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Substance-dependent women becoming mothers: breaking the cycle of adverse childhood experiences

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ABSTRACT

Parenting may be particularly challenging for substance-dependent mothers who have grown up with parents who themselves had substance use disorders (SUDs). The aim of this study was to explore how substance-dependent mothers describe their childhood experiences with substance-abusing parents and the association between these earlier experiences and their own role as caregivers. Using purposeful sampling, mothers admitted for 1 year to a family ward at a substance abuse clinic were approached. Through in-depth, qualitative interviews, nine substance-dependent mothers described their lives in the form of present, past and future tense. The findings indicate that substance-dependent women, who have experienced SUDs in their families of origin, face several major challenges when they become mothers. Some describe having lived their whole lives 'on the edge of society'. This makes their rehabilitation process more complex. All mothers work to abstain from substances, process traumatic experiences and integrate their family into society. They need help to build supportive social networks and to establish a safe and predictable family environment for themselves and their children. The therapeutic implications of these findings will be discussed.

INTRODUCTION

This paper explores how substance-dependent mothers with a newborn child, who themselves have grown up with parents with substance use disorders (SUDs), experience motherhood. The body of literature in this field has documented that the offspring of mothers with serious substance abuse problems face an accumulation of risk factors because of biological, psychological, social and environmental vulnerability. However, remarkably little is known about the perspectives and challenges experienced by children of substance abusers when they themselves become parents. To investigate the subjective experiences of these second-generation mothers with substance abuse, we have undertaken in-depth interviews with women admitted to a family ward together with their infants. In this study, we use the term SUDs to include diagnoses related to use of alcohol, prescription drugs and/or illicit drugs.

It is estimated that 8.3% of Norwegian children below 18 years live with parents with diagnosable alcohol problems (Torvik & Rognmo 2011). Children living with mothers with SUDs are at heightened risk for physical, academic and social-emotional problems (Conners *et al.* 2004). The risk for psychosocial problems is furthermore associated with dysfunctional parenting, e.g. harsh discipline, poor monitoring, low degree of parental warmth, in families with harmful parental use of substances (Keller *et al.* 2008; Bailey *et al.* 2009). Parental SUDs are also associated with unpredictability and family conflict (Haugland 2003).

The Adverse Childhood Experiences Study suggests that the development of substance dependence is

strongly associated with traumatic childhood experiences (Felitti & Anda 2010). Contemporary neurodevelopmental research show how adverse childhood experiences disturb healthy development (Anda *et al.* 2006; Perry 2010). Traumatic experiences, which occur early in life and last for some time, are especially harmful (Courtois & Ford 2009). The offspring of parents with SUDs are at risk for developing relational problems and insecure attachment (Van IJzendoorn 1995), which again may lead to aggressive behaviour, conduct problems, hostility (Pasco Fearon *et al.* 2010) or harmful use of substances (Dube *et al.* 2003). These research findings point to the importance of exploring the long-term adjustment of children growing up with parents with SUDs, especially looking at how their childhood experiences may be related to their experience of becoming parents themselves.

Studies indicate that parenting style may be transferred across generations (Belsky *et al.* 2009). Women, who experienced parenting characterized by anger, aggressiveness and hostility, tend to use the same negative parenting style towards their offspring (Caspi & Elder 1988). Furthermore, studies examining parenting practices and development of problem behaviour across three generations find signs of stability concerning parental behaviour, SUDs and externalizing behaviour (Bailey *et al.* 2009; Kovan *et al.* 2009). Lieberman *et al.* (1991), on the other hand, found that mothers who had been exposed to inadequate parenting and adverse life experiences still were able to give their children sensitive and adequate caring. Kerr *et al.* (2009) investigated fathers' constructive parenting in a three generational perspective. They found that constructive parenting helped develop better adolescent adjustment and more positive temperament. We have, however, limited knowledge about the mechanisms of intergenerational transference of negative parenting style in families (Belsky *et al.* 2009).

Women with SUDs tend to be isolated and lack a supportive social network (Green *et al.* 2002; Soederstroem 2012). A positive social support network is not only essential for mothers, but also for children (Scheldrup-Mathiesen 2007). The majority of mothers with SUDs are single mothers, or women living with partners who also have SUDs. This means there is no abstinent caregiver available for the child (Roberts & Leonard 1997). Third generation of children in families with SUDs may also lack available, abstinent grandparents. The inadequate social network may be one of several reasons why children in families with maternal SUDs tend to have more adverse childhood experiences and to a larger degree develop problems than children in families with paternal SUDs (Christoffersen & Soothill 2003; Forrester & Harwin 2006).

To prevent transference of problems across generations from women with SUDs to their children is of social and economic benefit both for the individual and society. The societal costs of drug use includes health care, productivity loss, crime, incarceration and drug enforcement (US National Institute on Drug Abuse 2014; Institute of Health Economics 2010). In addition, both individuals with SUDs and their next of kin may suffer from losses in health-related quality of life.

Limited research exists on the intergenerational transference of problems from the perspective of the substance-dependent mothers (Virokannas 2011; Soederstroem 2012). The present study is expanding this issue by exploring the experience of women growing up with parents with SUDs, developing SUDs themselves and subsequently becoming mothers. How do these mothers reflect upon the relationships between their current everyday life caring for a newborn child, their own childhood experiences and their plans for the future? By this approach, we hope to get better understanding of the challenges substance-dependent mothers with a family history of SUDs face. Knowledge about how these mothers understand motherhood and experience their challenges as caregivers may hopefully contribute to the development of more sensitive and effective interventions to support the women in establishing a safe family situation for themselves and their children.

METHODS

This study was conducted with cooperation from female patients on an inpatient family ward at a substance abuse clinic in Norway. To understand the lives of these patients, we wanted detailed and thick descriptions, i.e. descriptions that explain human behaviour in its context, so that the behaviour becomes meaningful from an outsider's point of view. A qualitative methodology was chosen (Kvale 2002), and data were collected using individual semi-structured in-depth interviews.

All interviewees had been diagnosed with SUDs according to the International Classification of Diseases 10, F10 – F19: Mental and behavioral disorders due to psychoactive substance use, usually classified as dependence syndrome (World Health Organization

2010). At the time of the interviews, they were not using substances, but were still considered to be substance dependent.

Participants

The women who were asked to participate in this study all met the following inclusion criteria:

Substance-dependent mothers

- admitted to inpatient treatment at a substance abuse clinic together with their infants (0–12 months) between November 2011 and May 2013, and
- who reported parental SUDs in their family of origin.

All patients who fulfilled the inclusion criteria were invited to participate and all accepted, resulting in a sample of nine mothers. The participants were interviewed twice, with a total of 18 interviews included in the analysis.

Six interviewees reported that their parents had SUDs for most of their upbringing. They had been living in single-parent families or in families where both parents had SUDs. These families were living on welfare, with low participation in working life, low income and poor housing. The other three participants reported having lived in families without harmful use of substances for 5 to 10 childhood or adolescent years. In these families, there was one caregiver without a SUD present, and at least one of the parents was employed.

The women were between 20 and 37 years (mean 25). All participants had been using illicit substances for many years (mean 5 years, range 3–15). Five participants had recently given birth for the first time, whereas three had one older child and one had five children altogether. Three of the mothers were admitted together with an older child (from 18 months to 3 years old) as well as their infant. All participants with older children had been involved with child welfare services.

Six mother and child dyads had no contact with the child's father. Two fathers were admitted to the ward together with the woman and child. According to the mothers, all fathers were substance dependent, most of them still engaged in harmful substance use.

Interview manual

The therapist in charge of the treatment assessed when each patient was psychologically ready to be interviewed. All patients who fulfilled the inclusion criteria were contacted by the first author. They received oral and written information on the study before informed consent was signed. The interviews were held at the clinic.

Asking substance-dependent women to reflect upon their parenting role might arouse difficult feelings and memories (e.g. shame, guilt). The interviewer (first author) was trained in noticing signs of excessive distress in the participants (e.g. physical activity, eye contact, sweat, tears) and the interviews were conducted with caution and sensitivity. The therapists offered additional help or emotional support after each interview, but no extra sessions were needed. The interviews were audiotaped and transcribed verbatim by the first author.

The interview manual was divided into three parts, comprising (i) descriptions of the mothers' current everyday life with their children in the inpatient unit; (ii) the mothers' recollections of childhood experiences with parents who had SUDs; and (iii) the mothers' reflections on the future for herself and the child, after discharge from the clinic. The first part of the interview focused on the present life of the mother and child in the hospital setting, using a lifestyle interview (i.e. review the everyday procedures in detail, chronologically). It was anticipated to be less upsetting for the mothers to describe current everyday life, as their situation on the ward was predictable, characterized by daily routines. This allowed the interviewer and the interviewee to connect and establish a rapport before continuing to more potentially adverse experiences. The second part of the interview focused on the mother's childhood with parents with SUDs. The mothers were asked to recall both difficult and enjoyable situations associated with their caregivers' use of substances, and how they felt during these experiences. The last part of the interviews focused on the mothers' plans for the future. How would they protect their children from adverse experiences similar to those they had recollected? Finally, the mothers were asked to suggest how they planned to build a social network to support the family. The mothers' plans for the future were included after descriptions of their childhood experiences, to allow them to connect the different experiences in accordance with narrative theory (Brockmeier & Carbaugh 2001).

Analysis

A phenomenological/hermeneutical analytical approach based on Giorgi's (2012) development of theory

Table 1 The process of analysis

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

by Husserl and Merleau-Ponty was chosen. The transcribed interviews were analysed according to a Giorgi-inspired analysis called systematic text condensation (Malterud 2012). This is a systematic, thematic, cross-cutting analysis suitable for analysing transcribed in-depth interviews. The first step of the process was to provide an overview of the texts and select those themes that were relevant for the research questions. The following four themes emerged: (i) *understanding my child*; (ii) *childhood experiences*; (iii) *why substances?*; (iv) *changes I have to make*. The next step was to identify meaningful units in the selected text and sort these units into different codes across the interviews. The third step was to condensate the codes in terms of their significance and meaning. The final step of this process of analysis was to synthesize the significance of the condensates into new concepts and descriptions, called categories. Each step of the analysis was thoroughly discussed between the first author and at least one of the co-authors. A table illustrating the process of analysis is inserted (Table 1).

FINDINGS

The findings are presented in accordance with the chronological structure of the interviews. First, the everyday life at the clinic is presented, then the mothers' reflections on the past, and finally the mothers' plans for the future. Some of the substance-dependent mothers were marginalized and felt they had been living their whole lives on 'the edge of society'. For some, starting to use substances was experienced as a natural part of growing up. Experiencing childhood trauma related to parental SUDs was common among the mothers.

Life on the edge of society

Present: a protected, but lonely existence

The respondents described their situation during the stay at the clinic as safe although it was also challenging for them. They struggled with feelings of loneliness, after having distanced themselves from their previous social networks and family. Many had no contact with their former partner, parents or siblings who were abusing substances. This choice had been made to protect their children from exposure to the chaos, violence and unpredictability that the mothers knew from their own experience would follow when in close contact with friends and families with SUDs.

> I know the amount of chaos my parents bring with them, so I don't want them to have any contact with my child at all.

Prior to the inpatient treatment, the mothers' social networks had mainly consisted of substance abusers. During their inpatient stay, the mothers mostly socialized with each other and the staff. They planned to build new friendships and support systems outside the clinic, by looking for fellow ex-addicts and by joining Narcotics Anonymous or other voluntary rehabilitation networks. Some of the mothers had maintained contact with their family of origin. When this was the case, the family members had overcome their substance abuse problems.

Past: an upbringing characterized by exclusion

Six of nine interviewees described an existence on 'the edge of society' since early childhood. Most of them had grown up in families where SUDs had been present for several generations. These families had poor housing conditions and did not have the material standards (e.g. clothing, toys, equipment for leisure activities) usually expected among Norwegian children. Parents were often unemployed. They socialized with other families with substance abuse problems, and this was the only social network for the family members. They seldom attended events in the local community such as school meetings or leisure activities. Most of the interviewees had moved many times during childhood. Families sometimes moved in order to hide from child welfare services. Most of the women had lacked stable friendships with peers, and attributed this to their families' having a different lifestyle from most families in the local community. Because of the substance abuse problems at home, while growing up, they usually did not bring friends home to visit. Some of their classmates or neighbourhood children were not allowed by their parents to visit the families. Some women had moved from one family to another after being taken into care by the child welfare services. Some of these described feeling being excluded from their foster families, being told that they did not belong, spending time alone in their bedroom, not being permitted to mingle with the rest of the family. All mothers who described feelings of loneliness and exclusion emphasized the importance for children to feel that they belong. One participant used the following metaphor to describe how she felt at the age of 12:

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

Future: structure and belonging

The mothers who described a past characterized by feelings of exclusion, not having experienced what they perceived to be an ordinary family life, and not having any abstaining caregiver present during childhood, emphasized the importance of being integrated in the local community. They were not sure what an ordinary family life would be, but knew it was different from the lifestyle they had experienced so far, and should include routines, predictability and being able to tolerate some degree of boredom. Most mothers wanted to start an education to get a job and to become economically independent to provide for their children. This was particularly important for those who had grown up with unemployed parents, living on social welfare. To achieve common material standards was an important goal for their future. They wanted to create an everyday life with their children that included the routines, rituals and traditions that are common in Norwegian culture. The mothers planned to provide a supportive environment for their children, although they also relied upon support from others. To be a good mother, they stressed a need to have the courage to contact child welfare services, regardless of their fear of losing custody for their child.

> Child welfare services have actually helped me a lot, my social network being so small. There is help available if you want it, but you have to dare ask. When you are supposed to be a mother, it's not good enough to make excuses with anxiety. You have to pull yourself together and ask for help.

Many of the mothers had, at the time of the interviews, started to build new relationships and social networks. Some had one good friend who did not use substances, and several mentioned a sister or a mother, who were ex-addicts, as possible support persons for their life outside the clinic. They described how they were going to experience good times with friends and families who had children of the same age, playing together with the children. Mothers also reported a need for self-development to fulfil an independent adult role in society and to have resources for their children.

> Going to school will give meaning to everyday-life, and I will meet others who are doing the same task as me. We will all be focusing on our education, and that will make us equal.

The mothers also described challenges they perceived in relating to others and building friendships and social support. All of them had memories of severe adverse childhood experiences. Some described having learned that discussions could result in

violence, and intentionally avoided conflicts in order to feel safe. Instead, they would turn to lying or trying to please.

> During the worst times, I learned to turn to lying. I had to please my father all the time, or he would become angry. So no matter how difficult the situation was, I knew how to come up with something to calm him down. I got used to this habit of lying in my early years. Of course this was not healthy.

Traumatic experiences

Present: memories of traumatic experiences emerging

During the inpatient stay, the women reported feeling safe, not being exposed to the violence and abuse they had experienced previously. Several participants reported that memories of earlier traumatic experiences appeared during the inpatient period. They reported having used substances prior to the inpatient treatment to escape from difficult memories. After giving birth, they focused on establishing everyday routines as mothers with a newborn child. A few months after the child was born, because of abstinence and therapy, painful memories surfaced, and caused emotional distress.

Past: an upbringing characterized by violence, abuse and neglect

All mothers described traumatic childhood experiences, including witnessing or themselves being exposed to violence. One of the interviewees reflected upon how these experiences had affected her:

> I knew my father used to beat up my mother. So when he asked me if she had been with another man – although the correct answer was no – I answered 'yes, she has'. I had experienced that the beating had to be done before we could have peace in our family, so I just made it happen faster. This shows how much impact our childhood experiences have on our development.

At the age of 4, one participant had accidently swallowed some tranquilizers. Instead of initiating first aid, she described how her caregivers had laughed at her because she looked funny having lost control over her movements. This had been a frightening incident for her, and she perceived it as an example of the neglect she had experienced.

Another participant reported the following traumatic experience:

> The landlord, the owner of our house, squeezed around my mother's neck, and she fell down on the floor. And my father just stood there watching, doing nothing. My mother fetched the shotgun and fired some shots after the landlord from the porch. I was extremely frightened. I didn't understand anything. I used to play with his daughter, and now, when he came round to pick her up, things went completely crazy. It felt very insecure. My father not doing anything to help, and my mother falling on the floor. – There were lots of incidents like that. My child is not going to experience such things.

Several interviewees had experienced the loss of their loved ones, dying in accidents or from illnesses. Those who remembered having found their mothers or fathers unconscious after overdoses described these incidents as frightening and painful.

Future: to protect the child

The mothers were concerned about protecting their children against traumatic experiences like those they had been exposed to themselves, living with parents with SUDs. They planned to keep the children away from people they feared would expose them to potentially harmful events. Those who had experienced many dramatic episodes during childhood stressed the importance of creating a predictable, stable and secure environment for their children.

> Interacting with my girl, I feel clearly that she needs the stability, the everyday routines. That I am there and follow up.

The meaning of the substance use

Present: craving for substances, risk of relapse and fear of losing the child

The mothers' lives at the institution were marked by the craving for substances. They were continuously working to resist the temptation. They saw substance use as incompatible with parenting, and perceived every thought and urge to use as a risk for relapse and a potential threat to lose custody of their children.

> You shouldn't take drugs when you are together with children. You are not able to take care of them.

Substance use implied an actual threat that the children would be placed in foster care, a knowledge that was in the forefront of their consciousness. Some participants had already experienced this with older children. In spite of this, all the women chose to cooperate with child welfare services.

> I still feel that the child welfare services are scary. I feel that they are coming in here to get me. I think that is quite common . . . Even so, I have taken the chance to cooperate with them.

One reason for not having contact with substance-using friends, family members and boyfriends was to resist the temptation to use substances themselves, so that they could continue to care for the child.

Past: to use substances was 'a natural choice'

For some of the women, using substances was perceived as a part of growing up, a normal thing to do for an adolescent. They described how they had looked forward to becoming old enough to use substances, usually around the age of 14. Using substances was perceived as a sign of being grown up and was associated with feelings of belonging and having a good time with friends. Some mothers reported having read brochures and information on substances, to be well prepared once they reached adolescence and were old enough to start using.

> It's a bit scary. One recognizes the culture in the substance community. It has always seemed attractive to me.

Some women seemed to start using substances to experience the excitement.

> Yes, I felt like I could rule the world. I really did. When I was high, life was like a dream.

The participants described their substance use as an intentional strategy to achieve important goals in adolescence/young adulthood. Using substances might give them an identity as adults, provide them with feelings of belonging to a social community, as well as bring excitement, feelings of well-being and/or escape from difficult feelings, even to the extent of being self-destructive.

> I was really not happy with my life at all at that time. Actually, I tried to kill myself through using.

Future: developing alternative strategies and planning for the future

All participants expressed being motivated to learn new strategies to achieve goals that had previously been reached by using substances. They realized that they needed new skills to achieve feelings of well-being without the substances. Some mothers had started planning and taking action to organize their future life. They had signed contracts with regard to housing, and arranged for the children to start in kindergarten. A distinction between mothers with more adverse childhood experiences (e.g. abuse, neglect, family violence) and mothers reporting less adverse childhood experiences emerged. Mothers with the more adverse childhood experiences were more occupied with planning and arranging their future lives. Mothers with less adverse childhood experiences thought that their children would be alright if only they, as caregivers, abstained from substances. The latter were more focused on the need to be emotionally and physically available for their children, and to follow up on the child's interests.

DISCUSSION

The aim of this study was to explore how substance-dependent mothers describe their childhood experiences with substance-abusing parent(s) and the association between these experiences, the mothers' current role as caregivers and the challenges they face creating a future for themselves and their children. The findings indicate that the mothers would have to overcome considerable challenges in order to create the life they wanted for themselves and their children. These challenges included abstaining from substances; processing adverse experiences from their own childhood; becoming a stable, secure, available and supportive caregiver, often without positive role models from their own past; building a social support network including abstinent friends and family members; and becoming integrated in society.

Having children is a major life change. To become sensitive parents, the women in this study faced additional challenges because of the lack of care they had received themselves as children. According to Bailey *et al.* (2009) and Kovan *et al.* (2009), it might be difficult to develop parenting strategies other than those the parents have experienced themselves as children. When the mothers reflected about their future, they emphasized two different issues with regard to parenting. They wanted to make sure their children would experience the love and predictability that they had lacked themselves and they also wanted to prevent their children from experiencing the childhood trauma they had suffered. This is in line with the descriptions from a British study on mothers who, during childhood, had been relocated by the child protection services because of abuse and neglect. They described becoming parents as a 'fear of the past and its impact on the future' (Weston 2013, p. 47). The women who had been criticized and shouted at wanted to learn how to use positive discipline. Those who had been neglected and abandoned emphasized the need to let their children feel valued and be sure that their parents were available for them. The women who had experienced low material standards under-

lined the need for their children to have toys and equipment, and to be able to participate in leisure activities. Those who had witnessed violence wanted to protect their children from exposure to such situations. The mothers offered detailed descriptions of what they wanted to protect their children from. They seemed to know what kind of parenting they wanted to avoid, but needed help to develop alternative positive parenting strategies. The mothers' urge to create a different environment for their children, compared with their own childhood experiences, may be explained according to cognitive dissonance theory (Berkowitz & Devine 1989), which describes how humans try to avoid having attitudes and behaviour in conflict, to prevent the unpleasant feeling of dissonance. The mothers remembered how it felt when their parents were under the influence of substances, and tried to protect their own children from experiencing similar feelings. One mother illustrated this challenge to the point:

> I work hard to avoid yelling at my child, because this is what I learned from my own parents.

The majority of the substance-dependent mothers had been socially marginalized, living their lives on the edge of society. These past experiences seemed to be related to the mothers' current need to belong to a substance-free community and to let their children feel that they belonged and were part of a community. 'Belonging' seemed to be a major concern for the mothers. Their descriptions were in line with Baumeister & Leary's (1995) suggestions that regular and satisfying social interactions is a basic human need, and that lacking a sense of belonging is related to physical, behavioural and mental distress and instability.

For the women in this study, the substance use had meant belonging to a social network, and protection from painful emotions and thoughts. Without the substances, they need alternative strategies. Previous studies have found that abstaining is different for women who have gained responsibility for a child. Having children seems to offer an opportunity to choose a different lifestyle with better self-care (Broden 2004; Dominelli *et al.* 2005). In line with this, the mothers in our study reported being motivated to stop using substances when they acknowledged the pregnancy.

All mothers reported adverse childhood experiences such as neglect and abuse. This is in accordance with findings from earlier studies on the relationship between parental substance abuse and adverse childhood experiences (Keller *et al.* 2008; Felitti & Anda 2010). For some, traumatic childhood experiences had recurred during most of their upbringing. Egeland & Susman-Stillman (1996) showed that mothers who managed to break the cycle of adverse childhood experiences were those who had managed to integrate their experiences and develop a coherent view of self. The mothers in our study underlined the importance of putting memories in its right place and work with oneself. As Courtois & Ford (2009) suggests, the mothers expressed the need for therapeutic support to work through their past traumas.

The substance-dependent women's understandings of what it takes to become a good mother seemed to be heavily influenced by their childhood experiences. The participants' desire to establish the stability for their children that they had missed in their own childhood may be understood in terms of narrative psychology, which explains that humans have a need for coherence, for understanding the course of their lives. Narrative story-telling may give form and meaning to their experiences. The stories we tell about ourselves will organize our sense of who we are. One uses particular narratives in order to achieve particular goals and this contributes to self-construction (Brockmeier & Carbaugh 2001).

Strengths and limitations

Our sample consisted of women who were admitted to a family ward during a limited period of time. All patients who had experienced SUDs in their family of origin agreed to participate. The participants were strategically elected. Thus, these findings can only present examples of understandings and descriptions, and cannot be generalized to all substance-abusing mothers, who have grown up with substance-abusing parent(s). The mothers in this study represent a highly vulnerable group, characterized by feelings of shame, guilt, low self-esteem and a chaotic lifestyle. This will often make it difficult for researchers to access these individuals. The present study, however, was made possible through the first author's employment in a research unit linked to the inpatient clinic where the mothers were admitted. This presented a unique opportunity for research, and reassured both the women and their therapists that the interviews would be conducted with sensitivity and understanding. In spite of this, the therapists assessed the women to be too vulnerable for an interview shortly after giving birth, so most of the mothers had been in treatment for several months before their first interview. Thus, their

responses to the interview were probably influenced by what they had learned during their inpatient stay.

Implications

The women at the family ward usually stay for 1 year. The clinic aimed at giving the mothers and children a good start. Regardless of this, when the mothers leave the clinic, they will need extensive follow-up for several years and probably further support to stay abstinent for the rest of their lives. They are lacking experience with abstinent life outside of the clinic, and need social support. In addition, they will also need close guidance by appropriate role models for motherhood. Lieberman *et al*. (1991) found that mothers can improve the quality of attachment and social-emotional functioning through psychotherapy. For many, therapy may need to continue after discharge.

The mothers had started learning parenting skills at the clinic, but they need prolonged guidance. Some participants described group sessions focusing on attachment behaviour and theory (e.g. circle of security; Powell *et al*. 2009) as helpful. They also referred to the usefulness of video-based interaction analysis like the Marte Meo method (Hafstad & Oevreeide 2004). The women also need to learn everyday family duties and activities, e.g. how to cook, clean, manage their finances and help children with homework. Child protection services and social welfare services may be essential for providing this type of guidance and support after the families have left the clinic.

The women in our study suffered serious impairment in their social networks. They needed to keep their old network at a distance to feel safe. Despite their need to build new support networks, many of these mothers were vulnerable in close relationships because of prior adverse experiences. It may be essential that the mothers obtain guidance and support on how to enter different social arenas for families with children (e.g. participating in leisure activities, school arrangements, arranging birthday parties). They may also benefit from participating in self-help networks like 12-step programmes, as described in Vederhus & Kristensen (2006).

CONCLUSION

The present study illustrates how women in treatment for substance abuse who have grown up with substance-abusing parent(s) perceive the challenges and possibilities they face when they become mothers. This knowledge can increase our understanding of the type and degree of help that may be required to be able to break the cycle of adverse childhood experiences across generations. The findings support the assumption that substance-dependent mothers may need guidance and support in many areas of life and over many years after inpatient treatment. The women may need therapeutic help to integrate their traumatic experiences and develop a coherent view of self. Through close guidance and monitoring in everyday life and having appropriate role models available, they may hopefully learn to create a safe and predictable family environment. Community-based programmes training parenting skills could be helpful. Participating in 12-step groups could support women to stay abstinent and start to build a social network. Child protection services and social welfare services should teach them to accomplish everyday family duties and activities as well as how to enter different social arenas for families with children and gradually develop a safe and supportive social network.

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