with addicted parents whose parenting is strongly affected by their addiction may need assistance in working out its own parental role in adulthood. As many SUD mothers lack a substance-free partner to help them with parenting (Roberts & Leonard 1997), they will often have sole responsibility for caring for and raising their children (Banwell & Bammer 2006).

Attachment theory states that children need to develop a relationship with at least one primary caregiver to ensure healthy social and emotional functioning. Children become attached to adults who are sensitive and responsive in social interaction with them (Ainsworth, 1967; Bowlby 1982; Fonagy, Gergely, Jurist, & Target, 2002). One may assume that addiction and other mental health problems will challenge parents' capacity to be sensitive to the needs of their children.

Killén and Olofsson (2003) have described five essential parental functions to capture what it means to be a good parent. The first parental function is the capacity *to perceive the child relatively realistically*. Children who are viewed and accepted as they are have a good basis for developing self-esteem. How parents perceive their child will affect how they treat the child and how the child perceives itself. The second parental function referred to by Killén and Olofsson (2003) is having *realistic expectations of the child's coping and achievement*. An American study found that addicted parents expected the child to cope alone at home at the age of six, while non-addicted parents in a control group thought that eleven was a suitable age (Kumpfer, 1987). Children exposed to unrealistic expectations will be unable to meet the demands made on them. The third parental function is capacity for *empathy with the child*. If a child is to learn to regulate its emotions, it must have parents who comfort it and show understanding of the child's anger and protesting. This is how children learn to regulate their emotions and develop the ability to empathise and put themselves in others' situations. The capacity for *emotional involvement with the child* is the fourth parental function. Children who feel that their parents are pleased with them develop self-esteem and optimism and their own capacity to be pleased and involved with others. Fifthly, parents need to *give priority to the child's developmental needs rather than their own needs*. For example, a parent who keeps a close eye on what happens to the child will be able to protect it from abuse (Killén & Olofsson, 2003). Killén and Olofsson, with their summary of essential parental functions, thus provide a guideline as to which areas health and social services can focus on in enhancing caregivers' parenting skills.

The other studies that have examined SUD mothers' perspectives on motherhood (Baker & Carson, 1999; Söderström, 2012; Virokannas, 2011) all show two different phenomena: 1) Although the mothers state that substance use negatively affects their children, they attempt to expand the understanding of what a good mother can be, saying that they can be both caring and sensitive even though they are addicted. Being addicted does not mean that one is a bad mother. 2) Mothers were reluctant to seek help because they were afraid of professional assessment of them as mothers. They had a defensive attitude to their identities as mothers.

Both Söderström (2012) and Virokannas (2011) point out the need to develop knowledge that can help to construct more productive and less defensive motherhood identities for addicted mothers.

2.4.1. Parenting style

Parenting style refers to how parents bring up their children and affect their socialisation process by being responsive and sensitive or placing demands on them (Baumrind, 1971). Parenting styles can be differentiated according to the degree of warmth and control and thus categorised as authoritative, authoritarian, permissive or neglectful (Baumrind, 1971). An authoritative parenting style is considered to be a positive parenting style with a balanced relationship between warmth and control. By contrast, an authoritarian parenting style might involve getting very angry when children make small mistakes or giving excessive punishment. Permissive parents can provide much love and care, but may have trouble setting boundaries for their children. Neglectful parents are those who pay little attention to what their children do, who they are with, how they are or where they are. Baumrind (1971) found that an authoritative parenting style is best suited to promote healthy adaptation in children. In therapeutic work, therefore, one goal may be to promote an authoritative parenting style.

Parenting style seems to be transferred from one generation to the next (Belsky, Conger, & Capaldi, 2009). Women who have grown up with irascible, aggressive or hostile parents tend to use the same parenting style with their own children (Caspi & Elder, 1988). In families with behavioural problems over several generations, both parenting style and substance use problems continue through the generations (Bailey et al., 2009; Kovan et al., 2009). Although there is evidence for the intergenerational transmission of parenting style, we have limited knowledge of the mechanisms that cause the transfer of negative parenting styles from one generation to another (Belsky et al., 2009).

Mayes and Truman (2002) conducted a metastudy of parenting style among substance users. They found a number of studies that showed that substance use interferes with parenting functions. SUD parents do not consider themselves to be good parents. Mayes and Truman point out a limitation to most studies in that the sample often consists of single parents, with low education, mental disorders and from urban areas. These are factors that in themselves are risk factors for poor parenting. Other studies have also found that addicted parents tend to have a negative parenting style, including stricter discipline, less attention to children and lower levels of care and affection (Keller et al., 2008; Bailey et al., 2009).

2.5. The importance of social support

Social support is defined as a person's experience of receiving love and care, being valued and appreciated, and belonging to a social network with mutual obligation (Cobb, 1976). Family members, friends and colleagues can provide different types of social support, such as emotional and affirmative support (love, care, acknowledgement), informative support (advice, guidance) or instrumental support (financial assistance, baby-sitting) (Thoits, 2010). The social support we perceive to be available to us can affect our mental health

(Thompson, Flood & Goodwin, 2006) and be a key factor in creating a caring and predictable environment for children (Mathiesen, Tambs & Dalgard, 1999).

Addicted women are often socially isolated (Green et al., 2002). They are often single mothers or live with a partner who is also addicted (Roberts & Leonard, 1997). This means that there is often no caregiver without substance problems available to the children. In families with intergenerational SUD, there may not be substance-free grandparents available to the children. It has been pointed out that an inadequate social network may be one of several reasons why children of addicted mothers seem to develop their own problems more than children of addicted fathers (Christoffersen & Soothill, 2003; Forrester & Harwin, 2006).

Suchman, McMahon, Slade, and Luthar (2005) found that addicted women may be capable of taking care of their children if they receive adequate social support. The mechanisms for this may be that the mother experiences belonging, feels better emotionally, and is thus better able to be sensitive to the needs of her children. Social support may also be effective by providing the mother with help, advice and guidance for the care of her children. To belong to a family or to have a network of friends or supportive neighbours is believed to be a protective factor for poor psychosocial adaptation and later development of substance abuse in the mother's children (Suchman et al., 2005). The psychological development of children can be affected by the social support the mother receives: directly because the support person provides social control, acts as a role model or facilitates contact with other people, and indirectly because the support person can make the mother feel socially at ease and capable as a mother (Boe & Schiefloe, 2007; Olstad, Sexton, & Sjøgaard, 2001). Social support may be especially important for children in families in difficult life situations and with low socioeconomic status (Kendler et al., 2005), such as children of addicted mothers who themselves have grown up with parental substance abuse (Banwell & Bammer 2006; Dawe, Harnett, & Frye, 2008).

Cohen (2004) has suggested that isolated individuals will particularly benefit from establishing new social contacts, but that people who feel alone or who have conflictual or ambivalent relationships with those around them will not always be capable of expanding their network. According to Cohen (2004), barriers to establishing new networks imply that service providers should facilitate and strengthen the ties that already exist between addicted mothers and people in their network.

Reciprocity has been highlighted as a central dimension of social support. Gouldner's (1960) norm of reciprocity states that two parties in a relationship should give each other a more or less equal amount of support over time. If one party has provided much support for a period, the other party should reciprocate at a later date. According to Gouldner, it may feel wrong to take advantage of others' good deeds. Therefore, people who receive more support than they give may feel overly dependent or lose faith in themselves (Shrout, Herman, & Bolger, 2006). It may appear that the norm to reciprocate is a condition for

equality in such a relationship. However, Farmer and Moyers (2008) found that one-way support can persist if it comes from close family members.

Addicted mothers and their children face many challenges in attempting to establish a substance-free life after inpatient treatment. A difficult life situation such as low socioeconomic status may weigh heavily on these mothers. McCurdy (2005) found that stress in mothers led to greater use of corporal punishment on their children. However, increased social support from partners or others mitigated the extent of physical punishment. McCurdy concluded that home visits by health or social services could provide support and counteract the effect of stress on mothering.

When addicted mothers of young children come from families with parental SUD, their social network may represent a particular challenge after inpatient treatment. On the one hand, they need social support to manage to continue a substance-free life and take care of their children. On the other hand, a substance-free life may necessitate distancing themselves from their old friends and family who are still addicted. Continued contact with the addiction scene may pose a risk of relapse, especially during the initial phase of rehabilitation (Marlatt & Witkiewitz 2009). Contact with friends and family who are still addicted can also represent a direct risk for the children in terms of unpredictability in relationships and exposure to violence, conflict and addiction-related behaviour. In order to protect their children from such experiences, these mothers may need to shun contact with their former network (Dube et al., 2003; Perry, 2010).

In this way, the kind of social support the mothers experience is seen to be important, but complicated. Social support may have a significant impact on how these mothers care for their children and can therefore also help to initiate and maintain healthy development in their children.

2.6. Prevention of intergenerational transmission of SUD-related problems between parents and their children: A treatment perspective

Young women who have been subjected to abuse and neglect may, despite their own childhood experiences, be sensitive and good caregivers for their children. Here, a crucial factor is treatment for their mental health problems (Lieberman, Weston, & Pawl, 1991). Studies have shown that giving birth can be perceived by addicted women as a crossroads in their lives, allowing them make new choices (Brodén, 2004). Focusing on these women's understanding of their maternal role may enhance the suitability of interventions in such families. By reflecting on their own childhood, addicted mothers can become aware of changes they want to make and aspects of their parents' behaviour they want to pass on to their own children. Such reflections may help a woman to understand and accept her own story and think more consciously about her maternal role (Klette, 2007).

The past few decades have seen a trend from aiming treatment solely at individuals to including their family in treatment. Today, certain family members, including children, are also entitled to receive help on an independent basis. Copello, Velleman and Templeton (2005) recommend a more comprehensive approach to addiction treatment that integrates many different aspects of the lives of family members. Killén (2010) argues that services aimed at children must have a holistic systemic approach and that focusing solely on teaching parents to be competent and sensitive to the needs of their children is insufficient in families with addiction. In addition to the treatment of addiction, the parents' internal working model of parenting should be assessed, including how they cope with parenting, their potential for development, how they interact with the child, their attachment style and environmental factors, such as social support and financial resources (Killén, 2010). This suggests a form of assistance in which service providers aim to enhance the parenting skills of the addicted person *and* treat the addiction.

Millar and Stermac (2000) examined factors to improve recovery for addicted people who had experienced childhood neglect. They found a need for interdisciplinary service provision, focusing on managing emotions, attachment style, and re-shaping the concept of self. Copello and colleagues (Copello et al., 2005; Copello, Templeton, & Velleman, 2006), in a study of treatment for SUD families, found greatest effect for the addicted person, for family interaction and family members' mental functioning when relatives and the rest of the social network were included in the treatment.

In Norway, addicted parents and their children may be admitted to a family inpatient unit in an addiction treatment facility. This type of treatment is funded by the public health service, and must comply with the current guidelines laid down by the health authorities. People with pronounced addiction problems are entitled to suitable treatment. In addition, treatment is to be offered to family members, including children, who are affected by the addicted person's problematic substance use. The aim is to reduce the negative consequences of substance use for the individual, for the relatives and for society (Helsedirektoratet, 2017).

2.6.1. Interaction training

Slade (2005) developed the term "parental reflective functioning", based on attachment theory (Fonagy), which describes parents' representations of the child and the relationship between the child and the caregiver. Fonagy and Target (1996, 1997) show that the ability to understand interpersonal behaviour in the form of mental states (mentalisation) plays an important role in the organisation of the self and the regulation of emotions. They argue that the psychological self is formed through knowledge of mental states. The child's understanding of mental states is developed through the care provider mirroring the child. The development of this understanding may be impaired if the child is exposed to serious relational conflicts or shortcomings, acute stress or trauma. Secure attachment is believed to have a positive effect on mentalisation, while insecure attachment weakens it. A

mother's mentalising ability with regard to her child will affect her parenting skill and thus the child's ability to develop secure attachment and its own capacity to mentalise (Fonagy & Target, 1996, 1997). Pajulo et al. (2010) used a coding system developed by Slade (2005) to investigate the role of mentalising ability for addicted mothers in treatment. They found it useful to train the ability to mentalise in order to develop sensitivity to the child and to improve interaction. Söderström and Skårderud (2009) argue that addicted parents may have difficulty paying attention to their children's needs because their attention is drawn to the substances they use. This leads them to believe that the children's development of self-regulation and social skills is at risk. They therefore recommend interdisciplinary long-term treatment for families with addicted parents that focuses on training of parental ability to mentalise.

Suchman et al. (2010) used items from the Parent Development Interview (PDI) (Slade, Aber, Bresgi, Berger & Kaplan, 2004) to study addicted mothers caring for infants and toddlers. They categorised the mothers' relationships with their children into two dimensions, self-mentalisation and child-mentalisation, respectively the mothers' ability to understand themselves and their ability to understand how their children feel "on the inside". Both functions were important for the mothers' caring ability as measured by the PDI. On this basis, Suchman et al. (2010) suggest that training in self-understanding can be a critical first step in improving interaction between addicted mothers and their children.

2.6.2. The therapists' perspective

Rutman, Strega, Callahan and Dominelli (2002) examined the experiences and perspectives of social workers who worked with young mothers who had been or were in care. Both the mothers and the social workers were concerned about the intergenerational transmission of problems, but they had different ideas about what could break this cycle. The social workers tended to consider intergenerational transmission as inevitable, partly because the mothers were unable to give priority to parenting and possibly did not deserve to continue to care for their children. The mothers, on the other hand, saw having children as an important crossroads and the opportunity for a better life. The mothers were concerned that their children would have similar problems to themselves if taken into care. The mothers also seemed to have greater hope of breaking the generational cycle of addiction than the social workers had.

It is reasonable to assume that therapists' opinions as to whether or not addicted mothers can learn to take care of their children will affect the outcome of inpatient treatment for addicted parents with young children. Even if the attitudes of therapists are not made explicit to the patients, their attitudes will be reflected in their therapeutic work.

2.7. Summary

Negative childhood experiences related to parental substance abuse, such as exposure to violence, traumatic events and neglect, can impair children's psychological development (Perry, 2010; Anda et al., 2006). There is also an association with the development of substance abuse problems in adulthood (Felitti & Anda, 2010). To prevent the intergenerational transmission of psychosocial difficulties, addicted parents and their children are an important risk group for targeted interventions. Helping SUD parents to become substance-free, develop a healthy parenting style and function well as parents can significantly reduce the risk of the children experiencing difficult and traumatic events. In an overview of epidemiological studies of psychopathology and mental problems in young children, Skovgaard (2010) found that the mental problems of a large proportion of these children could have been detected before they were 18 months old. Skovgaard emphasises that the parent-child relationship is of major importance for the development of mental health problems. Signs of disturbances in this relationship could be detected by nurses during routine home visits and at health centres.

Prevention of transmission of problems from addicted mothers to children is important for the individual and for society. The costs of addiction to society include health care, loss of productivity, crime, imprisonment and substance-related law enforcement (Institute of Health Economics in Canada, 2010). Addiction also leads to health problems and reduced quality of life for both the addicted person and the person's relatives (Helsedirektoratet, 2006).

Addicted women who have grown up with problematic parental substance use can have a number of challenges when they have children. Their children may have an increased risk of developing addiction or mental illness (Belsky et al., 2009) and the mothers may have challenges in establishing for their children a secure and predictable environment with adequate social support.

The aim of the present project is to gain knowledge of how second-generation SUD mothers in active treatment understand their challenges in caring for their children, and how service providers and other support people can enhance healthy development in these families.

3.0 Research questions

The overall objective of the three sub-studies is to enhance understanding of intergenerational transmission of substance use problems from mothers to their children. The focus is on environmental factors that can be influenced by service providers and society as a whole. To learn more about the childhood environment, we wish to explore how addicted mothers describe their own motherhood and how they relate their role as caregivers to their own upbringing with SUD parents.

In order to investigate the subjective experiences of addicted mothers who had grown up in SUD families, we conducted individual in-depth interviews with mothers admitted with their infants to a family inpatient unit in an addiction treatment facility. With the exception of a few studies (Baker & Carson, 1999; Söderström, 2012; Virokannas, 2011), there has been little research focusing on the mother-child relationship and intergenerational transmission of psychosocial problems from the perspective of addicted mothers. In order to expand this field, we wished to focus on addicted mothers who had grown up in SUD families. This would provide enhanced knowledge of the challenges facing a vulnerable group of addicted mothers of infants.

Article 1: Substance-dependent women becoming mothers. Breaking the cycle of adverse childhood experiences answers the following research questions:

1. How do addicted mothers who have grown up in SUD families understand their role as a mother?
2. How do addicted mothers who have grown up in SUD families relate their childhood experiences to their own role as a mother today?
3. Following inpatient SUD treatment, what challenges do the mothers face in establishing themselves as substance-free caregivers?

In order to explore how society and the local community can help addicted mothers to remain substance-free and take care of their children, we need knowledge of the social support available to them. Addicted mothers whose own childhood was marked by SUD are thought to be particularly vulnerable in terms of their social network. If substance use has dominated their network of family and friends, it can be challenging to build a substance-free and supportive social network. The aim of the second sub-study was therefore to explore the relationship between the addicted mothers and their closest support person/significant other. What social support do the mothers receive from the support people? What other social support is available to the mothers and their children?

Article 2: Social support available for substance-dependent mothers from families with parental substance abuse answers the following research questions:

4. What characterises the relationship between an addicted mother who has grown up in an SUD family and her support person?
5. What characterises the social support that support people can provide to addicted mothers who have grown up in SUD families?

The third and last part of the research work focused on how staff of the family unit where the mothers and their children were admitted understood their role and how they described their work with the addicted mothers and their infants. This sub-study included the employees' work with all the patients in the family unit, irrespective of whether they had experienced parental SUD. The focus was on the efforts of the staff to prevent the children in these families from developing substance use problems and their attempts to facilitate the best possible start in the lives of these children.

Article 3: Rescue the child or treat the addiction? Understandings among practitioners in family-oriented substance abuse treatment answers the following research questions:

6. How do the staff describe working with addicted parents and their children?
7. How do the staff understand their role in preventing intergenerational transmission of SUD?

4.0 Method

4.1. Choice of method

Qualitative methods are suitable for providing knowledge of phenomena as experienced by people. In little-researched areas, it is particularly appropriate to use an open, exploratory approach. In order to understand the challenges of addicted mothers of infants who themselves have been exposed to parental SUD, we wanted detailed and thick descriptions (Geertz, 1973). This implies that the findings are interpreted and condensed, and that theory is applied to the interpretation of the empirical findings. We aimed for descriptions that explain human behaviour in its own context in such a way that it becomes comprehensible to an outsider. This was the rationale for choosing a qualitative, phenomenological-hermeneutical method (Kvale, 2002) and for collecting data through in-depth interviews.

Semi-structured in-depth interviews were chosen for the sub-studies of the mothers and their support people, while the staff were interviewed in focus groups. Since we wished to talk about the mothers' childhood experiences, we assumed that sensitive information would arise and that individual interviews would therefore be most appropriate for both the mothers and the support people.

Focus group interviews were chosen for staff as this is a method suitable for exploring experiences, attitudes and needs among employees (Wilkinson, 1998) and is commonly used for in-depth studies that can provide insights and understandings of personal viewpoints. Participants are interviewed in groups that have something in common, such as a life situation (Parker & Tritter, 2006).

To create good qualitative research, a thorough and systematic analysis is vital to elicit descriptions and stories that can lead to changes in practice. Knowledge is developed by collating and interpreting systematised experiences. The data obtained from qualitative in-depth interviews is constructed in interaction between the interviewer and interviewee(s).

4.2. Theoretical framework

The qualitative approach of this research study was inspired by a phenomenological-hermeneutic interpretative tradition based on the theory of Husserl (1970/1936) and Merleau-Ponty (1966). Husserl believed that people primarily need answers to questions about the meaning of existence. He therefore wanted to reintroduce a more humanistic view of knowledge where the human world forms the basis of knowledge. Husserl's phenomenological approach to knowledge development devotes greater attention to everyday and lived experiences. On this basis, it is interesting to explore how people view their own lives and how they justify their everyday activities and their "being-in-the-world". Phenomenology originates precisely in the lived lifeworld. In Husserl's view, such knowledge

is often overlooked. A phenomenological-hermeneutic approach is based on an understanding that our social reality is socially constructed and that people seek meaning in life. People have intrinsic intentionality, albeit not always conscious, and create their own social reality. Reality is created through understanding and social interaction and does not exist as an exact, independent phenomenon. Actions allow for different interpretations and there are several truths. Researchers belong to the same world as they research, but have their own understanding of the lifeworld. The researcher's role will thus be to position herself so that the phenomena under study can reveal themselves to her (Dahlberg, Dahlberg & Nyström, 2008). The researcher seeks to gain insight into how the research subject understands and creates her own world.

Merleau-Ponty (1966) believed that awareness and understanding of "taken-for-grantedness" in our lifeworld is necessary knowledge. Our understanding of the concrete lived world will be enriched by reflecting on it and building theories around this knowledge. Such knowledge will, however, never be absolute, but must always be open for reassessment. An important point for Merleau-Ponty was that personal experience takes place through the body, which means that experience is subjective. Without subjective descriptions, it will be impossible to understand the lives of other people. As the Norwegian saying goes, "It's the person wearing the shoe who can tell where it's pinching". Therefore, a researcher who aims to study other people's personal experiences and understandings must try to imagine "what it's like to be wearing the shoe". One way of finding this out is to approach the people "wearing the shoe" and ask them to describe and explain how it feels.

Merleau-Ponty also believed that people's past and future are present in the world now. In the case of addicted mothers, their adverse childhood experiences will affect their lifeworld here and now, and their future. Their thoughts and dreams for the future will also have an impact on their life here and now. If they think it will be difficult to get a flat and a job, or that they will be lonely, this may affect their motivation for treatment here and now.

The concept of social constructionism or social constructivism centres on the notion that human understanding of reality is continuously changing. Our understanding of reality is shaped by new experiences and the particular situation in which we find ourselves at the time (Berger & Luckmann, 1966). Addicted mothers are a stigmatised group that may experience being on the margins of society. This marginalisation may mean that children who grow up in SUD families feel that they are not part of the majority society and thus more easily develop their own addiction. They thus continue to be marginalised and increase the risk of SUD in the next generation. If the marginal state is considered to be a social construction, it can be changed. According to Hacking (1999), rather than ask what social constructions are, we should try to find out the purpose of a social constructivist analysis. Why should we examine whether a particular concept is merely a social

construction? The purpose must be to raise our awareness to enable us to modify our understanding of the concept or phenomenon.

Constructionists maintain that classifications are not determined by the way the world actually is, but are merely convenient ways to represent the world. The world does not exist as a ready-made package of facts; the facts are rather the consequences of the ways in which we represent the world. People who are classified in a particular way can find out that they are classified in this way. For example, addicted mothers of young children may find that they are marginalised. They may then choose to live in a way that fits this classification, or in a way that enables them to escape from it. If these women and children feel they belong to society, this will enhance their adaptation and well-being and decrease the risk of intergenerational transmission of substance abuse.

I chose to base my interviews with the addicted women on the women's and children's everyday lives and ask questions about what happens, how it happens, the intentions behind it and when it takes place. My aim was to elicit open, nuanced and detailed descriptions of everyday life, as recommended by Andenæs (1996) and Kvale (2002). The interview guides were designed from an everyday life perspective to enable the interviewees to describe precisely and in detail their everyday activities and routines and related experiences and feelings. A systematic and varied inquiry into how mothers understand their own and others' behaviour can provide knowledge of how parenting and care for children are created, maintained and changed on the basis of the particular situation of these families. In the interviews with the support people, my approach was similar, but here the topic of conversation was cooperation on care of the children and support in everyday life. The focus was on detailed descriptions of cooperation with the mothers: what happened, how and why. The interviews with the staff of the treatment facility focused on detailed descriptions of specific episodes with patients, their personal treatment philosophy, and their thoughts on their priorities and on what they considered important in their work.

Interviews take place in the here and now. They are digitally recorded and transcribed, ending up as written text. The text becomes the data the researcher must interpret. What are the common and distinguishing features? Are there any particularly surprising elements in the texts? The researcher's task is to interpret and abstract these understandings, and connect them to scientific explanations. In the presentation below, I attempt to illuminate the interviewees' understandings, partly by including various direct quotations. I also present my interpretations as a researcher. Whose voice is heard will thus always be open to question. A researcher will never be able to render the interviewees' understanding of their world entirely correctly. Geertz (1973) explains that the researcher should seek out and reveal meaning-creating processes, not actual actions. The analysis is an interpretation of the interviewees' interpretation, not an absolute truth about the social world. Therefore,

the validity and relevance of qualitative research must be based on whether it is useful and can provide enhanced knowledge on which to base further research.

4.3. Preparation for the study

Addicted mothers are a stigmatised group and are difficult to converse with. It is a taboo for mothers to have substance use problems (Green et al., 2002) and there may be barriers to contacting service providers, partly because asking for help involves the risk of losing custody of their children. Nevertheless, there are some addicted mothers in treatment facilities, and these can potentially be interviewed while admitted. The present project was planned on the basis of my work in a centre of substance abuse expertise specialising in pregnant women and mothers of young children. The centre had established good cooperation with Norwegian addiction facilities offering treatment to pregnant women and mothers of young children. This cooperation enabled me to contact one of the facilities to ask if I could contact their patients for interview. A cooperation agreement was then signed with the treatment facility.

Addicted mothers of young children are a vulnerable group and ethical sensitivity and protection of the interviewees are needed when talking to them about sensitive topics, such as their childhood with SUD parents and their own parenting. In connection with the application process, interview guides were prepared for all three sub-studies.

The mothers were recruited from a facility where addicted mothers, and sometimes their partners, are admitted during pregnancy or just after giving birth. They usually stay until the child is about one year old. Addicted single fathers with children may also be admitted, but these are rare cases. No single fathers were admitted during the period of this research.

The SUD facility is part of the publicly funded specialist health services in Norway that treat both addicted people and their relatives. The facility has established a separate inpatient unit to treat addicted mothers with infants (the family unit). The aim of the family unit is to prevent intergenerational transmission of substance use problems. The work is based on what the staff term a family and generational perspective. The facility thus acknowledges that the entire family is affected by the addiction of one family member. They wish to use the family as motivation for treatment, actively involve family members in the treatment of the addicted person, and provide separate support to family members, including children (Copello et al., 2005). The purpose of the treatment is to teach parents both abstinence and parenting skills.

4.4. Selection criteria

4.4.1. The mothers

The mothers were selected according to the following inclusion criteria:

Addiction

- admitted to the family unit of a particular SUD facility together with their infant (0-12 months) from November 2011 to May 2013.
- reported having had an addicted parent

All mothers who fulfilled the inclusion criteria were invited to participate in the study and all agreed. Eighteen interviews were conducted with nine mothers. Most families consisted of mother and child, but in three cases both parents were admitted with their child(ren). All participating mothers had been diagnosed with a substance abuse disorder according to the International Classification System ICD-10, F10-F19 "Mental disorders and behavioural disorders related to the use of psychoactive substances", usually referred to as an addiction disorder (WHO, 2010). The mothers had been admitted and were therefore substance-free when interviewed. The mothers explicitly stated that they did not want to continue using substances when they realised they were pregnant, but that they needed help with this. Most women either asked for help themselves or enabled the health services to learn of the pregnancy. Five of the women were admitted voluntarily, and four were admitted under the enforcement section (10:3) of the Health and Care Services Act (Helsedirektoratet Ministry and Care Services, 2011). One of the women lost custody of her child after the first interview, but continued with the second interview and remained included.

The mothers had lived with parental SUD for at least five years of their childhood. According to the mothers, some parents had had a heavy use of opiates, some had used only prescription drugs or alcohol, and some had used amphetamines. Six of the mothers reported problematic parental SUD during most of their childhood. They had lived with single parents or in some cases with two addicted parents. These families were dependent on welfare benefits and the parents were often unemployed, had low income and in some cases poor housing. The three other mothers had had between five and ten years of their childhood without any parental substance use. In these families, there was mostly a substance-free caregiver and at least one of the parents had a job.

Upon inclusion, the mothers were between 20 and 37 years old (average 25, median 23). They had all taken illegal substances for many years (3-15 years, average 5 years). Five had recently given birth for the first time, while four had one or more older children. Two of the mothers were admitted with an older child (1½ to 3 years) in addition to the infant. All the mothers with older children had previously been in contact with the child welfare services. Six of the mother-newborn dyads had no contact with child's father. Three fathers were admitted with the mother and child, but one of these subsequently had to leave the family unit due to continued substance use. According to the mothers, all fathers were addicted, and most were active substance abusers.

All mothers had had mixed substance abuse. One had only used alcohol and cannabis, but the others had also used amphetamines. Many had also used benzodiazepines, and some had used opiates.

4.4.2. Support people

In the interviews, the mothers were asked to name their closest support person, apart from service providers. This was to be someone they thought would provide support and help after their treatment. At an average of about 15 months (from 2 weeks to 29 months) after discharge, the mothers were contacted by telephone and asked to supply contact details of their support person. All except one provided this information and said they would tell the support person to expect a call. One mother wanted the treatment to be a closed chapter of her life and therefore did not want the support person to be interviewed. It was a challenge to contact all the support people by telephone. Some did not answer phone calls from unfamiliar numbers as they had received threatening calls. All the support people agreed to be interviewed, and were allowed to decide where the interview would take place. Seven interviews took place in the support person's home and one in the SUD facility.

About half of the support people had had addiction problems, but had stopped using substances several years previously (2-12 years). One was in medically assisted rehabilitation but near the end of treatment. The other support people had not had SUD problems of their own, but many had experienced SUD in people close to them, apart from the mother. Some of these support people had grown up in families with substance abuse problems.

Table 1. Demographic information on the mothers and their support people

Mother			Support person	
Pseudonym	Age	No. of children	Type of relationship	Age
Anne	25-29	1	Friend	25-29
Beth	20-24	>1	Sister	30-34
Claire	20-24	1	-/-	
Diana	35-39	>1	Mother	55-59
Emma	25-29	1	Grandmother	65-69
			Grandfather	70-74
Fay	20-24	>1	Mother	50-54
Grace	20-24	1	Sister	30-34
Helen	25-29	>1	Partner	25-29
Ingrid	20-24	1	Partner	25-29

The fathers selected by the mothers as support people had completed the treatment with the mother and child. One support person had been a close friend of the mother since early adolescence. The other support people were close relatives of the mother: two sisters, two mothers and two grandparents. The support people were interviewed once. The total data

thus consisted of 26 interviews (8 with support people and 18 with mothers), with 18 different interviewees (see Table 1).

4.4.3. The staff

The third sub-study was devoted to the perspectives of the staff of the family unit. It was agreed with the head of the family unit that the staff could be interviewed in groups. The staff of the family unit consisted of a small group of *therapists* and a larger group of *ward staff* (in Norwegian called “miljøterapeuter”, literally translated as environmental therapists). The *ward staff* work in the unit where the families live and spend their working day with the patients and their children. The *therapists* provide consultations and therapy sessions, both individually and in groups, and have their own rooms.

During the interview period, there were 12 ward staff in the unit. They had a variety of qualifications, in e.g. nursing, kindergarten education, social studies, maternity care and domestic science. Two focus group interviews were conducted, involving 11 of the 12 ward staff. The first focus group interview was with seven, and the second with four.

In the third focus group interview, four out of the five therapists participated. The fifth was on sick leave. The therapists were responsible for treatment sessions for individuals, couples and groups in the family unit. Their educational background was in family therapy, psychology, child welfare or social science.

4.5. Interview guides

4.5.1. Interviews with mothers

The interview guide for mothers was divided into three parts. The first part dealt with the mothers' everyday life with her child in the family unit. It was assumed that it would be least stressful for mothers to start by talking about their life here and now and everyday life in the unit with its predictable daily routines. This allowed the mothers to develop confidence and trust in the interviewer before the more difficult topics were introduced. This part of the interview was conducted as a life-form interview in which the activities of everyday life are elicited in chronological order (Haavind, 1987).

The second part of the interview guide dealt with the mothers' childhood experiences. They were asked to recall specific episodes that they connected with parental substance use and episodes where they remembered their parents as good parents. They were asked to say how they felt during the various episodes and what they thought and did.

The third part of the interview guide concerned the mothers' future plans after the family had left the treatment facility. How did the mother intend to protect her child from experiencing difficult episodes like those she had talked about? Finally, the mothers were asked what social support they expected to have after treatment. I chose to focus on the mothers' childhood experiences before talking about future plans to allow them to connect

the various experiences and plans, as described in narrative theory (Brockmeier & Carbaugh, 2001).

4.5.2. Interviews with support people

The interview guide used with the support people focused on the social support they presumed was available to the mothers, primarily based on what they themselves contributed. The interviews were conducted some time after the families had been discharged from the treatment facility. The interview guide was divided into four parts. We wanted to hear the support person's perspective on the following points:

- I) Common history of the support person and mother
- II) The support person's current relationship with the mother
- III) How the support person envisaged his/her future relationship with the mother and child
- IV) Other social networks that the support person thought were available to the family

4.5.3. Focus group interviews with staff

The main question for the group interviews was: How do you work to prevent the transmission of substance abuse problems to the children? Although the opening question was identical for all three groups, the discussions developed in different directions, with different follow-up questions depending on the thematic focus. Examples of questions for the focus groups were: What motivates your work? What do you and your colleagues emphasise and find particularly important in the treatment? Please tell us about some families whose stay here was a success and some whose treatment was not so successful: What are the success criteria?

In the first focus group interview of ward staff, there was a strong focus on how to use here and now situations therapeutically. In the second interview of ward staff, the focus was on the lack of resources and influence, while the third focus group, which consisted of therapists, discussed how complex and challenging their therapeutic work was.

4.6. Implementation and the researcher's position

My position as a researcher in this field could be described as that of an "informed outsider" (Middelthon, 2001). I was an outsider because I had no experience of addiction in my close family and I had never worked in this type of family unit. I was informed because I have knowledge of the field from my work in a centre of substance abuse expertise, previous experience from work with addicted people and as an AIDS nurse, and experience from maternity nursing in specialised health services. This background affected how the interviews and focus group discussions were conducted and probably also made it easier to

gain access to the respondents and instil sufficient confidence to allow them to talk about sensitive topics.

When new patients who met the inclusion criteria were ready to be asked to participate, I received a message from the therapist concerned or the head of the family unit. It took a long time to gain access to the interviewees, despite ongoing dialogue with the therapist and head of the family unit. Mothers who had experienced parental SUD were asked by their therapist if they could be interviewed. The therapist assessed when a patient was ready to be contacted. The therapist considered how far a mother had progressed in the treatment, whether she was able to sit and talk about herself and whether participation in the study might be detrimental to her development and recovery process. This meant that the mothers were not interviewed at the start of treatment, as originally planned. Most of the mothers had already been in the family unit for at least four months before the first interview. The therapist was ready to assist the mothers after the interviews if needed.

At my first meeting with the mothers, they received oral and written information about the research study, and we agreed on the date of the first interview. It was emphasised that the mothers could withdraw from the study at any time until the data were used in the analysis. They signed an agreement to participate in the study at the meeting for the first interview.

It proved to be a challenge that the mothers were often unavailable at the agreed time of the interview. All the interviews were postponed at least once, either because the mother said it was not suitable after all or because the mother was not present at the agreed time. The mother might be out with the child or at the dentist. However, the long stay in the family unit (about 12 months) made it possible to conduct two interviews with a two- or three-month interval with eight of the mothers. The ninth mother was admitted near the end of the data collection period, which only allowed time for one interview with her. During one of the interviews, there were technical problems resulting in poor audio quality. A third interview was therefore conducted with the mother in question. The three interviews were also spread over time. The total data collection period was 18 months.

Great emphasis was placed on showing the mothers respect and being open and positive, in order to build a trusting relationship with them right from the first meeting. At the end of the first interview, the mothers were asked to take part in a second interview. The second interview was intended to sum up the first one, with the opportunity to provide additional information and clarify topics from the first interview.

Any patients who lost custody of their child were usually discharged from the family unit and were therefore not included in the study. One of the mothers lost custody before the second interview. She participated in the second interview and continued as an interviewee in both the first and second sub-studies.

The first interview with the mothers lasted about 90 minutes and the second interview about 45 minutes. All the interviews were audio recorded and transcribed verbatim by the author. When a researcher conducts and transcribes interviews herself, it gives the analysis a head start and the opportunity to adjust the interview guide on the basis of data collected.

At the end of the first interview, the mothers were told of the wish to interview their closest support person. They were asked to consider, before the next meeting, who would be their closest support person after discharge. They all mentioned a support person. The mothers were contacted again after discharge and asked to provide the contact details of the support person. It was always challenging to get hold of both the mothers and support people on the telephone. Eight of the nine women provided the contact information of their support people. Interviews with the support people lasted for about 90 minutes and were audio recorded and transcribed verbatim. These interviews were also conducted and transcribed by the author.

The head of the family unit agreed with the staff on the time and place for the focus group interviews and arranged for the staff to participate in their working hours. Three focus group interviews were held with different participants. Focus groups are suitable to explore the experiences, attitudes and needs of employees, and may be useful if there is a desire to determine the dominant values involved (Wilkinson, 1998).

Focus group interviews are usually used for in-depth studies of a topic we know little about. The goal is often to provide insights and understandings about personal viewpoints. Participants are invited on the basis of something they have in common, such as a disease or a life situation (Parker & Tritter, 2006). The common element here was that they all worked in the family unit. This type of group interview is called a focus group interview because it is focused on a particular topic. The interviewer facilitates a discussion among the participants and it is the dynamics of the discussion that is of interest (Parker & Tritter, 2006). In a focus group interview, the discussion can take unexpected turns, as many people are involved at the same time.

Parker and Tritter point out the importance of the composition of focus groups. In our study, we chose to differentiate between the different levels of the organisation. One group consisted of therapists, while the other two consisted of ward staff. If the groups had consisted of both therapists and ward staff, there could have been greater disagreement and more varied perspectives, which could have provided more dynamic discussions. However, there was a risk that the participants would talk less freely if they were mixed (Wilkinson, 1998). The possibility of an interview with familiar colleagues who work on the same level and with similar jobs may facilitate the recruitment of staff who might otherwise be reluctant to participate.

Each focus group interview lasted for 90 minutes. The interviews were led, audio recorded and transcribed by the author alone.

4.7. Analysis

Giorgi's phenomenological method forms the basis for the two analytical methods used. In phenomenology, experience from the lifeworld of the subjects is considered valid knowledge. The researcher must attempt to bracket her preunderstanding in order to describe the object of study as thoroughly as possible. Malterud's (2012) method of *systematic text condensation* informed the analysis in the first two sub-studies, while *thematic analysis* as described by Braun and Clarke (2006) was used in the third sub-study. Both analytical methods are suitable for cross-cutting analysis with several respondents.

4.7.1. The first sub-study

The interviews with mothers were analysed using systematic text condensation (Malterud, 2012). Malterud's method consists of four steps. The first step is to gain a general idea of the transcribed texts and extract preliminary themes relevant to the research questions. In the next step, the texts are read closely and text fragments that constitute meaning units are identified. Meaning units that deal with the same theme are then sorted into codes. In the first sub-study, this resulted in the following four codes across all interviews: *1. Understanding my child. 2. Childhood experiences. 3. Why substances? 4. Changes I have to make.* The third stage of the analysis process is condensation, which is a systematic method of abstracting the content and finding the underlying meaning of each of the codes. The fourth step is to synthesise the content of the condensates to develop new descriptions and concepts, which Malterud calls categories. Here the different elements are reassembled to provide comprehensible stories that shed light on the original research questions.

After the first interviews with four mothers, the transcripts were discussed in detail with the co-authors. This highlighted weaknesses and ambiguities and areas suitable for further exploration. In this way, the interview guide was further developed during the interviewing period and interviewing techniques were improved for later interviews, both with the same respondents and with new respondents. In the analysis of the interviews with the mothers, each step was discussed in detail by the author and several of the co-authors of the article. It was especially important for me to draw on the rich research experience of my supervisors to enable me to learn and develop as a researcher. To help us to maintain an overview of the whole picture during the process, we developed two different matrices. The first contained a summary of the data from each mother and the second contained overall themes across the interviews. Table 2 shows the analytical process in the first sub-study.

Table 2. The analytical process in the first sub-study

Themes	Codes	Categories	Headings in Findings		
			Life on the edge	Traumatic experiences	Meaning of the substances
Understanding my child	Structure	Protected but lonely	X		
	Prioritising the child				
	Knowing my child	Traumatic childhood experiences emerging		X	
	A good mother	Craving for substances. Fear of relapse. Keeping custody of the child			X
Childhood experiences	Marginalisation	Exclusion	X		
	Adapting				
	Being abandoned	Recalling violence, abuse and neglect		X	
	Trauma				
	Possible hope				
Taking adult responsibility					
Why substances?	Escape	Using substances – a natural choice			X
	Thrill, fun				
	Natural development				
Changes I have to make	Self-reflection	Developing alternative strategies			X
	Taking responsibility	To protect the child		X	
		Establishing structure and belonging	X		

4.7.2. The second sub-study

Systematic text condensation was also used in the analysis of the second sub-study. This time the focus was on the mothers' social support. The interviews with the mothers were re-read with this in mind. Two themes were extracted from the interview texts: *a) Returning to a life outside the clinic - fear and hope*, and *b) Characteristics of the relationship between mother and her significant other*.

The latter theme also emerged from the interviews with the support people. Here, two additional themes were identified: *c) The significant others are supporting, but also struggling with their own problems*, and *d) Poor social resources*.

The next step in the analytical process was to identify meaning units in the transcribed texts and sort them into different codes across the interviews. Examples of codes that emerged were *frequency and duration* and *giving advice*. The codes were then condensed, resulting in e.g. *building a social network* and *a complementary relationship*. The fourth and final step of the analysis was to synthesise the content of the condensates. This led to the following categories: *a) Returning to a life outside the clinic - hopeful but insecure*, *b) Close and long-lasting relationships - offering many-faceted support*, *c) Three types of relationships*, and *d) A thin and brittle network*. Each step of the analysis was discussed in detail by the author and at least one of the co-authors of the article.

4.7.3. The third sub-study

In the third sub-study, we wished to explore the perspectives of the staff regarding the addicted parents and their infants. In all three focus group interviews, the difficulty of prioritising between different aspects of their work was discussed. Despite this, the discussions varied considerably between the three groups.

The first focus group interview, with seven ward staff, concentrated mainly on how they made therapeutic use of everyday here and now situations in the family unit. In the second focus group interview, with four ward staff, the participants focused on the complexity of the families' challenges. The third focus group interview, with therapists, dealt with the challenging and complex nature of their work with the addicted mothers.

The first step in thematic analysis (TA) is to familiarise oneself with the data. Braun and Clarke (2006) describe this step as transcribing the data, reading and re-reading and noting down preliminary ideas. Also in the third sub-study, the researcher conducted and transcribed the interviews herself.

The next step in TA is to sort elements from all the texts systematically and code the groups that emerge. The third step is to collate the codes into potential themes. The fourth step is to check whether these themes function well both for the initial text fragments and for the entire data set, while the fifth step is to define and name the themes. This is an ongoing analysis in which the themes are refined in an attempt to find the particular characteristics of each theme and the overall meaning of the analysis. The final step is to select vivid and

characteristic examples of excerpts from the texts and relate them to the research questions and research literature.

Co-authors read through the transcripts and contributed to the analysis. Each step of the analytical process was discussed in detail by the first author and at least one of the co-authors. After listening to the audio files and reading the transcripts several times, the following main groups were identified: *a) Training in activities of daily living in the unit, b) Complex challenges, c) We need more resources and must cooperate better, and d) A need for the therapists to support each other professionally and emotionally.* In the analysis in this sub-study, greater emphasis was placed on *dialogue* between the participants, rather than on small text fragments from individual participants. Following the main grouping, the transcripts were read more closely and systematically, and nine different codes were chosen to represent the content of the group discussions. We then attempted to raise the codes to a higher level of abstraction, resulting in seven expressions of the meaning of the different codes. Further synthesis eventually led to the three themes used as headings in the presentation of the findings. The table below illustrates the analytical process in the third sub-study.

Table 3: The analytical process in the third sub-study

Codes	Potential themes	Final themes
Focusing on the addiction	The angle of treatment approach	'Rescue the child' versus 'treat the addiction'
Focusing on the interaction		
Structure in everyday life	Routines	Supporting the mothers - everyday life, routines and care
Teaching the parents to understand their child	Reflective functioning	
Training in social skills	Social competence	
Therapists must support each other	Tensions between professionals	A demanding line of work
Addiction field not desired	Risk of burnout syndrome	
A wish to help the marginalised		
Ward staff feel frustrated	Attitudes mirroring the marginalisation	

4.8. Ethical considerations

The study was approved by the Regional Committee for Medical and Health Research Ethics (REK South-East No. 2011/879b) and has complied with the ethical guidelines of the Declaration of Helsinki (World Medical Association, 2013).

To ask addicted women to reflect on their role as a mother can elicit difficult emotions, such as sadness, anger, shame and guilt. The interviewer was an experienced health professional, trained to notice and deal with signs of overwhelming emotions among interviewees (such

as agitation, lack of eye contact, sweating and tears). An attempt was therefore made to conduct the interviews with care and sensitivity. To address possible emotional difficulties, agreements were made with each interviewee's main therapist to provide a session with emotional support after the interview, if necessary. However, there proved to be no need for such additional support. The support people were given the telephone number of the interviewer and were invited to contact her as needed. As a health worker, the interviewer was obliged to notify the child welfare services if care of children was inadequate or gave rise to concern.

All participants have been anonymised in the written material. Individual participants were de-identified by presenting the ages of mothers and support people in five-year age groups. There is no indication of which mothers used which substances, or which support people had had a substance abuse problem. Descriptions of how we decided on the addiction facility and the support people and where the interviews took place were also less detailed than originally intended, in order to ensure the anonymity of the participants. We also chose to specify the qualifications of the staff in general terms, without revealing the number of people in each category.

5.0 Results

5.1. The first sub-study

Wiig, E.M., Haugland, B.S.M., Halså, A. & Myhra, M. (2014). Substance-dependent women becoming mothers: breaking the cycle of adverse childhood experiences. *Child & Family Social Work*. DOI: 10.1111/cfs.12190.

Combining addiction and parenting can be challenging. If the parents grew up in SUD families, the challenge may be even greater. The first sub-study aimed to explore addicted mothers' descriptions of motherhood, their childhood experiences with addicted parents, and how they related those experiences to their current role as caregivers. The participants were recruited from an addiction facility that had established a unit for addicted mothers with their infants. The family (mother, child and, if possible, also the father) were admitted during pregnancy or just after giving birth, and they usually stayed in the facility until the child was one year old. Qualitative in-depth interviews were conducted with nine mothers, who described their parenting experiences with the help of reflections on their past, present and future.

The findings indicate that addicted women who have grown up with parental substance abuse face major challenges when they have children. Some had been marginalised for their whole life and felt that they did not belong in society. This kind of marginalisation experience can complicate the rehabilitation process. The mothers felt protected in the SUD facility, but nevertheless felt lonely because part of their rehabilitation was to leave the addiction scene and they therefore had to distance themselves from their family and former friends. Many mothers talked about a marginalised childhood in families who had had addiction problems for several generations. They described poor living conditions with fewer toys and appliances than in other families. The parents were often out of work, and family friends also often had addiction problems. They rarely took part in recreational activities, and several of them had moved house many times during their upbringing. Some mothers reported having been placed in foster homes several times, resulting in a lack of stable friendships. In the foster homes, they also felt a lack of belonging. Because of their experiences of marginalisation, these mothers wished to give their children a sense of belonging. They wanted to give the children a structured, secure life with regular routines. They wanted to become "normal" families, although they were not sure what that implied. The mothers had plans to get an education and a job and wanted to support their children themselves. They wanted to build new social networks, but several reported finding it difficult to trust other people and to cope with interpersonal conflicts.

All the mothers mentioned traumatic experiences from childhood and, in many cases, also from the adult substance abuse environment. Memories of such episodes appeared as the mothers became substance-free. These memories troubled them emotionally and made it difficult to focus on their present life with their infant in the family unit. As children, some of the mothers had witnessed serious violence, threats and suicide attempts, while some had

lost a parent as a child. Some mothers felt that their childhood had had a harmful effect. In future, they wanted to protect their children from such traumatic experiences. They were keen to keep their children away from an addiction environment and wanted their childhood to be predictable.

Addiction implied a constant threat of losing custody of the child. The mothers were afraid of the child welfare services, but understood that they needed to cooperate with them. They had different explanations of their substance abuse. For some, it was an element of growing up. Substance use was a natural part of the feeling of belonging in social contexts. Some had looked forward to being old enough to use substances and had prepared themselves by reading brochures and other information material they could find. Others had experienced a thrill when using substances and reported feeling sure of themselves when high or drunk. Some had used substances to escape from difficult feelings and a tough life. For the future, all mothers wanted to learn new strategies to experience good feelings without having to resort to substances. The most marginalised mothers were the ones who were most concerned about planning and organising their future lives. Those who had had a less marginalised childhood thought their children would do well as long as they managed to stay clean and be there for them. All mothers wanted to be integrated into society and planned to get an education and a job to support their children. However, few had specific plans for how to succeed in this.

5.2. The second sub-study

Wiig, E.M., Halså, A. & Haugland, B.S.M. (2016). Social support available for substance-dependent mothers from families with parental substance abuse. *Child & Family Social Work*. DOI: 10.1111/cfs.12341

The second sub-study included a re-analysis of the interviews with the mothers when they were admitted, combined with new interviews of the support person/significant other of each of the mothers after the families had been discharged from the addiction treatment facility. The results showed that the mothers had distanced themselves from those elements of their social network that still abused substances. This meant that they had few people left to support them. Most of the fathers were still active substance abusers, and many of the mothers were left with sole responsibility for their child.

The relationship between the mothers and their significant other was described as close. The person provided support in a variety of areas. They gave practical help such as transportation and baby-sitting. Some gave financial support and some provided advice on childcare. Some advised the mothers on how to live a substance-free life and some served as parenting role models. All the support people were generally available to the mothers and gave them emotional support. These relationships had lasted for many years, and in some cases for their entire lives. The support people “monitored” the mothers by looking

out for risky situations that could lead to relapse into substance abuse. They tried to balance monitoring and trust in the mothers, which implied giving them freedom as independent adults. Both mothers and support people reported that their relationship had stood up to the considerable stress of substance abuse and they were confident that the relationship would continue in the future.

The results also showed that the mothers' relationships with their support person could be divided into three types, depending on the degree of reciprocity. The support people who were mothers or grandparents of the addicted mothers mainly provided practical support, and these relationships were minimally reciprocal. Relationships where the support person was a sister or female friend were more reciprocal, but the support people reported having given more support than they had received. The most reciprocal relationships were those where the support person was the mother's partner and father of the child. These couples viewed the child as their joint responsibility. However, these were also the relationships that had lasted the shortest time and both mother and father had had addiction problems.

It evolved that many of the support people had similar challenges to the mothers. Many had several addicted family members and some had had their own substance-related problems. Many had grown up with parental SUD and had limited social networks. The support people themselves had poor finances and low education. They had limited psychological, practical and financial resources. They worried about the mothers and their children and supported them as best they could. The mothers trusted these significant others who had often stood by them, even through difficult periods.

5.3. The third sub-study

Wiig, E.M., Halså, A., Bramness, J., Myra, S.M. & Haugland, B.S.M. Rescue the child or treat the addiction? Understandings among professionals in dual treatment of substance use disorder and parenting. (Submitted after revision 07.01.2018)

The third sub-study dealt with the employees' understanding of the therapeutic work to prevent intergenerational transmission of addiction, based on focus group interviews with 15 employees working in the family unit for addicted parents with infants. Two of the focus groups consisted of ward staff and one group consisted of therapists.

It was a common understanding among the staff that this was complicated and demanding work. Treatment consisted of many different components intended to work in combination to create substance-free, well-functioning families. This provided a potential for different priorities and tensions among the staff. They seemed to find it a complicated matter to address the dual goal of the family unit, namely to help the parents quit substances and to teach them parenting skills. The findings indicate that most staff focused primarily on one goal, either the treatment for addiction, or the enhancement of parenting skills and

interaction with the child. Nevertheless, they clearly stated that they wanted to direct the treatment at the family as a whole: addicted mothers, addicted fathers and their children.

Three different approaches to treatment emerged. The staff with the most experience in the field of addiction wanted to stabilise the parents emotionally and begin with traditional addiction treatment. Those with less experience with addicted people focused more on parenting and the needs of the child. The rationale for these different priorities appeared to be that the new staff had brought novel ideas about focusing on the child while the more experienced staff were more interested in traditional addiction treatment of adults. The third treatment approach was to focus on everyday life in the family unit and make therapeutic use of the here and now situations. This approach was most prominent in the focus group consisting of both new and experienced ward staff. By using here and now situations and daily routines in the unit, the staff appeared to be on their way to integrating the two first-mentioned approaches. In this way of working, they focused on the mother's/parents' emotions, craving for substances, motivation to be substance-free and the structure of the adults' lives, while at the same time they emphasised interaction with the child and the ability to understand the child's communication.

The work was felt to be emotionally draining. Some employees stated that it was difficult for them to keep their emotional balance. The therapists thought it was important to take care of themselves and each other, while the ward staff were interested in more cooperation with the team of therapists. These tensions between employees indicate a need for better integration of the different approaches. Greater harmonisation in terms of focus and approach could enhance support and understanding between the groups of employees.

6.0. General discussion

6.1. Methodological and ethical considerations

The research questions determine the most suitable methods of data collection and analysis. We wished to explore how addicted mothers and their support people understood their lifeworld, as well as how the staff understood their role and contribution in the treatment of the families. Based on these aims, we chose a phenomenological perspective. We wanted to include the understanding that the interviewer herself also affects the interview situation. The interviewer and the interviewee create the results together. The texts are then interpreted by the researcher. A combination of phenomenological and hermeneutic (interpretative) methodology and a qualitative research approach was therefore chosen.

There are different ways of assessing the quality and credibility of qualitative research (see for example Mays & Pope, 2000; Altheide & Johnson, 1994). According to Kvale and Brinkmann (2009), all phases of the research process should be validated to ensure the quality of a study. In this context, validation means verifying and substantiating that the method is suitable for its purpose. This includes demonstrating that the research questions govern the methodological choices made at different stages, and that all phases of the research process are described in as much detail as possible, including various reflections and choices; this will enable outsiders to assess the quality of the work.

Tong et al. (2007) have drawn up a quality assessment checklist for qualitative research consisting of 32 elements, called COREQ (COnsolidated criteria for REporting Qualitative Research). This is a compilation and comparison of 22 previous checklists for assessing the quality of qualitative studies. The main features of COREQ are that the following should be stated: a) how the sample of respondents has been selected, b) the context of the study and the methods chosen for data collection, c) whether the participants have “approved” the findings, (d) the method of data recording, (e) a description of discrepancies in the themes, and (f) the inclusion of quotations to support the findings. How these main features of COREQ have been addressed is described in the method section.

Malterud (2011) has suggested dividing assessments of the quality of qualitative research into internal and external validity. This division is adopted below.

6.1.1. Internal validity

In order to determine internal validity, i.e. to what extent the results are valid for the sample and the phenomenon under study, we must ask whether the tools and methods used are relevant to the phenomenon we wish to investigate. Have we really explored what we wanted to explore? In this PhD, 29 interviews were conducted with 33 respondents. The interviewed mothers comprised all the patients who met the inclusion criteria at the chosen SUD facility in the specified period. Since this group of mothers is difficult to access for researchers, it was a strength that they all agreed to participate. To gain a clear

understanding of the mothers' social support, their most important support person/significant other was interviewed, in addition to the mothers themselves. We consider it a strength that these people were chosen by the mothers. Only one mother did not allow us to contact her support person. It was a further strength that every person invited to an interview agreed to attend. Our understanding of the mothers' social support could have been further enhanced by interviewing more people in their network. However, some mothers found it difficult to identify support people whom they thought could assist them after the treatment. To find more support people might therefore have been challenging. The greatest weakness in the sampling is thought to be in the third sub-study. It would also have been possible to interview staff in similar units at other Norwegian SUD facilities. This could have provided a broader insight into the treatment challenges of this type of unit. Another way of expanding the study, which could also have been a strength, would have been to conduct more interviews with each focus group. The third sub-study is therefore considered to be methodologically weaker than the other two sub-studies.

Malterud, Siersma and Guassora (2015) have introduced the concept of *information power* to assess the internal validity of qualitative research. *Information power* is operationalised as *aim of the study, sample specificity, use of established theory, quality of dialogue and analysis strategy*. In the following, our three sub-studies, particularly the first sub-study, are assessed on the basis of these categories.

The aim of the first sub-study was to investigate the understanding of addicted mothers of infants of their maternal role and their challenges to prevent their children from having similar adverse childhood experiences to those they had had themselves. There is little research on addicted mothers of infants who themselves have grown up in SUD families. The first sub-study was seen as an exploratory study with a relatively broad objective. Studies with broad aims, according to Malterud et al., require a larger sample. It may therefore be regarded as a weakness of this sub-study that it included only nine respondents, all recruited from the same SUD facility. Mothers admitted to a similar facility elsewhere in Norway might have provided new understandings beyond those found. However, this was not possible with the available resources. In the third sub-study, the staff discussed their experiences based on the entire group of patients, irrespective of whether or not the mothers had grown up in SUD families. It is a strength that all staff interviewed worked in the same unit, since they related to the same clinical setting as the mothers. However, it may be considered a weakness that their statements concerned a larger group of mothers, not only those with parental SUD in their childhood.

The second point in Malterud et al.'s *information power* is specificity of the sample, i.e. the extent to which the interviewees have specific experiences, knowledge or characteristics that are suitable to elucidate the research questions. Being addicted and a mother is associated with stigma and shame, which makes it difficult to recruit such mothers to research studies. There are only a few SUD facilities with family units in Norway, and these

are far apart geographically. Even at the selected facility, which is one of the largest in the country, it took 18 months to recruit the nine mothers. However, the participating mothers are considered to represent the target group very accurately. Only addicted mothers of infants who had grown up with parental SUD were included, and the specificity is therefore considered to be addressed. The mothers also had varied experiences and descriptions, which suggests that such a small number of respondents may have been sufficient. The same applies to the second sub-study, where all the mothers' support people participated. In the third sub-study, only two employees were missing (one did not attend and the other was ill). The experiences of the staff did not only relate to addicted mothers with parental SUD, which was the focus of the study, but also other addicted mothers. The study could have been strengthened by conducting repeated focus group interviews, giving the staff time and space to discuss more perspectives of the research question and by allowing all participants to discuss a number of the themes in more detail.

The third aspect of *information power* is the use of established theory. Malterud et al. (2015) state that a study that lacks a solid theoretical basis requires more respondents. This is a challenge in the present study, where theory from many different fields and disciplines is combined. It was not possible to identify specific theories on which to base the entire study. An inductive method was therefore chosen for all sub-studies, which involved drawing conclusions from individual experiences and generalising to a larger group. An inductive method is based on the data, not a general theory. The present study is considered to have a medium level of theoretical basis, and nine interviewees is considered to be a medium number for qualitative studies. With regard to this aspect of *information power*, the third sub-study again shows a weakness in that only staff from one SUD facility were included and only three focus group interviews were conducted.

Quality of dialogue is the fourth aspect of *information power*. This depends on a trusting relationship between interviewer and interviewees, how well the interviewees are able to express themselves and the interviewer's conversational skill. There was a strong emphasis on building a good relationship with each mother (and also with the support people and the staff in the focus group interviews). In the first sub-study, the interviewer was "recommended" by the mothers' therapist, with whom they had had a long treatment relationship. They then met the interviewer for information and consent. This enabled them to form an impression and hopefully inspired a feeling of confidence before the first interview took place. Respect and acceptance were in focus. The interviews took place in the familiar setting of the SUD facility (or at home, in the case of the support people).

The interviews started with topics related to the mothers' everyday life with their children in the family unit. This is thought to be less threatening. When better contact had been established, the talk turned to the mothers' childhood experiences. Many mothers recalled very difficult experiences that affected them emotionally. There were some episodes they

had never talked about before. It was emphasised that they should also try to remember situations involving good care, from either their parents or other adults.

It should be noted that the first interviews did not delve as deeply as subsequent interviews. There was an initial focus on making progress and treating the respondents with care and consideration. After the first interview with the first four respondents, the interviews were transcribed and a preliminary analysis started. Following discussions with the co-authors, certain topics were followed up in later interviews. Interviewing the mothers several times made it possible to return to and elaborate on topics from previous interviews. The dialogues with the interviewees were generally considered to be of a high quality.

The final element in assessing internal validity is the analysis strategy (Malterud et al., 2015). In the choice of analytical strategy, methodology was used that has been carefully described step by step and could be followed precisely by a novice; this ensures a systematic analysis. In addition, it was necessary to use a cross-cutting analysis to evaluate data from nine respondents and 18 interviews. A cross-cutting analysis, i.e. a study of a whole group at a certain point in time, requires more respondents than a case study, which explores in detail the experiences of a single interviewee. Malterud's method of *systematic text condensation* has been described in detail, well tested in Norwegian conditions and is based on the acknowledged theory of Giorgi (2012) known as *grounded theory*.

The aim of the second sub-study was to explore the social support available to the addicted mothers. The main goal was to determine whether, and if so how, the support people facilitate adequate social support for these families. This was a more specific objective than in the first sub-study, but was still relatively open. Specificity is well addressed because the mothers themselves pointed out who supported them and also described the social support they experienced. Secondly, the same theme was examined from the perspective of the support people. It was difficult to find specific theory about the social support of addicted mothers of infants. We had to draw on theory and concepts from different fields and disciplines. The dialogues with the support people are thought to be good, probably because these interviewees were recommended by the mothers. All the support people were cooperative and interested in contributing to the study. In selecting an analytical strategy, here it was also important to use a method that has been described in detail and that could be followed exactly, in order to ensure a systematic analysis. In addition, it was necessary to use a cross-cutting analysis since data were needed from a large number of respondents (nine mothers and nine support people, in 26 interviews).

The third sub-study aimed to provide descriptions by staff of the family unit on their work to prevent intergenerational transmission of substance abuse problems. The sample consisted of 15 employees with different educational backgrounds and responsibilities. We wished to explore the perspectives of the staff of the same unit that treated the mothers. The sample was therefore specific to the objective of the sub-study. The majority (15 out of 17) of the staff of the family unit participated.

The third sub-study also involved an inductive method with an open and exploratory perspective. Here too, it was not possible to choose a specific theory as a basis for the study, which again necessitated the inclusion of theory from different fields and disciplines. The dialogue in the focus group interviews was typical of group discussions; it was mostly the respondents who were speaking and reacting to each other's viewpoints. The therapists were interviewed in a separate focus group interview since they were in a clear minority, and it was considered probable that both therapists and ward staff would speak more freely in the company of their closest colleagues at the same level of the organisation. Most participants had worked together closely for many years and knew each other well. The dialogue flowed naturally, and the participants were highly engaged. Any participant who was reluctant to speak was asked directly and this prompted everyone to contribute. The fact that the group discussions branched out into different topics may be taken as a sign that the respondents brought up what they considered important, resulting in a powerful dialogue.

For the third sub-study, a different analytical strategy was chosen, namely *thematic analysis* (TA), as described by Braun and Clarke (2006). This method is also based on *grounded theory* (Giorgi, 2012). Thematic analysis, like systematic text condensation, contains a step by step description. The detailed description of the six steps of TA enables a systematic and thorough analysis. The analysis emphasised the talk between the participants and how they responded to each other. Also in the third sub-study, an inductive method was used, which is one of the possibilities in thematic analysis. Other qualitative approaches in *grounded theory* (Giorgi, 2012) and *interpretative phenomenological analysis* (IPA) (Smith & Osborn, 2003) may be more strongly linked to theory. The analysis of the third sub-study focused on a back and forth movement between details and the whole, and a continuous reassessment of the established themes.

6.1.2. External validity

External validity refers to the extent to which the findings are relevant and can be applied to other settings (Malterud, 2001). Qualitative research does not provide absolute truths with a high level of generalisability, but places more emphasis on pointing out the phenomena that the results help us to understand better (Malterud, 2011).

Our study concerns the particular mothers interviewed and their social support. However, these mothers' experiences and descriptions are likely to be relevant to other addicted mothers of young children, both in Norway and abroad, especially those who have experienced parental substance abuse. For example, the mothers had a common and powerful experience of marginalisation. The findings provide knowledge of the experience of addiction rehabilitation of mothers with parental SUD. Parts of the descriptions may therefore also be relevant to addicted people without children, if they have grown up in SUD families.

The connection between addiction, parental addiction and a poor social network is likely to be relevant for addicted people without children. Also in such cases, the addicted person may have support people who are relatives, and similar challenges related to violence, loss of close relatives, low education, limited work experience, poor finances and inferior housing.

Descriptions by the staff of their roles and responsibilities may be relevant to similar treatment at other SUD facilities. In countries with inferior public funding for health and social care, our findings may be of less relevance, as the Nordic model of publicly funded inpatient treatment will be unavailable. In outpatient treatment, therapists may have a different role, rendering our findings less relevant. For example, it will be more difficult to make therapeutic use of the here and now situations of everyday life.

Descriptions in the present study may be relevant to other marginalised groups in society. Single-parent families with poor social networks or low education may face similar challenges in building new social networks. Other people with adverse childhood experiences associated with dysfunctional parents may experience similar parenting challenges to the addicted mothers in this study; for example, they may have a better understanding of what they want to avoid as parents than of alternative positive strategies they can use.

6.1.3. Reflexivity

Research will always be influenced by the researcher's personal and professional experiences, knowledge, values and attitudes. This will affect the choice of research questions and methods, data collection, method of analysis and reporting of results. The researcher should therefore reflect on how her preferences affect the research process (Stige, Malterud & Midtgarden, 2009; Finlay, 2002).

Considerable professional experience with mothers and children can be viewed as an advantage in the research, but can also be a constraint in creating preunderstandings. The research questions may be influenced by challenges familiar to the researcher from previous professional practice, rather than the most important challenges for the respondents. There is also a possibility that the interviewer's previous experience as a therapist may make the interviews resemble therapy sessions more than research interviews. Experience as a mother can provide insight and understanding of the mothers' situation, but also make the researcher's own experiences colour her understanding of the mothers' descriptions. For example, in the first interviews, the researcher needed to show care and consideration towards the mothers. It was therefore difficult to keep to and elaborate on distressing topics. In order for the researcher to make sound assessments, a certain distance is required. For an experienced clinician, it was challenging to adopt a meta-perspective with sufficient distance to the topics discussed in the interviews. It was important to communicate genuine interest and empathy with the interviewees, but this may be a constraining factor compared to the view of an outsider with an open mind.

It is often difficult, both ethically and practically, to gain access to sensitive personal data. The researcher may find it a strain to get involved in difficult life stories. In an interview situation, it is challenging to act as a neutral outsider when the stories arouse emotions in both interviewee and interviewer. For a time, it was difficult to deal with the feeling of despondence about the mothers' situation. Learning about a person's distressing life may require a "debriefing" with sympathetic colleagues afterwards. The researcher therefore discussed her emotional responses from the interviews with the co-authors in the data collection period.

The researchers involved in the study had a variety of backgrounds (two doctoral research fellows with a nursing background, one medical specialist, one specialist psychologist and one sociologist); however, all had practical/clinical and academic experience. The research team had experience of using both quantitative and qualitative methods. The interdisciplinary composition may have prevented one-sided perspectives and enabled an open mind towards the study, untainted by personal or professional preferences. The fact that the author herself conducted and transcribed all interviews ensured a uniform approach to these procedures and enabled the influence of the *researcher as an instrument* to remain the same throughout the research process. It was a methodological strength that all the transcribed texts were read and discussed in detail by at least two of the researchers involved in the various publications.

6.1.4. Ethical considerations

According to Kvale and Brinkmann (2009), ethical considerations should be made throughout the research process, with particular emphasis on informed consent, confidentiality, consequences of the research and the role of the researcher. In research interviews, there will always be a power imbalance between interviewer and interviewee. The interviewer controls the talk and the situation to a greater extent than the interviewee (Brinkmann & Kvale, 2005). It is therefore important to provide interviewees with maximum information on what participation entails, the purpose of the study and their role in the study. They must also be informed of the possibility to withdraw from the study. All our respondents received oral and written information about the study in advance. In order to minimise the power imbalance, the interviews took place in settings familiar to the interviewees.

The data were handled with care. The audio files and transcribed texts were stored in a locked cupboard and will later be shredded. In cases where individual respondents are mentioned in the articles, they have been given a pseudonym. Mothers and support people are identifiable only by age group and mothers were sorted into two groups, one for one-child mothers and one for those with more than one child. Ward staff and therapists are only referred to as groups, without specifying individual qualifications. It is stated that the mothers and staff were from the same SUD facility in Norway, but its name is not mentioned.

Research on people in vulnerable situations requires ethical caution. With this in mind, the therapists assessed when the mothers were ready to be interviewed and they were prepared to provide additional therapy after the interview if necessary. The fact that there was no need for extra sessions may suggest that the interviews were not a negative experience for the mothers.

It can be challenging to find a balance between investigating (the researcher's role) and helping (the therapist's role). The researcher should be a "neutral" outsider. However, the interviewer's experience of the therapist's role gave her the ability to talk to people about difficult topics. It is vital that the researcher makes an effort to help the interviewees to feel relaxed in the situation and under no pressure to say more than they want to.

6.2. Discussion of findings

6.2.1. Summary of the main findings:

- The mothers were marginalised, but dreamed of a "normal" life. Marginalisation posed a challenge for their rehabilitation.
- The mothers had traumatic experiences from their childhood and/or life as an addicted adult. This affected their functioning, and even though they and their children felt secure in the family unit, their traumas represented a challenge for their future life and functioning as a family after treatment.
- For some mothers, substance use had been a completely natural part of adulthood.
- The mothers had close relationships with their support people, which had lasted for many years.
- The relationships had different degrees of reciprocity.
- The support people faced many of the same challenges as the mothers: their own experience of substance abuse and/or mental illness, many close relatives with addiction, limited social network, low education and poor finances.
- The staff found it demanding to provide both addiction treatment and parenting training at the same time and often ended up prioritising one of the two.
- The staff found it important to make therapeutic use of here and now situations in the everyday life of the family unit.
- The complexity of the treatment meant that the staff expressed a need for help to regulate their emotions and closer cooperation between groups of employees.

6.2.2. A marginalised existence

The addicted mothers who participated in this study had all grown up with parental SUD. Many of them felt that they had lived their entire life on the margins of normal society. Because of their parents' substance abuse, they felt different from other families and not

really a part of society. One of the mothers recalled how she had described this when 12 years old:

“A globe, all the people in the world were walking around in a rainbow of colours. I hung on the far edge with only one foot on Earth, and I was completely grey.”

The mothers had distanced themselves from friends and family members who still abused substances. This meant that they were left with sole responsibility for their child. This concurs with studies by Byqvist (2011) and Dawe et al. (2008) showing that addicted women are often socially isolated. However, social isolation can be a double challenge for mothers of SUD parents; they not only have to distance themselves from friends and perhaps an addicted partner, but also from their own family. They may find themselves alone in caring for their child and isolated from family members. While staying in the family unit, mothers may feel less isolated because they interact with staff and other patients. The challenge may be greatest when they have to establish a home for themselves and their child outside the treatment facility. The post-treatment phase can be critical for all addicted people (Dahle & Iversen, 2011; Ilgen et al., 2008), but leaving a secure and predictable environment to establish a life of one's own in society is likely to be especially challenging for those mothers who have never experienced normal family life.

The feeling of marginalisation, which may originally have been linked to parental substance abuse, can also be reinforced by challenges linked to childhood experiences and/or prenatal addiction (such as cognitive developmental difficulties) if their mothers used substances during pregnancy (Lewis et al., 2012; Nygaard, Slinning, Moe & Walhovd, 2015; Nygaard, Slinning, Moe & Walhovd, 2016; Walhovd, Watts, Amlien & Woodward, 2012). Such negative factors may have reinforced their feeling of being different from their peers.

Mothers had experienced that caregivers died or left them. Some had lived in several foster homes, which included homes where they found they were not part of family activities in the same way as the biological children. Some mothers said that they had had fewer clothes, toys and appliances than most other children. They had also had responsibility for tasks usually performed by parents, such as caring for younger siblings. They described a lack of regular routines at home because their parents were unavailable due to substance abuse. These findings agree with Haugland's (2006) descriptions of “parentification”, where a child takes over parts of the parents' role and loses some of its childhood when the parents fail in their parenting. Our findings are also consistent with previous studies, such as those of Young et al. (2007) and Keller et al. (2008), which found a correlation between parental SUD, parenting failure and neglect.

We found a difference between the descriptions of mothers whose entire childhood and adolescence was marked by substance abuse and those of mothers who had experienced part of their upbringing without disruptive parental substance use. The latter group had a stronger belief in their ability to give their children a good life after treatment. This group

included mothers who had grown up in families where there was a non-addicted parent to care for the children, provide regular routines and maintain family rituals. This concurs with Haugland's (2003; 2005) descriptions of life in families with an alcohol-dependent father, where it is crucial for the children that the non-addicted mother is able to maintain family routines and rituals. It seemed to make a difference whether the addicted mothers experienced parental SUD for most or only part of their childhood and adolescence.

To start using substances may be linked to a desire to escape from distress or alternatively be a quest for fun and thrills (Crawford, Pentz, Chou, Li & Dwyer, 2003). This agrees with the descriptions given by the mothers in our study. However, several of the mothers also said that they began to use substances as a matter of course and a natural part of growing up. One of the women commented that she had looked forward to being old enough to start using drugs. She had read a great many brochures about drugs to teach her what she needed to know when she started. Some mothers associated substances with pleasant socialising among adults. They linked substance use with adulthood and looked forward to being old enough to get high or drunk. Substance use was an equally natural part of growing up as wearing a bra, and they started to use both at about the same age (13 or 14). We have not found similar descriptions in previous addiction research. The fact that the mothers at such an early age viewed substance use as a natural part of life and growing up may have been a factor in their marginalisation, providing further confirmation of their experience of being different and not part of mainstream society.

Lindgaard (2013) conducted a study of adults who had grown up in families where one or both parents had had alcohol problems. In this sample, she found an increased risk of developing a range of psychosocial problems, such as anxiety, depression, eating disorders, suicide, low self-esteem, dependency on others and problems with intimacy. Such problems are likely to increase the feeling of being different. In a retrospective Norwegian qualitative study, Werner and Malterud (2016) showed that adults from families with parental alcohol problems make great efforts to appear normal. During their childhood, they try to compensate for the parental responsibilities their parents do not fulfil and hide the alcohol abuse from the outside world. They want to look like other families, just as the mothers in our study dreamed of being "normal".

For these mothers to feel that their family can be "normal", it may be beneficial to view their place "on the margins of society" as a social construction. Marginalisation can be taken for granted and perceived as inevitable by addicted mothers, their children and society at large: "that's just the way things are". However, using a social constructivist approach (Hacking, 1999), it may be possible to change this understanding. The problem can be addressed by changing society's view of families with addicted mothers, and/or by changing the family members' views of themselves. Both methods presuppose an awareness that marginalisation is merely a social construction: "things could be different".

6.2.2. Traumatic experiences

All the mothers in our study described traumatic childhood experiences. They described parents who were physically and/or emotionally inaccessible and parents who were violent and/or uninterested in how they were. Some of the mothers had experienced parental attempted suicide, and for some, a caregiver died while they were still children. Many had witnessed and been subject to violence. This is in accordance with research that shows that children of addicted parents are at risk of experiencing childhood trauma (Dube et al., 2001; Rossow, Felix, Keating & McCambridge, 2016). One mother reported having lived with a violent father who beat her mother and that, as a five-year-old, she had encouraged her father to hit her mother because she knew that when her father was angry, there would be no peace in the family until the violence was over. Others talked about dramatic events in their family involving weapons. Some mothers mentioned sexual abuse, sometimes from their caregivers.

These findings support the knowledge that parental addiction poses a risk of mental, physical and sexual abuse, violence, physical and emotional neglect and a high level of conflict during childhood (Dube et al., 2001; Lindgaard et al., 2011). SUD parents also have difficulty in being sensitive and balancing love and boundaries (Siqueland & Moe, 2014; Siqueland, Haabrekke, Wentzel-Larsen & Moe, 2014). Bosquet Enlow, Englund and Egeland (2016) studied the intergenerational transmission of various problems and found that mothers who had experienced neglect as children tended to have children with mental health problems. They suggest that neglect, rather than the addiction in itself, leads to the transfer of problems to the next generation. Pincham, Bryce, Kokorikou, Fonagy and Pasco Fearon (2016) have shown that it is possible to improve emotional regulation in youth at risk. Improvement of emotional regulation in the young mothers in our study may be a suitable therapeutic approach to increase their ability to be sensitive towards their children.

Siqueland, Smith and Moe (2012) underlined the importance of working with addicted mothers' experiences of attachment and understandings of motherhood in order to enhance their sensitivity towards their children. Waters, Ruiz and Roisman (2015) found a significant correlation between secure attachment in adolescence and having received sensitive care from the mother from birth until the onset of adolescence. This underlines the importance of working with the attachment style of addicted mothers. Behrens, Haltigan and Gribneau Bahm (2016) have studied the intergenerational transmission of attachment style. They found a direct association between parents' and children's secure attachment. This demonstrates the importance of "mothering the mother", as expressed by the staff of the family unit. Such emotional support to mothers can increase the likelihood of their children developing a secure attachment style. If this happens, they will be less prone to developing addiction or other mental disorders (Schindler & Bröning, 2015).

6.2.3. Life after the SUD facility

The mothers were proud of having put their child before substances by stopping their substance abuse and agreeing to be admitted to the SUD facility. However, several had not

realised that they were pregnant for some time, up to the fifth month of pregnancy. Söderström (2012) interviewed addicted pregnant women admitted with their family to a Norwegian SUD facility. She describes their ambivalent attitude towards their pregnancy. They felt guilty for having abused substances, but at the same time, the pregnancy gave them hope of a substance-free life with their children. This ambivalence was also expressed by the mothers in our study.

The mothers wanted to give their children a sense of belonging and an upbringing in a structured family situation with regular routines. They had plans for education and work and wanted to support their children themselves. However, most of them lacked good parenting models. The mothers and children will probably need close monitoring and support from health and social services for many years after leaving the SUD facility in order to achieve their goals. An approach involving home visits with long-term monitoring of interaction between mother and child and their mental health will probably be beneficial for second-generation addicted mothers and their children. This approach is similar to the NSPCC UK Minding the Baby Home Visiting Programme for young mothers (Grayton, Burns, Pistrang & Pasco Fearon, 2017).

6.2.4. A long and close relationship with the support person

The second sub-study showed that the addicted mothers had poor social networks. Nevertheless, they were all able to mention a person whom they could rely on for support after leaving the SUD facility. The relationships between the mothers and support people were well-established, close and trusting. Both parties expressed a desire to maintain the relationship in the future and stated that it had continued despite difficult periods in the past. A mother's support person can be a starting point for building a larger social network around the family. Barnard (2007) emphasised that it would be worthwhile to support the already existing support people, for the sake of both the addicted person and the support person, as also indicated by the results of the second sub-study. A study by Ness, Borg and Davidson (2014) shows that supportive relationships are of great importance in the recovery of patients with dual diagnosis (addiction and mental health problems).

6.2.5. Three types of relationship

Social support is related to the need for reciprocity (Gouldner, 1960). The relationships between the mothers and support people/significant others had different degrees of reciprocity. When the child's father lived with the mother and child, he was indicated as the support person. These partner relationships were relatively reciprocal. However, the other relationships seemed to be mainly one-way, with the support person giving more support than he/she received back. Nurullah (2012) conducted a meta-study on the relationship between received and given social support. Nurullah found that social support does not necessarily promote health; this depends on the situation and the type of support. Gouldner's (1960) norm of reciprocity states that a person should not take advantage of another's good deeds over time. The person should reciprocate, or else he/she will feel dependent or have problems with self-esteem.

The social support received by the mother-child dyads in our study was mostly one-way; the mothers were not in a position to reciprocate. However, the relationships had lasted for many years and through difficult periods. The reason may have been the close family ties between the mothers and their support people. Farmer and Moyers (2008) explain that relationships with non-mutual support are possible to maintain in the case of close family ties, such as those between grandparents and grandchildren. Support people who are close family members may feel that they get enough in return even though the support is one-way; for example, they feel the joy of being close to their children and grandchildren and improving their well-being (Taylor, Coall, Marquis & Batten, 2016). Support people may also have expectations of the role of grandmother or aunt as a person who helps regardless of whether or not the help is reciprocated.

6.2.6. A limited, vulnerable network

Given that the mothers had grown up with SUD problems in their family, it was understandable that their close family members had experienced similar difficulties to those reported by the mothers. The support people needed to distance themselves from family members who still had addiction problems. Many had also felt marginalised, like the mothers. They had poor finances, low education, traumatic experiences related to violence and death of close relatives, and some had previously abused substances themselves. This made the mothers' network vulnerable. It would be helpful if service providers supported relationships between mothers and support people, for example by also offering assistance to the latter. Copello et al. (2005) have shown that providing support to relatives can be effective in addiction treatment. Work to strengthen mothers' social networks can start while they are still in treatment. Muller, Skurtveit and Clausen (2017) found that a crucial factor in enhancing the quality of life of addicted people was to develop their social networks during treatment. Although the mothers in this study needed to build new social networks, some had difficulty in trusting other people. Some also reported having difficulty in dealing with conflicts, preferring not to get involved with others to avoid such situations. The mothers' relational challenges provide additional reasons for strengthening their social networks and building new ones, on the basis of their relationships with the support people.

6.2.7. Different treatment approaches

It seemed to be challenging for the staff to treat the mothers' addiction and teach them parenting skills at the same time. The focus group discussions indicated that most of the staff ended up concentrating on *either* the addiction treatment *or* advice and training to improve care of the child. This was despite their statements that the treatment was intended to include both aspects. This contradiction may be the result of new priorities being introduced into traditional addiction treatment. Practice has previously been to stabilise the mother's emotions before changing the treatment focus to her interaction with her child. The assumption has been that mothers will be unable to concentrate on the child as long as they have cravings and difficult memories disturbing them. Some employees believed that focusing on motherhood and interaction training too early would only lead to

new experiences of failure for the mothers. Others believed that interaction training should be started at the outset to provide the best possible conditions for the child and mother-child relationship. In this line of thinking, attention to the child is assumed to push the mother's craving into the background and increase her motivation to become addiction-free to take care of her child. Both therapists and ward staff who emphasised interaction training had worked in the family unit for a relatively short time (about three weeks to three years). Staff who emphasised starting with addiction treatment for the mother had worked in the unit for longer (about 10 years). The different priorities among the staff may be an expression of different speeds of adoption of new treatment principles (Oreg, 2006). It may easily be perceived as opposition if some staff do not implement new strategies at the same pace as others. Such a perception can give rise to tensions between employees, as we see in our study. However, previous research (Oreg, 2006) has shown that those who spend more time adopting new strategies are hesitant because they want to ensure that strategies that have worked well in the past will not disappear.

A review article by Neger and Prinz (2015) examined the combination of addiction treatment and parenting guidance. The 21 studies included showed consistently good results in both reducing substance use and improving care of the children. It would therefore seem possible to succeed with the dual goal of the treatment used in the family unit in our study. Based on these results, Neger and Prinz recommend combining addiction treatment with parenting skills and parent-child interaction. However, they found that parents appeared to derive the most benefit from treatment that first focused on basic psychological mechanisms, such as emotional regulation, before turning to the training of specific parenting skills. They also point out that some addicted parents are isolated, and they recommend the involvement of family members and significant others in the treatment, as our study findings also showed. Neger and Prinz (2015) also stress the importance of a secure, supportive and non-judgmental environment. However, they point out that the included studies were of varying quality and that there was a need for further research, for example with mixed methods, and more long-term follow-up studies of families after discharge from the treatment facility.

Family treatment of addicted parents and their children has gained prominence over the last 30 years. Harvey, Schmied, Nicholls and Dahlen (2012) found that giving children health care in the same place as their mothers receive medically assisted rehabilitation could both support the mothers and improve the health of the children. Akram and Copello (2013) also found encouraging, though limited, results for the health of both addicted people and their family members from interventions aimed at the whole family.

Glavin and Schaffer (2013) performed a comparative study of the care provided by Norwegian public health clinics and the US Nurse Family Partnership Program. In the latter, specially trained nurses visit first-time high-risk mothers (e.g. addicted mothers) throughout their pregnancy and until the child is two years old. Glavin and Schaffer believe that the US

programme could be beneficial to families at risk in Norway, as an expansion of the work of public health clinics. The family unit provides more extensive care, since the mothers are inpatients from pregnancy until the child is one year old. An intervention involving close follow-up care in the home and good role models for the mother is likely to benefit the families after discharge from SUD treatment. There is currently no fixed system of home visits for addicted mothers of young children in Norway.

Euser, Alink, Stoltenborgh, Bakermans-Kranenburg and Van Ijzendoorn (2015), in a meta-analysis of measures to prevent neglect, found that the interventions reduced neglect, but failed to prevent it completely. This study dealt with neglect in general, not only in relation to substance abuse. However, the findings are confirmed to some extent by Hjerkin, Lindbaek and Rosvold (2013). They followed addicted mothers and their children from pregnancy, where the families were receiving enhanced public health care. At the age of 6-13, the children who had lived with their mother showed poorer psychosocial functioning than those who had been placed in foster homes. Hjerkin et al. (2013) suggest a need for further research to examine challenges in addicted mothers' parenting styles, and to enhance knowledge of how services can provide guidance to these mothers.

In the family unit, measures are taken to improve the care of the children before they show signs of possible maladaptation, based on a risk assessment due to the mother's addiction. Perry and Conners-Burrow (2016) argue that early intervention is important because negative parent-child interaction affects children's biological stress system and thus also their mental health. One of the measures in the family unit is to train the ability to understand the child's feelings and responses (parental mentalisation ability). Individual studies suggest that a focus on parents' mentalisation ability can improve children's functioning (Pajulo et al., 2010; Ordway, Sadler, Dixon & Slade, 2014).

The staff of the family unit found it difficult to provide care for the whole family, and usually ended up giving priority to either the parent or the child. The inclusion of children in their parents' addiction treatment is quite a new concept and represents new challenges for SUD facilities. Whittaker et al. (2015) conducted a focus group study of staff working with families with parental addiction. They found that the staff were unsure of their role in supporting the parents and were afraid of taking on responsibility for interventions for families that they described as difficult to engage. They were also worried about uncertain access to resources and a lack of support in their own organisation. Whittaker et al. found similar anxiety related to helping both parents and children to that seen in our study. However, the staff interviewed by Whittaker et al. felt more reassured about the addiction treatment aimed at the parents. In a Norwegian study, Selbekk and Sagvaag (2016) found that families with addicted family members have major challenges (such as conflictual family relationships). Although family treatment was the recommended and desired method, the result was usually that the professionals focused on the individual addicted

patient. This supports our finding that it is difficult to relate to both parents and children at the same time.

6.2.8. Making therapeutic use of everyday situations

The third sub-study showed that the staff saw inpatient treatment as an opportunity to use everyday here and now situations to enhance the mothers' awareness of interaction with their child, their own emotions, and the child's feelings and reactions. According to the staff, here and now situations in everyday life in the unit were also suitable for supporting parents in exercising impulse control and resisting cravings. The staff took advantage of the opportunities provided by inpatient care to show respect for patients, to structure their days and to train activities of daily living related to the child. Stern (2004) points out the therapeutic potential of "present moment" situations. According to Stern, change is based on lived experience that includes the feelings and the actions of the present moment. This moment is based on the subjective experience precisely when it happens, not the way it may seem afterwards when put into words.

In a meta-study, Miller and Moyers (2014) found very little difference between addiction treatment methods in outcomes for patients. However, different therapists led to very different results; according to Miller and Moyers, this demonstrates the importance of relational factors in treatment outcomes. A sound therapeutic relationship assumes that patients are treated with respect and feel that the therapist can be trusted and maintains hope for them. This was also highlighted by the staff in our study. Similarly, Ness, Borg, Semb and Karlsson (2014) write about the importance of having dialogue and "walking alongside" people with substance abuse or mental health problems. The staff in our study stressed the importance of being predictable and available for the families. A secure environment, respect, available staff and meaningful programmes are also mentioned by Dahle and Iversen (2011) as important ingredients in SUD treatment.

The staff felt it was important to provide training in everyday routines and structure for the families, as many of the mothers had grown up in dysfunctional and chaotic families. Weisner (2010) describes how performing everyday activities can in itself enhance well-being, self-esteem, a sense of belonging, and feeling of coping like other people. It may therefore be therapeutic for addicted mothers to learn how to perform normal activities of daily living. Haabrekke, Slinning, Walhovd, Wentzel-Larsen and Moe (2014) recommend inpatient treatment for pregnant women with substance abuse problems. They found that children of addicted mothers had a lower risk of maladaptation if their mother had inpatient treatment during pregnancy.

Inpatient SUD treatment provides opportunities in work with mothers and their children, but this probably depends on a good patient/staff ratio. The ward staff also expressed the need for more employees and resources to make better use of here and now situations and improve availability to mothers and children.

6.2.9. Cooperation and tension between staff

Participants in the focus group discussions emphasised the importance of good cooperation among employees and with the local service providers who will monitor the patients and provide follow-up care after they leave the SUD facility. Child welfare is one of the services involved with the families both during and after inpatient treatment. A qualitative study from the UK (Hood, 2016) studied cooperation between service providers involved in the care of children and adolescents (child welfare, social services, education, health care and juvenile crime). Hood found that the staff felt pressure to adapt their roles and activities to the system they were part of, which meant that they sometimes renounced their professional requirements. Hood's conclusions concur with statements from the staff of the family unit that it was demanding to fulfil all the expectations of the families, colleagues and the rest of society.

The therapeutic work was perceived as complicated and challenging, and some staff reported finding it difficult to maintain their emotional balance. They pointed out the need to take care of themselves and support each other in order to stay in the job over time, and justified this with great emotional stress. Burnout-related turnover among employees is a known problem in addiction treatment (Young, 2015). Young conducted a literature study to examine both individual and organisational factors related to burnout. He found that work in organisations with a hierarchical structure, rigid rules and limited resources can lead to burnout. This may possibly apply to the situation for the ward staff in our study, who faced difficulties in collaborating with higher levels of the SUD facility, especially with the team of therapists. Hierarchical organisation can thus adversely affect emotional and cognitive relationships between colleagues and thereby also increase the risk of burnout and turnover.

Some employees specifically wanted to help addicted people because they had reacted negatively to the stigmatising attitudes of service providers towards these people. Others saw addiction as a rather unattractive field of work. The perception of the addiction field as unattractive may be related to various factors, but it may also reflect the general stigma towards substance abusers in society. The addicted mothers in our study did not feel confident about contacting services and asking for help. They said that they needed to pluck up courage to contact child welfare or social services because they were afraid of encountering depreciating attitudes or losing custody of their children. This is supported by other research. Fowler, Reid, Minnis and Day (2014) showed that addicted mothers find that health services make them feel unwelcome and alienated. Herland and Helgeland (2014) also showed that women who have grown up in a conflictual family situation, like many of the mothers in our study, feel stigmatised as mothers. Such an experience means that these mothers negotiate what they consider necessary to be a satisfactory mother (Herland & Helgeland, 2014). Rutman, Strega, Callahan and Dominelli (2002) found that employees in social services tended to view intergenerational parenting problems as inevitable when the mothers had been in a foster home, as was the case with some of our mothers in our study.

Powis et al. (2000), Rhodes et al. (2010), Trulsson (2003) and Virokannas (2011) also found that addicted mothers are very ambivalent about seeking help. They are unsure of how they will be received by health and social services and are afraid of losing custody of their children. Virokannas (2011) found that addicted mothers had different strategies to meet this challenge, but few of the strategies involved collaboration with service providers. Some of the mothers in our study objected to the social services' view of their ability as caregivers. Such an attitude was also found by Myra, Ravndal, Torsteinsson and Wiig (2016), who investigated addicted pregnant women compulsorily admitted to treatment facilities under Section 10:3 of the Norwegian Health and Care Services Act. A number of the women in the study by Myra et al. indicated that they objected to being compulsorily admitted, although they later felt that it gave them security.

Sælør, Ness, Borg and Biong (2015) found challenges in the working conditions of employees in addiction rehabilitation. Here, the staff found that work organisation could be too rigid and restricted and did not allow for the flexibility and openness they considered necessary to maintain hope. This applied to both the employees' hope that their efforts would lead to recovery and the patients' own hope of recovery. In one of the focus groups of ward staff in our study, it was mentioned that they were about to give up hope of being of real help to the families. They found it demanding to achieve good cooperation and they did not have sufficient time to do a good job. At the same time, the group of therapists described emotionally demanding patients and the need to support each other in their work.

We saw expressions of frustrations among employees and tensions between different groups of employees. When the goals of the treatment are complex and challenging, and the work is found to be emotionally demanding, some degree of tension between employees is perhaps to be expected. Such tension may be acceptable for a short period of time, but measures should be taken to improve cooperation and understanding among employees. Better integration of the different perspectives and a more coherent approach and focus may be important for enhancing support within and between the groups of employees. Greater sharing of staff-patient experiences and joint reflection on goals and strategies can lead to common priorities and increased motivation and hope among employees. Such an attitude among staff would also reassure the mothers that service providers are there to help them and that it is useful to ask for help.

7.0 Conclusions

This study shows how addicted women who have grown up with parental substance use problems perceive the challenges and opportunities they face when they have children of their own. This knowledge can enhance understanding of the kinds of help and support needed by these families to prevent intergenerational transmission of SUD problems. The findings show that these addicted mothers of infants need guidance and support in many areas of life and probably for a long period after discharge from inpatient treatment. The mothers wanted to be substance-free in the future, to establish a secure and stable life in a caring environment for their children, and to become part of mainstream society. People who have grown up in homes with substance abuse and become addicted themselves will tend to lead a marginalised life without structure or substance-free friends. Some mothers had felt they were on the margins of society throughout their lives. This marginalisation was a challenge in terms of building new substance-free social networks. Having a child is a major life-changing event for all women. Given the feeling of marginalisation that these women have experienced from childhood to adulthood, coupled with their traumatic childhood experiences, they can be expected to face major challenges. Work to integrate these families into broader society will therefore be an important goal of the treatment, in addition to therapy to treat the traumatic experiences.

With close follow-up care, good parental role models and parenting training, these women may be able to provide a secure and predictable environment for their children.

Participation in self-help groups could also help them to remain substance-free and build a social network. Child welfare and social services should pay particular attention to addicted mothers who have grown up with addicted and marginalised parents, and provide training in the duties and activities of family life. They should also teach them how to participate in social activities for families with young children and establish a social network.

Although the social networks of the mothers were small and vulnerable, they had a long, close and trusting relationship with their main support person. These significant others provided emotional and practical help, advice and guidance. Many of these relationships were mostly one-way, where the support person contributed more to the relationship than the mother. Lack of reciprocity may constitute a risk, but these relationships had persisted over time, probably because the support person was often a close relative.

Many of the support people struggled with their own challenges. Many were close family members of the mothers and had therefore had similar negative experiences. They might also be marginalised, have experienced traumatic events and have few substance-free friends and family members. The support people pointed out that the mothers' feeling of shame could be a barrier to making contact with others and building new social support networks. This may suggest that work to strengthen addicted mothers' social networks should start with the support people already available in the mothers' lives.

To simultaneously treat addiction and teach parenting skills is complex work. The treatment must address the parents' SUD problems and the needs of the infant and the family as a whole. The staff often ended up by choosing either addiction treatment or interaction training as their first priority. The different approaches appeared to create tensions between employees. Furthermore, they found the work to be emotionally demanding, which may also challenge employee collaboration. One of the focus groups underlined how the treatment in the family unit was used to provide training in everyday routines and to utilise here and now situations therapeutically. The inpatient setting also provided the opportunity for patients and staff to build alliances, which enabled training in parenting skills, mentalisation ability, structure and the ability to resist cravings. The staff involved in this seemed to be on the way to integrating the two different treatment approaches, as this way of working focuses on both addiction treatment and parenting skills.

In complex treatment with many parallel therapeutic goals, it is particularly important to combine the different skills of the employees. Measures should be taken to ensure that they stand together and cooperate well. The families stayed in the unit for at least one year, but will also need close follow-up care for many years afterwards. Although this will be costly, it can still be profitable, both financially and personally, if the cycle of intergenerational transmission of substance use problems is broken.

As this is a small local study, the results must be treated with caution. There is a need for further studies describing the challenges involved and the prevention of intergenerational transmission of addiction in the treatment of SUD mothers of infants. It will also be interesting to follow second-generation addicted parents of young children for extended periods of time, in order to understand how further transmission of SUD problems can be prevented. The addicted mothers and their children live most of their lives outside the treatment facility. The interviews with their support people took place on average 15 months after the mothers were discharged, but we have no further knowledge of how well these families have coped. It would be useful to conduct a longitudinal study of these families and also to interview employees in the various services (child welfare, public health clinic, school, kindergarten, social services), and perhaps the specialist health services, with which the families are in contact. This would enable the identification of good and bad developmental pathways over time, not merely the challenges the mothers and children face during and soon after inpatient treatment. All mothers have expressed their willingness to be contacted again, which will allow for further study. It would also be interesting to examine support services in general for this type of family, unconnected to the respondents in this study, to increase knowledge about the prevention of intergenerational transmission of SUD problems.

8.0. References

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Rescue the child or treat the addiction? Understandings among professionals in dual treatment of substance use disorders and parenting.

ABSTRACT

Aims: Dual treatment of parents with substance use disorders (SUD) is an approach which aims to meet the needs of both SUD patients and their children. Whereas the parents need treatment for their SUD and help to develop good parenting skills, the children are at risk of psychosocial problems during their upbringing, and of developing SUD in adulthood. In this study we explore the possibilities and challenges of this joint approach from the perspectives of professionals in an inpatient facility for families with parental SUD.

Methods: A qualitative design was used comprising three focus group interviews with 15 professionals: two groups with ward staff and one with therapists, all working at a family – ward for parents with SUD and their children. Data were analysed using thematic analysis.

Results: Some professionals seemed to focus their attention on the parent with SUD, while others focused on the wellbeing of the child. Present moment situations were explored to help parents become more conscious of the child, their interaction with the child, and their own feelings. Dual treatment of families with parental SUD appears to be challenging. Professionals face difficulties prioritising between the needs of parents and children.

Conclusion: Combining treatment of parental SUD, interventions to improve parenting roles and practice, and at the same time focusing on the developmental needs of children, is a complex and demanding task that may cause tensions between professionals. Even though professionals experience inpatient dual treatment as challenging, they believe this approach facilitates positive development.

INTRODUCTION

A considerable intergenerational transference of substance use disorders (SUD) has been documented (Dube et al., 2003; Barnard, 2007; Jääskeläinen, Holmila, Notkola & Raitasalo, 2016). Prevention of such transference is an important challenge that needs to be tackled. Intergenerational transference relies on a strong genetic liability interacting with environmental factors (Kendler, Aggen, Tambs & Reichborn-Kjennerud, 2006; Verhulst, Neale & Kendler, 2015). A recognized hereditary component may identify vulnerable individuals, giving opportunities for psychosocial preventative interventions.

Parental SUD is associated with parental unpredictability and family conflict (Haugland, 2005), which are also important risk factors for poorer child development and adjustment (Weisner, 2010). More generally, dysfunctional parenting has been found to mediate child outcome in families with parental SUD (Anda et al., 2006; Keller, Cummings, Davies & Mitchell, 2008). This means that for intergenerational transference of psychosocial problems to be prevented, parenting needs to be an important focus in treatment of parents with SUD (Arria et al., 2013). Dube et al. (2003) and Felitti and Anda (2010) found that the development of substance dependence is associated with traumatic childhood experiences. Helping parents with SUD to develop adequate parenting skills and to protect their children from experiencing adverse and traumatic episodes, may prevent the intergenerational transference of SUD, and should therefore be given high priority.

Slade (2005) introduced parental reflective functioning as a concept for parents' representations of and interaction with their child. Mayes, Rutherford, Suchman and Close (2012) have shown that there is a neural and physiological reorganisation and adaption in adults when they become parents and start caring for their child. The caring experience stimulates the production of oxytocin. Mayes et al. suggest that parental substance dependence, depression, or anxiety might have an impact on this neural and physiological mechanism. This suggests that parenting interventions should not only include educating the parent about what the child needs, but should also reflect on how becoming a parent has an impact on the adult patient.

Families with parental SUD are high-risk families (Anda et al. 2006; Nygaard, Slinning, Moe & Walhovd, 2015; Zucker, Donovan, Masten, Mattson & Moss, 2007). Having SUD is associated with unemployment, mental and physical health problems, as well as violence and criminality (US National Institute on Drug Abuse, 2017). To reduce the environmental risk-factors for children of parents with SUD, interventions should target the whole family, preferably from the time of pregnancy or birth of the child. The children and their parents are expected to have most of their life ahead of them and may benefit from being better integrated into society with regard to education, work, and social networks (Wiig, Haugland, Halså & Myhra, 2014). Such integration could imply large long-term financial savings for society (e.g. health care, social welfare, criminality costs).

In Norway, treatment for SUD is generally funded by the government, and the institutions providing treatment must abide by political guidelines (i.e. evidence-based, expert-consensus approaches) to receive funding. The guidelines for SUD-treatment (Norwegian Directorate of Health, 2017) state that services should be provided to individuals with extensive substance abuse problems and adjusted to their individual needs. Family members, including children, who are affected by someone else's problematic use of substances, should also be involved in the treatment in their own right. The goal is to reduce the negative consequences of SUD, for individuals, for family members, and for society. Consequently, there has been a development in treatment philosophy and practice away from an individual perspective involving only the SUD patient in the treatment, towards a systemic perspective which involves other family members, including children (Copello, Templeton & Velleman, 2006). The dual treatment investigated in this study involves mothers and fathers with SUD and their infant/preschool children.

These changes have resulted in the development of designated inpatient family -wards in SUD institutions, which aim to treat the SUD patient and prevent development of SUD in the next generation (Arria et al., 2013). Most treatment programmes described in the research literature are outpatient facilities (Neger & Prinz, 2015). To the best of our knowledge there are only a few inpatient family –wards where the stay for the whole family may last as long as 12 months. Residential SUD -treatment for the whole family including minor children typically lasts for three to four months (Clark Hammond & McGlone, 2013).

There are limited descriptions and evaluations of long-term inpatient family treatments of SUD (Neger & Prinz, 2015). Family-oriented treatment has, nevertheless, been recommended as a treatment of choice for parents with SUD (Copello, Templeton & Velleman, 2006; Goldenberg & Goldenberg, 2012; Neger & Prinz, 2015). To decide whether inpatient dual treatment should be more widely implemented, we need more information about this approach. A first step could be to explore the experiences of professionals who are actually working in family –oriented treatment of parents with SUD and their preschool children within an inpatient context. Therefore, this study explores how dual treatment is understood and practised by professionals in an inpatient facility for parents with SUD and their children. We focus on the treatment of the mothers, as they are usually the primary patients.

From an earlier interview -study of mothers with SUD in inpatient family-oriented SUD treatment, we concluded that the mothers had a range of major challenges (Wiig et al., 2014). Some mothers experienced themselves as outsiders, and needed help to reduce their feelings of marginalisation. All the mothers had the challenges of abstaining from substances, processing traumatic experiences, building supportive social networks, and establishing a safe and predictable family environment for themselves and their children.

An important challenge in SUD treatment in general is the high rate of turnover among clinical staff. This turnover has been linked to burnout syndrome (i.e. emotional exhaustion, cynicism or a diminished sense of efficacy) (Young, 2015). When treatment includes additional demands, not only focusing on the SUD patient, but also on parenting and the development of the child, it is not unlikely that professionals may be extra vulnerable to emotional burnout. It would therefore be of interest to study how different professionals view their therapeutic roles and their contributions during inpatient dual treatment of families with SUD.

Hopefully, this may increase our understanding of the content, the advantages, and the challenges within this type of family-oriented SUD inpatient treatment.

METHODS

Participants

We approached an institution committed to SUD treatment within a system-perspective. The inpatient family-ward at this institution admits pregnant women and families with young children, where parents are diagnosed with SUD. Most patients are single mothers, but two-parent families are also admitted. The head of the family -ward was contacted and scheduled the focus group -meetings with the staff. The staff members were allowed to take part in the focus-groups during their working hours.

This resulted in three focus group -meetings, comprising a total of 15 employees (13 women, 2 men). Two focus groups comprised seven and four staff members respectively. These were staff members who spend most of their working hours on the ward together with the patients and their children, hereafter called "ward staff". They were registered nurses, midwives, nursing assistants, preschool teachers, social workers, and housekeeping staff. The third focus group consisted of 4 staff members responsible for the parents' and families' scheduled treatment sessions, both individual and group sessions. This group comprised the following professions: child psychologist, family therapist, child welfare therapist and social welfare therapist. To distinguish them from the ward staff, they will be called "therapists".

At the time of data collection 12 ward staff members and 5 therapists were employed at the ward. All were invited to participate in the study. One therapist was on sick leave and unavailable. Eleven ward staff members and four therapists participated.

Treatment and treatment setting

The family ward admits up to 13 families with serious SUD (according to ICD10, F 10-19), including pregnant women and parents with infants and preschool children (mostly 0-4 years). Usually the inpatient treatment lasts 12 – 18 months, from pregnancy or birth until the child is approximately one year old. The ward comprises small apartments with shared

facilities (e.g. kitchen, living room, laundry room and nursery). Common rooms facilitate different families' spending time together. Staff also encourages patients to take part in joint activities (e.g. physical training, walking with the children in strollers, artistic hobbies).

The treatment also includes a range of components with the aim of helping the patients become sober and at the same time preparing them for parenthood and to care for the child. An important aim is also to help patients prepare for life as a family after inpatient treatment is terminated. The infants are admitted together with their mothers, with the fathers usually admitted as the mother's partner. The following components are central during different, partly overlapping, phases of the inpatient treatment: bodily changes related to giving birth, everyday life with the newborn child, handling difficult emotions in the mothers that surface during treatment, training for the parenting role, processing negative events/trauma related to the parents' own childhood, and planning life for the families after discharge from treatment.

The treatment furthermore includes interventions to treat SUD (e.g. increasing emotional regulation, structuring everyday life, building positive coping strategies to reinforce sobriety), helping the parents reflect on their attachment -relationship and the interaction with their infant (e.g. Circle of Security; Powell, Hoffmann & Marvin, 2009 or Marte Meo; Hafstad & Oevreeide, 2004), social skills training, and introducing routines and skills needed for everyday family life (e.g. cooking, having a family meal, leisure activities with children). The aim is to assist parents in facing the challenge of parenthood without being substance-dependent. Different treatment modalities are used combining group-therapy, individual sessions, couple-therapy, thematic classes, and joint household chores. Efforts are made to support families in cooperating with relatives, as well as collaborating with social and child protection services.

Ward staff -members spend most of their time supporting the patients in their everyday lives at the ward, whereas the therapists are responsible for the different treatment sessions.

Interviews

All three focus group meetings were held at the institution where the staff members were employed. The overall interview question was: *how do you understand your therapeutic roles and your contributions during inpatient dual treatment of families with SUD at the family -ward?* The discussions were audiotaped and later transcribed verbatim by the first author. Each focus group interview lasted for approximately 1.5 hours.

Focus group interviews are suited to investigate experiences, attitudes and needs among employees, and may be useful for studying dominating cultural values (Wilkinson, 1998). Group -interviews may, furthermore, facilitate discussions where unexpected themes may appear. Individuals who feel they have nothing to say or are reluctant to participate for

other reasons, may feel more comfortable or find it easier to express themselves when participating alongside their colleagues. We chose to interview the therapists and the ward-staff in separate groups. It was likely that the experiences and perspectives of the two groups of professionals would differ. If the groups were mixed, the ward staff would have been the majority in all the groups. Participating alongside others may cause difficulties in sharing opinions which differ from the majority of the group (Wilkinson, 1998). Therapists in the minority might not be heard, or ward staff might not feel able to share their opinions in groups with more senior colleagues.

The interview guide was formed around the following key question: How do you understand your therapeutic roles and your contributions during inpatient dual treatment of families with SUD on the family -ward? After sharing their personal information (name, education, and duration of this employment), each group member was asked to reflect on *their motivation for their work*, and *what they found to be important* in their professional practice. The facilitator followed up the initiatives from the focus-group members, for instance by asking: *You said 'Being the child's voice'. Could you give an example of how you do that? Or when a therapist stated that: 'We work hard to make them notice their children, that they start talking about them, to try to awaken interest and engagement, to make the children come alive for the mothers', the facilitator commented: What words do you use? Could you try to elaborate this further?*

The interviewer was careful not to direct the discussions towards any particular themes or direction. The questions in the interview guide worked as support if the conversation ended.

Analysis

All authors read the transcripts and contributed to the analysis. Each step was thoroughly discussed between the first author and at least one of the co-authors. Analyses were done in a Giorgi-inspired manner (Giorgi, 2009) using *thematic analysis* (Braun & Clarke, 2006). During analyses we tried to stay open minded and bracket our own presuppositions. After listening to the audio-recordings and reading the transcripts several times, a first impression with some initial ideas was noted. These ideas developed as a result of topics the respondents spent a lot of time talking about, and the issues that several respondents talked about during the discussions. Initial codes were generated through systematic coding of extracts from the texts that seemed relevant to the research question (see table 1). After new readings, initial codes identified as particularly relevant for elucidating the study question were collated into potential themes. In the next step these potential themes were checked to make sure they functioned both for the initial codes and for the whole data-set. For example, the potential code *The choice of treatment approach* was tested to see if it captured the meaning of the initial codes *Focusing on the addiction* and *Focusing on the interaction*. Then the data set was reread, to check that the potential codes were relevant and valid to the data set as a whole. A synthesis of the potential themes resulted in three

different final themes, described in the results -section. Table 1 gives an extract of the process of analysis.

Insert table 1 here.

Ethical considerations

The study was approved by the Norwegian Ethics Committee for Medical Research (REK number 2011/879b) and followed the guidelines from the Helsinki Declaration. The participants received both oral and written information on the study before they decided to join the interviews.

RESULTS

In all three focus –groups the participants discussed the difficulties of prioritising between different treatment aims and tasks. Otherwise, the themes that were discussed were quite different in the three groups. The first group consisted of seven ward staff, some with more than 20 years of experience working with SUD patients, others quite new (from 3 weeks to 3 years of experience working with SUD patients). Their discussion focused on issues related to the patients’ practising skills for everyday life. The discussion in the second focus group, comprising four ward staff -members, all with long experience working with SUD patients (five years or more), was focused on the complexity of the patients’ needs. In this group we heard a quite critical voice. They expressed the need for better cooperation with the therapists, as well as the need for increased staff -resources. The third focus group, comprising four therapists, most of them newer to the treatment of SUD patients (1 – 3 years), discussed the need for therapists to support each other, and the need to regulate their own emotions during demanding treatment sessions. The therapists focused on collaboration within their own working group. Hence, the group –sessions revealed a tension between the perspectives and priorities of ward staff and those of the therapists.

Three dominating themes emerged from the transcripts: I) *‘Rescue the child’ versus ‘treat the addiction’*, II) *Using everyday life at the ward to support abstinence and parenting*, III) *A demanding line of work*.

‘Rescue the child’ versus ‘treat the addiction’

The treatment approach seemed to be an area of discourse among the professionals. A key issue raised in the interviews was whether they should regard the patients as “SUD patients with children” or as “mothers with SUD”. Although both ward staff and therapists wanted to help both parents and children, their priorities were characterised by different understandings of whether the parent or the child was their primary concern. The professionals had various arguments to justify their treatment focus. Their attitudes were positioned along a continuum from a) *rescue the child from difficult experiences* towards b) *treat the addiction first*.

Rescue the child

Ward staff and therapists who expressed that the child was their primary concern, taking the 'rescue-the-child' position, were all relatively new to the addiction field (i.e. less than three years). Their main motivation for therapeutic work with SUD patients was to contribute to positive development for the children.

Therapist, new: *I decided to accept this position when I realised that it would be possible to build a treatment plan for the young children.... To gain access to the children I had to connect with their parents.*

Therapist, new: *We must prioritise the children's needs... ' How will it affect your child if you keep thinking about substances?' ... We need to focus mainly on parenting.*

These respondents wanted to secure a good start for the child together with the mother, even if the mother was in danger of losing custody of her child. They argued that a good start in life would be important for the child either way.

Ward staff, new: *On the family -ward we have the opportunity to make a difference, first and foremost for the child. How can we reverse the generational transference (of SUD)? What might happen to the child if it really experiences caring and security?*

Treat the addiction

Professionals who regarded the addiction itself as the primary treatment focus, taking the treat-the-addiction position, claimed that staff should take advantage of the child's being a unique motivational factor for the parents. Positive experiences when interacting with the child, and coping as a parent, might help the patients to withstand the craving for substances and maintain their motivation for the addiction treatment. The staff claiming this position were primarily experienced SUD professionals (i.e. more than five years of working with SUD patients).

Therapist, new: *It's different when you work only with adults. Having the children present on the ward makes it important to take advantage of the possibilities the pregnancy and the child offers, because the child provides a "window of opportunity" for change.*

These professionals argued that they were trying to help the parents to experience that the wellbeing of the child was worth the hardship they endured when abstaining from substances. According to these professionals, the mothers had previously used substances to escape from bad feelings. However, caring for the children could motivate them to tolerate the strong emotions that emerged as they became abstinent.

In addition, they stressed that the parent's traumatic childhood experiences needed to be addressed first, to prevent these from disturbing the mother's therapeutic progress in other areas (e.g. tapering from substances, sensitivity towards the child).

Ward staff, experienced: *The sooner the parents start trauma-focused treatment, the sooner they will be available for processing the other tasks. If they implement this (trauma-focused treatment) early in the process, and start getting enough sleep and having daily routines, they will be open to participation in the rest of the treatment plan. ... They have experienced difficult things and become substance-dependent. If they have been exposed to trauma, the trauma will disturb the healing process we are trying to start here.*

Ward staff, experienced: *It's difficult to work with the interaction with the child when the mothers are so heavily burdened emotionally. They are advised by the therapists to postpone the trauma-oriented treatment until after this inpatient stay. It must be terribly frustrating for them.*

These professionals, most with many years of experience from treatment of SUD patients, acknowledged that the mothers might have coping experiences when interacting with their child and when observing the child's developmental progress. However, they claimed that, in general, the mothers would not be able to concentrate on parenthood until they had solved some of their other therapeutic challenges, such as substance abuse, poor emotional regulation, and trauma. They were concerned that focusing primarily on the parent-child interaction would only give the mothers more experiences of failure.

Ward staff, experienced: *If the mother is not really emotionally present here and now, ... it's of no use. If her head is filled up with everything else, it's impossible for her to concentrate on improving the interaction with her child.*

These professionals wanted the parents first to cope with their own problems. Only after this has been achieved would they be able to offer security and structure for their child. They claimed that '*parents cannot help their children before they are able to help themselves*' (ward staff, experienced).

Different approaches caused tensions

All the professionals seemed to support a systems theory perspective on SUD treatment with family-therapy approach as a shared perspective. In spite of this, there seemed to be at least two different interpretations of the treatment approach: one focusing on helping the mother to deal with her own disturbing thoughts, increase her ability to regulate emotions, overcome previous trauma experiences, and create structure in everyday life, all ingredients of a traditional SUD treatment. The other primarily focusing on the mother – child interaction, helping the mother care for and interact with her child to secure a safe and caring environment for the child. These different interpretations of a family –treatment approach caused tensions between the professionals. The first focus group comprised a combination of new and experienced ward staff members. They focused mainly on everyday life on the ward (as described in the next finding), and no tensions in treatment focus and aims were articulated. The second focus group included only experienced ward staff

members. They expressed doubts about the 'rescue-the-child' approach of the therapists, and tensions were revealed. They sometimes felt their arguments were ignored by the therapists.

Ward staff, experienced: *The mothers are not in contact with their own emotions, so how can they understand the child's emotional needs?*

Ward staff, experienced: *It takes too long, we don't feel that our concerns are taken seriously enough by the therapists.*

New principles meeting traditional treatment

Most therapists had worked with SUD patients for a short time (< 3 years). They seemed to represent a new way of thinking, prioritising the child and the interaction between mother and child, i.e. the 'rescue-the-child' position. Thus, the dominant perspective within the focus –group comprising the therapists, may be a result of most therapists being less experienced in traditional treatment principles of SUD patients. In the second ward staff group, all the participants were experienced with SUD patients, and they all expressed frustration about the perspective of the therapists'. The members of this group emphasised the 'treat-the-addiction' approach. The first ward staff group, however, comprised both new and experienced ward staff members. In this group the two treatment perspectives seemed to exist as parallel approaches. No tension between treatment perspectives was expressed during this discussion. Instead the members seemed to agree on a focus of helping the mothers train for everyday life on the ward.

Supporting the mothers – everyday life, routines and care.

Training for everyday life on the ward was a major topic in the discussions, especially in the first focus group with ward staff. The professionals described how they intervened to support the family to function together. They used 'present moment' situations to help the parents reflect on their interaction with the child, their own feelings, and what might be going on in the mind of their child.

The staff kept firm routines for everyday life on the ward. They stated that it was an important treatment aim in itself to introduce structure in the daily life of the parent, and that this was an aim the mothers seemed to appreciate.

Ward staff, new: *We use routines a lot, with the parents, and with the child as well. This will prepare them for their daily life outside the institution, including going to school or work. They need to avoid everything becoming unsystematic, unstructured, and chaotic, and to transfer this to the child. For a child with parents who are not used to routines, this is especially important. ... We practise this through rules such as getting up for breakfast at the same time every morning, or by checking that they keep their rooms clean and tidy.*

The staff described how they built a strong therapeutic alliance with each patient through supporting them in their daily household chores and childcare routines. A ward staff member explained the success criteria concerning one patient succeeding in her treatment.

Ward staff, new: *I think she felt that we could be trusted, and that we were available for her, all the time. ... I guess she felt that we weren't there to point out her shortcomings, but to help her become the best mother possible. That she could confide in us.*

By reinforcing structure, daily routines and household skills, the staff simultaneously tried to support parenting skills, increase the parent's reflective functioning, and strengthen positive parent-child interactions.

Training for everyday life at the ward was not only used to increase parental skills. Through close monitoring and verbal reminders ward staff also tried to increase the parents' ability to resist craving for substances. During training in everyday life on the ward, opportunities arose where the staff could talk about impulse control and remind parents of their goal of becoming sober. Thus, by this approach they seemed to a certain degree to combine the aims of *rescuing the child* and *treating the addiction*.

Ward staff, new: *The parents have trouble controlling their impulses. Suddenly they feel tempted (to use substances), and we must "draw them back in": 'Remember your goal. Remember why you are here. What will the consequences be? ... Think again! How will you feel about this tomorrow?'*

The respondents stated that most of the SUD patients have grown up in dysfunctional families with parents who have poor parenting skills. During the everyday experiences on the ward they tried to show the mothers how to care for their children through experiencing being taken care of emotionally themselves by the ward staff. They explained that they as professionals had to *'fill the mothers' emotional reservoirs'* (ward staff, experienced), so that they in turn have something to give to their children.

Ward staff, experienced: *It's difficult to explain how complex this is. I find the expression 'mothering the mother' to be suitable. I wish we could decide to prioritise this. There's no point in explaining to the patients what soothing is, if they never have experienced it themselves. They have to experience these emotions themselves, what it feels like to be taken care of....*

Ward staff, experienced: *To be able to give, you must have received something. If we expect the mothers to give to their children, ... well, then we are the ones who have to fill them up.*

Ward staff used spontaneous moments of intersubjective mother-child interaction during everyday life at the ward to support and prepare the mothers for their role as caregivers. The following quote shows how they trained reflective functioning:

Ward staff, new: *'Mama, look at me now!' ... Now he needs to "fill up his cup"...*

Ward staff, experienced: *'How was this for you when you were a child? How do you imagine your child is feeling now?' ... We try to make them remember their own childhood. What do they want to change for the next generation?*

A demanding line of work

Exhausted by mood changes, unpredictability, and changes in focus

All professionals expressed that working on the family -ward was emotionally challenging. The therapists described some of the strategies used by the parents, as challenging. During treatment sessions it was, for example, difficult for the therapists to keep focused, due to sudden and unpredictable mood changes in the patients with recurrent changes in focus, during conversations. Therapists described that it was sometimes difficult to stay emotionally balanced during therapy sessions. After sessions they needed to calm down, take care of themselves, and support each other.

Therapist, new: In the sessions the parents meet us with an armour we have to deal with. The armour can be to act really sweet, kind and agreeable, or it might be to give very short answers, but still be polite, or they can act threateningly, or talk a lot about unimportant stuff. ... These are strategies that may charm us or confuse us. ... We often meet individuals with strong emotions, which they don't regulate themselves. It is hard to be with those individuals who need so much help, but don't ask for it.

To care for themselves the therapists also expressed the need for working in teams during sessions.

Therapist, new: The therapists need to work together. This is alfa and omega in order to make a difference for the children. ... I soon understood that it would be impossible to achieve anything in this line of treatment if I worked alone, so we started to arrange the family-meetings with two therapists, as a therapeutic team. ...The importance of teamwork: All the time we meet individuals with personality disorders. This characterises our sessions and sometimes make us lose track. ... I believe that it might be damaging for the therapist to work alone with these issues, an emotional burden. ... We must try to balance ourselves to prevent becoming burnt out. ...

Different motivations

When the professionals were asked about their motivation for working with families with parental SUD, different attitudes emerged: Some were motivated by a wish to help individuals in difficult circumstances, like the SUD patients, and took the 'treat-the-addiction' position, whereas others described that working with addiction was less appealing. Some therapists expressed that they did not originally plan to work with SUD patients. They had been reluctant to work on the family -ward, but accepted the position, because it provided an opportunity to work with small children (the 'rescue-the-child' position).

Some professionals seemed to have attitudes towards this work which mirror the social stigma patients with SUD meet elsewhere in society. The attitudes may reflect attitudes that reinforce the marginalization of substance dependents in our society, as well as an understanding of the addiction-field as highly demanding and exhausting. A therapist described this attitude:

Therapist, new: *I hesitated for a long time (about taking this job), because I never planned to work with addiction.*

Others, however, seemed to have a genuine desire to help individuals with SUDs.

Ward staff, experienced: *My starting point for beginning to work here was the wish to contribute to a better life for SUD patients, to be able to use myself to make things better. I have seen enough of how they are met in the health services. This has always provoked me. I wasn't passionate about working with dual treatment, but for the cause of helping individuals with SUD towards a better everyday life.*

Both attitudes described above may imply an understanding of a highly demanding and low-status field of work. The professionals experienced it as challenging to handle what they experienced as emotionally unregulated parents, with sudden changes in behaviour, strategy and focus of attention. These challenges made the interaction between professionals and patients difficult, but the challenging work also seemed to cause tensions between the professionals.

Ward staff, experienced: *There has been a great change in recent years. Some of us are frustrated and tired. There is a gap between ward staff and therapists. I believe some of us ward staff members feel that our competence is not appreciated...*

DISCUSSION

Three different themes emerged from focus group discussions with therapists and ward staff at an inpatient family -ward for dual treatment of parents with SUDs and their unborn, infant or preschool children: 1) *Rescue the child versus treat the addiction*, 2) *Using everyday life on the ward to support abstinence and parenting*, and 3) *a demanding line of work*. Many treatment-components needed to be addressed to achieve abstinence and facilitate a well-functioning family. This gave potential for different prioritising and tensions between professionals. The three focus groups were quite different and emphasised different themes. A closer look at the composition of each group reveals that the first focus group consisted of a mix of experienced and new ward staff -members. The second focus group comprised exclusively ward staff members with long experience with SUD patients (> 5 years). They expressed frustration about the lack of cooperation with the therapists, as well as the lack of resources to be able to cope with the complexity of the patients' needs. The third focus

group, comprised the four therapists and most of them were less experienced in the addiction field (1-3 years). They focused on the demanding treatment tasks and the need to support each other as therapists and to balance themselves emotionally. The fact that the viewpoints expressed in the three focus groups were so different, may be caused by dominant voices making it difficult for others to express differing viewpoints or experiences (Wilkinson, 1998). We tried to prevent this by sorting therapists and ward staff into different groups, but it might have been even more difficult to express arguments that differed from their closest colleagues, at the same level of the organisational hierarchy. The differences may also be understood as a result of the professionals' length of experience, as the more experienced professionals seemed to agree on the 'treat-the-addiction' perspective, the newer professionals chose the 'rescue-the-child' perspective, and the focus –group which was mixed of new and experienced ward staff members, chose to focus on everyday life on the ward, instead.

1. Different treatment approaches

Professionals seemed to have different approaches - some focusing on the wellbeing of the child and the parent-child interaction, others mainly focusing on the SUD and related problems in the life of the adult patient. According to the institution, the treatment at the family –ward comprise many therapeutic tasks and treatment aims focusing on treating the parent's SUD and trauma history, couple therapy, as well as caring for the child, the parent-child interaction, and the integration of the family into society. The staff seemed to disagree on which treatment focus needs to come first – which seemed to create tensions between staff members and different groups of staff. There is a growing understanding of the importance of focusing on the child in families with SUD (Dube et al., 2003; Felitti & Anda, 2010; Pajulo et al., 2012). However, by focusing mainly on the wellbeing of the child, one may be in danger of trivialising how difficult it is for SUD -patients to taper from substance use, and signalling that the SUD parent is of less interest as a patient, being in danger of reinforcing the patient's already low self-esteem and feelings of stigma.

In a review by Neger and Prinz (2015) dual treatment of SUD and parenting could reduce substance use and strengthen parenting skills. According to their findings the timing of treatment approaches should start with treating fundamental psychological processes in the parent (i.e. developing better emotional regulation), and then teach the SUD patients parenting skills. This is in line with the understandings of the experienced ward staff members who expressed frustration when the focus was primarily on the parenting role with no trauma-oriented treatment. According to Neger and Prinz' (2015) better outcome is found when SUD patients through treatment have addressed fundamental psychological processes first, and then afterwards taught to care for the child. This argument seems to support the 'treat-the-addiction' approach.

Mayes et al. (2012)'s findings on neural and physiological reorganisation and adaptation, call attention to how adults transition to parenthood, and suggests that this is an open and dynamic developmental phase which is initiated by caring for an infant. Mayes et al.'s study supports the idea of emphasising parenthood early, in pregnancy or infancy. However, the authors also underline that the parental reflectiveness should first focus on thinking about their own development as parents.

While employees who emphasised interaction training first were relatively new to the addiction field (from 3 weeks to 3 years), those who argued for prioritising fundamental psychological processes were experienced addiction workers (5 – 23 years). The different opinions could be an expression of the phenomena of rapid and slow responders within employees when implementing new treatment principles (Oreg, 2006). The slow responders do not necessarily resist change, but try to protect strategies they believe function well (Oreg, 2006). The lack of collaboration between ward staff and therapists might have led to a wider gulf between the two perspectives. The professionals might reach a common understanding of timing of approaches if they explore the different arguments further together.

If the discourse – to treat the addiction or rescue the child - is acknowledged and reflected upon by the professionals, they might be able to implement comprehensive practices that simultaneously incorporate the needs of both parents with SUD and their children, and the interaction between family members. Discourses among professionals constitute and change institutions, the patients' identities, and the social relations, both inside and outside of the institution (Jorgensen & Phillips, 2002).

2. Focusing on everyday practises allows for present moment situations.

A major finding was the emphasis on training for everyday life among the ward staff using everyday routines to integrate structure in the life of the SUD families. The staff aimed to motivate the parents to continue structuring their everyday life also after discharge from the family –ward, because this was important for both children and parents. This finding is supported by Weisner's (2010) research, which stress the importance of sustaining a meaningful daily routine. Weisner argues that participation in the everyday routines which are appreciated in your cultural society, will foster wellbeing.

Another important element of the inpatient stay was the description of how the staff used present moments to facilitate growth in the SUD patient, concerning impulse control as well as sensitivity towards the child. This may be an example of dual treatment in practice. Stern (2004) describes how a shared moment includes a physical and emotional lived story. The patient may become conscious of his/her own thoughts and feelings because they are reflected back from another person's mind in the present moment. The ward staff, in particular, used shared moments in the everyday life at the ward, to support interaction between the parent and the child or between co-patients. They used present moments to

support the parent's reflective functioning, a concept described by Slade (2005) as the parent's ability to understand the mental states of their child, trying to demonstrate to the parents how their children signaled emotional, physical and social needs. The professionals also used present moment situations to reinforce new behaviour in the parents, such as increased sensitivity towards the children. Plant and Panzarella (2009) describe how treatment strategies which support patients' experiences of coping may increase the patients' perception of self. An improved self-perception may also strengthen their belief in their ability to achieve an integrated 'normal' family life outside of the family -ward, an aim previously identified as being of major importance for these families (Wiig et al. 2014).

By being trustworthy, predictable, available, and supportive the professionals tried to build a therapeutic alliance with the parents, a major ingredient of treatment. Facilitating the development of a therapeutic relationship is described as particularly important to support mothers with SUD in parenting (Fowler, Reid, Minnis & Day, 2014). Ward staff used the term 'mothering the mother' to explain how they tried to support the mothers in caring for their child through experiencing being taken care of themselves.

It seems that the focus on everyday life was the way these professionals' found of combining the two treatment approaches including both the focus on the child and the parent-child interaction, and the focus on the addiction.

3. More collaborative work.

According to the focus group discussions prioritising and timing of different treatment components was complex and challenging. Also it was evident that the emotional burden associated with dual treatment is significant. The SUD patients have multiple risk factors, and may have developed survival strategies that is a challenge for the professionals to understand and deal with during treatment. The professionals may feel that their interventions are insufficient or inadequate. When they also experience tensions between professionals due to different treatment focuses, they may experience emotional exhaustion. Previously high turnover rates and burnout syndrome among clinical staff have been found for substance abuse treatment in general (Young, 2015). However, dual treatment includes additional ambitious treatment aims, where also the lives of the infant child is at stake, and may therefore be experienced as even more challenging than individual treatment of SUD patients.

It is essential to acknowledge the demanding features of dual treatment of parental SUD, parenting skills, and the wellbeing of the child. This may be a turning point for professionals to achieve the support and cooperation necessary to combine different focuses inherent in a dual treatment approach. The quote from an experienced ward staff member '*I wish we could decide to prioritise this*' signals the tension between the two groups of professionals, where the ward staff feels that their competence is not fully appreciated by the therapists. The therapists, on the other hand, seem to struggle to take care of themselves and support

each other. When the aims and tasks are both multiple and challenging, some degree of tension between the professionals may be acceptable for a short period, until the different approaches make an integrated whole.

Some professionals said they had reservations about working in the addiction field. If this work does not appeal to professionals, the parents' feelings of marginalisation may be reinforced. Attitudes towards the addiction field as less appealing may influence how staff members interact with SUD patients, and in worst case, mirror the societal stigma often experienced by SUD patients. Rutman, Strega, Callahan and Dominelli (2002) found that social workers had a tendency to see generational transference of psychosocial problems in mothers who had been under care as unavoidable, partly because the mothers were unable to prioritise the parenting role and partly because they were 'undeserving' mothers. Rutman et al.'s findings may be relevant as the attitudes SUD professionals have towards their work and the SUD patients, and the degree to which they believe SUD mothers can learn to care for their children, may influence the results of the treatment. It is for many reasons important to maintain hope, for both the patients and the professionals (Sælør, Ness, Borg & Biong, 2015) .

Strengths and limitations

An important limitation of the current study is that only one institution, with the experiences of 15 employees, has been explored. Therefore we cannot exclude the possibilities that the findings are not generalisable and only provide local descriptions. However, the descriptions and the tension between staff members having different priorities may also have relevance for other professionals and institutions offering dual treatment of SUD, parenting, and the welfare of children in these families. The review of Neger and Prinz (2015) indicate that tension between different treatment focuses and timing of treatment components may be a relevant and significant discussion in the field of family –treatment of SUD patients.

Recruiting as many as 15 of 17 employees at this particular family -ward may be considered a strength of the study. One employee was on sick –leave, so there were only 16 employees available for the study. The quality of the focus –group discussions seemed good, with all participants raising their voices in the discussions, and interesting features of the research question being discussed. However, the three focus groups took different paths, with one different dominating theme in each group. This may be due to dominant voices making it difficult for others to share differing opinions, or it may imply that the discussions floated freely, so that the discussions took unexpected paths.

CONCLUSION

Dual treatment of SUD and parenting skills is highly complex and challenging. The treatment targets mothers and fathers with SUD, the newborn child, and the family as a whole. To

balance the different tasks, aims, and perspectives demands highly resourceful professionals with a range of different competencies. In our study, the professionals seemed to choose either the addiction or the parenting as their primary focus. The work felt exhausting, and therapists, in particular, expressed the need to take time to support each other and balance themselves emotionally. The professionals may have lacked the capacity to create a functioning cooperation between the different staff groups, contributing to the tensions observed between ward staff and therapists.

The members of our focus groups stressed the importance of facilitating training of the parents in everyday life skills through using present moment situations. They described how inpatient treatment provided opportunities for building strong alliances between patients and professionals, which could help parents develop both parenting skills and reflective functioning.

The finding that different professionals advocated different treatment approaches underlines the need for cooperation and teambuilding, both within and across professional teams. Breaking the circle of intergenerational transference of SUD problems is of major importance for individuals, families and society. Although it is recognised that environmental factors play an important role in generational transference of SUD, inpatient treatment is still not often implemented. Therefore, this treatment approach needs to be investigated, to establish the principles and timing of treatment components that may be worth developing further. In order to consider further development of family –wards, a necessary first step is to investigate how the treatment is understood from the professionals' perspective and what treatment components they find important.

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Tables

Table 1.

Process of analysis for codes, potential themes and defined themes emerging from the focus group discussions

Codes	Potential themes	Final themes
Focusing on the addiction	The angle of treatment approach	'Rescue the child' versus 'treat the addiction'
Focusing on the interaction		
Structure in everyday life	Routines	Supporting the mothers – everyday life, routines and care.
Teaching the parents to understand their child	Reflective functioning	
Training in social skills	Social competence	
Addiction field not desired	Tensions between professionals	A demanding line of work
A wish to help the marginalised	Risk of burnout-syndrome	
Therapists must support each other	Attitudes mirroring the marginalisation	
Ward staff feel frustrated		

Interview guide

Overall question: How do you understand your roles and contributions?

1. Personal information (name, education, and duration of this employment).
2. How did you become interested in working at this ward? What are the top qualities of this work?
3. How could you explain to someone outside of the addiction field what you do to prevent intergenerational transference of SUD or other problems?
4. How do you think the mothers would describe your work? – or the fathers? – or the children (if they could speak)?
5. How does the society around you describe your work (the public, the media, ex-patients, employees from other institutions in the same field)?
6. Give an example of a successful treatment-story and try to describe the essentials.
7. – and a non-successful patient-story?
8. What patient-needs do you meet really well?
9. How would you improve the ward and the treatment if you had the necessary resources? What is the most important issue to continue with or develop further?
10. What arguments would you use to try to convince politicians to support your work?

Søknad om Errata

Navn kandidat: Eli Marie Wiig

Avhandlingstittel: Substance dependent women becoming mothers – breaking the intergenerational transference of substance use disorders.

I forbindelse med oversettelse av avhandlingen fra norsk til engelsk har det skjedd tre feil som jeg beklageligvis ikke oppdaget før jeg sendte avhandlingen inn til bedømmelse. Jeg ber om at disse blir rettet opp:

1. Paginering har falt ut
2. Overskrift 6.1.3: <reflectivity> skal erstattes med <reflexivity>.
3. I paragraf 4.1 ligger det inne et spørsmålstegn bak <phenomenological-hermeneutic> som skal fjernes.

Dessuten vil jeg gjerne få lagt inn korrekt referanse til siste artikkel under <Publications>.

Jeg foreslår følgende forklarende tekst under:

Den siste artikkelen har senere blitt omarbeidet og publisert med følgende referanse:

Wiig, E.M., Halså, A., Bramness, J., Myra S.M. & Haugland, B.S.M. (2018). Rescue the child versus treat the adult? Understandings among professionals in dual treatment of substance use disorders and parenting. *Nordic Studies on Alcohol and Drugs*, Vol 35 (3). DOI: 10.1177/1455072518773615

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