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

Eli Marie Wiig
Universitetet i Oslo Det medisinske fakultet, Oslo, Norway

Astrid Halsa
Høgskolen i Lillehammer, Oppland, Norway

Jørgen Bramness
ROP Nasjonal kompetansetjeneste for samtidig rus- og psykisk lidelse, Sykehuset Innlandet HF, Divisjon Psykisk Helsevern, Brumunddal, Norway

Siv Merete Myra
Universitetet i Oslo Det medisinske fakultet, Oslo, Norway

Bente Storm Mowatt Haugland
Uni Research AS, Bergen, Norway

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 to learn to live without substances, the children need a predictable and structured environment with parents who are sensitive and psychologically available. In this study we explore the possibilities and challenges of this joint approach from the perspectives of professionals employed in an in-patient facility for families with parental SUD. **Methods:** A qualitative design was used comprising three

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Corresponding author:
Eli Marie Wiig, Universitetet i Oslo Det medisinske fakultet, PO Box 1039 Blindern, NO 0315 Oslo, Norway.
Email: eli.marie.wiig@borgestadklinikken.no

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:** Professionals faced difficulties combining the needs of parents and children and seemed to choose to prioritise either the adult with SUD or the wellbeing of the child. However, some professionals described what might be a third and alternative solution by supporting the mothers in everyday life, routines, and care, through exploring present moment situations. This approach seemed to help parents become more conscious of the child, their interaction with the child, and their own feelings. Professionals described working at the family ward as emotionally challenging. **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 experienced as a complex and demanding task. Different priorities and treatment aims may enhance tensions between professionals. Even though professionals experience in-patient dual treatment as challenging, they believe this approach facilitates positive development in substance dependent parents and their children.

Keywords

dual treatment, emotionally challenging work, focus group interview, inpatient family-treatment, parental SUD, parenting, present moment situations, professional collaboration, thematic analysis, therapist perspective

A considerable intergenerational transference of substance-use disorders (SUD) has been documented (Barnard, 2007; Dube et al., 2003; Jääskeläinen, Holmila, Notkola, & Raitasalo, 2016). Prevention of such transference is an important challenge that needs to be addressed. Intergenerational transference relies on a strong genetic liability interacting with environmental factors (Kendler, Aggen, Tambs, & Reichborn-Kjennerud, 2006; Verhulst, Neale, & Kendler, 2015). A recognised 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 poor child development and adjustment (Weisner, 2010). More generally, dysfunctional parenting has been found to affect child outcome in families with parental SUD (Anda et al., 2006; Keller, Cummings, Davies, & Mitchell, 2008). Dube et al. (2003) and Felitti and Anda (2010) found that the development of substance dependence is associated with traumatic childhood experiences. Thus, helping parents with SUD to develop adequate parenting skills and to protect their children from experiencing adverse and traumatic episodes, may contribute to the prevention of intergenerational transference of SUD (Arria et al., 2013), and should therefore be given priority.

To reduce the environmental risk factors for children of parents with SUD, interventions should target the whole family (Copello, Templeton, & Velleman, 2006), preferably from the time of pregnancy or the child's birth. The children and their parents may benefit from being better integrated into society with regard to education, work, and social networks (Wiig, Haugland, Halsa, & Myhra, 2017). Such integration could also contribute to the prevention of intergenerational transference of SUD, and may imply large long-term financial savings for society (e.g., healthcare, social welfare, and criminality costs).

The current study explores employees' perspectives of the therapeutic treatment (treatment which aims to heal, e.g., a disease) delivered at a family ward in an in-patient

facility for families with parental SUD. In a previous study we have interviewed mothers admitted to the same family ward (Wiig et al., 2017). We found that the mothers reported experiencing a range of major challenges. Some mothers experienced themselves as outsiders in society (e.g., having no education, minimum job experience, poor social support, feelings of being stigmatised), and needed help to reduce their experiences of marginalisation. All mothers needed to abstain from substances, process traumatic experiences, build new supportive social networks, and establish a safe and predictable family environment for themselves and their children (Wiig et al., 2017).

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. According to the guidelines, 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, internationally, as well as in Norway, 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 also involves other family members, including children (Copello, Templeton, & Velleman, 2006). In spite of research and guidelines recommending that SUD treatment should include family members (Copello, Templeton, & Velleman, 2006; Goldenberg & Goldenberg, 2012; Neger & Prinz, 2015), in reality this is often not implemented (Selbekk & Sagvaag, 2016).

However, there has been a development of designated in-patient family wards in SUD institutions, where the aim is to treat the SUD patient and at the same time prevent development of SUD in the next generation (Arria et al., 2013). This dual treatment approach aims to address both substance abuse and parenting difficulties simultaneously. This development is supported by Mayes, Rutherford, Suchman, and Close (2012)'s findings on neural and physiological reorganisation and adaption in SUD parents during pregnancy and after birth. They call attention to how adults change when facing parenthood, and suggest that this is a developmental phase which is initiated when the parents start caring for a child. Mayes et al.'s study emphasises the need to support parenthood early on, during pregnancy or infancy. However, Arria et al. (2013) found that the relative focus on parenting issues in dual treatment was less than the addiction treatment issues (e.g., increased emotional regulation, structuring everyday life, building positive coping strategies to reinforce sobriety).

Most dual treatments described in the research literature are outpatient treatment (Neger & Prinz, 2015). Residential SUD treatment for whole families, including children under the age of 18 years, typically lasts for only three to four months (Clark Hammond & McGlone, 2013). Consequently, there are limited descriptions and evaluations of long-term in-patient family treatments of SUD (Neger & Prinz, 2015). In Norway in-patient dual treatment usually lasts for at least 12 months. Due to more hours together with the patients in their everyday lives, long-term in-patient treatment may give a better opportunity to explore *present moment* situations (Stern, 2004). Stern 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 from another person's mind in the present moment.

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. However, Pajulo et al. (2010) found it useful to train reflective functioning to develop

sensitivity to the child, and to improve interaction, between addicted mothers in treatment and their children. Parental reflective functioning is a concept for understanding parents' interaction with their child (Slade, 2005). Fonagy and Target (1997) show that the ability to understand interpersonal behaviour in the form of mental states plays an important role in the organisation of the self and the regulation of emotions. The child's understanding of mental states (i.e., reflective functioning) is developed through the care provider mirroring the child's emotional state. The development of this understanding may be impaired if the child is exposed to serious relational conflicts, neglect, acute stress, or trauma. A mother's reflective functioning is assumed to affect her parenting skills, the child's ability to develop secure attachment, and eventually also the child's own capacity for reflective functioning (Fonagy & Target, 1997).

To better understand the barriers and facilitators in the implementation of a new treatment approach, it is valuable to explore the professionals' attitudes towards the approach (Oreg, 2006). Rutman, Strega, Callahan, and Dominelli (2002) investigated social workers involved with mothers who had been placed in foster homes as children. Rutman et al. found that the professionals had a tendency to see generational transference of psychosocial problems as unavoidable, partly because the mothers were unable to prioritise the parenting role and partly because they were perceived as being "undeserving" mothers. This was a study of mothers who had been under care, but the findings could also be of relevance for mothers in dual substance abuse and parenting treatment. In line with this, Virokannas (2011) found that SUD mothers were reluctant to seek help because they were afraid that professionals might assess them as not being good enough mothers. 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 in-patient 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.

An important step in evaluating a residential dual SUD treatment, may be to explore the challenges and opportunities of this treatment approach from the perspective of the professionals. With this starting point we aim to explore the following research questions: How do professionals describe the opportunities and challenges they experience when working with addicted parents and their infant children? How do they understand the aims of the treatment, and their own roles as professionals, in preventing intergenerational transmission of SUD?

Methods

Treatment and treatment setting

The following description is based on the first author's previous research interviews with mothers treated at the in-patient family ward (Wiig et al., 2017), several visits to the ward, three focus-group interviews conducted with staff members, and the institution's written guidelines (unpublished). The family ward admits up to 13 families with serious parental SUD (according to ICD10, F 10–19), including pregnant women and couples with infants and preschool children (mostly 0–4 years). Most families comprise single mothers with infants. Usually the in-patient 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 encourage patients to take part in joint activities (e.g., physical training, walking with the children in strollers, artistic hobbies).

The treatment includes a range of activities aiming to help patients become sober and at the same time prepare them for parenthood and to care for their child. An important aim is to prepare the patients for life as a family after the in-patient treatment. The following components

are central during different, partly overlapping, phases of the in-patient treatment: coping with bodily changes related to giving birth, everyday life with a newborn child, the parents learning to regulate their own difficult emotions, parenting training, processing negative experiences/trauma from the parents' own childhoods, and planning a life for the families after discharge from treatment.

In addition, the treatment includes regular SUD interventions (e.g., problem-solving skills, structuring everyday life, building positive coping strategies to reinforce sobriety), helping the parents reflect on their attachment patterns and how they interact with their infants (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 overall aim is to assist parents in facing the challenges of parenthood without using substances. Different treatment modalities are applied 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.

Participants

The head of the family ward was contacted and scheduled the focus-group meetings with the staff. 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, two men). Two focus groups comprised staff members who spend most of their working hours at the ward together with patients, hereafter called "ward staff". They were registered nurses, midwives, nursing assistants, preschool teachers, social workers, and housekeeping staff. All were considered to actively participate in the therapeutic work with the patients. The first group consisted of seven ward staff, some having more than 20 years of experience working with SUD patients, while others were quite new (from three weeks to three years of experience). The second focus group comprised four members of ward staff who all had long experience working with SUD patients (five years or more). The third focus group consisted of four staff members, all responsible for the parents' and families' scheduled treatment sessions, both individual and group sessions. The members of this group had the following professional backgrounds: child psychologist, family therapist, child welfare therapist and social welfare therapist. To distinguish them from the ward staff, they will be called "therapists". In general, the therapists were more inexperienced in treating SUD patients (between one and three years).

All employees were invited to participate with 15 of 16 employees (94%) taking part in the focus-group interviews.

Interviews

All three focus-group meetings were held at the institution. The discussions were audio-taped and later transcribed verbatim by the first author. Each focus-group interview lasted for approximately 1.5 hours.

The aim of the interviews was to investigate experiences and perspectives of employees towards working with addicted parents and their children. We wanted to facilitate discussions among professionals where unexpected themes might appear and where individual experiences and perspectives could be described and elaborated on in discussions among colleagues. Hence, focus-group interviews were chosen as the data collection method (Wilkinson, 1998).

However, when using the focus-group method, it is essential to facilitate a safe environment for the participants, so that they feel comfortable and find it easy to participate and express themselves. It was likely that the experiences and perspectives of the ward staff and the therapists would differ, since they are situated at different levels in the institutional

hierarchy. Therefore, we chose to interview them in separate focus groups. In group interviews it may be difficult to share opinions which differ from the majority in the group (Wilkinson, 1998). If the groups had been mixed, the ward staff would be in majority in all groups. Therapists might not be heard, or, alternatively, ward staff might not share their opinions in groups with therapists, who are situated higher in the institutional hierarchy.

The interview guide was based on the following main question: How do you understand your roles and contributions during in-patient dual treatment of families with SUD at the family ward? After sharing their personal information (name, education, and duration of 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, trying to make the focus-group members elaborate on their descriptions, 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 on this further?"

All participants elaborated on their personal understandings of the aims of dual treatment and how they contributed to the therapeutic work with the families. The interviewer was careful not to steer the following discussions towards any particular theme or in a particular direction. The questions in the interview guide were intended to be used as clues if the conversation paused.

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. The study focuses on exploring the experiences of the professionals. In phenomenology, experiences from the personal lifeworld are considered valid knowledge (Giorgi, 2009). Analysis was carried out using *thematic analysis*, an analytical method described in detail by Braun and Clarke (2006) where the stepwise methodology facilitates a systematic analysis. Thematic analysis was chosen because it is viewed as suitable for cross-cutting analysis with several respondents.

During the analysis we tried to stay open minded and to bracket our own preunderstandings in order to describe the object of study as thoroughly as possible. In phenomenology and qualitative research it is considered especially important to be alert to the researchers' own preunderstandings.

After listening to the audio-recordings and reading the transcripts several times, a first impression with some initial ideas was noted, based on topics the respondents spent a lot of time talking about, as well as issues that several respondents emphasised during discussions. Initial codes were generated through systematic coding of extracts from the texts that seemed relevant to the research question (see Table 1). After rereading the transcripts, initial codes identified as being particularly relevant for elucidating the research question were collated into potential themes. In the next step these potential themes were checked to make sure they fitted both with the initial codes and the whole dataset. For example, the potential code *The angle 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 dataset was reread, to check that the potential codes were relevant and valid to the dataset as a whole. A synthesis of the potential themes resulted in three final themes, described in the results section. Table 1 gives an extract of the process of analysis.

Ethical considerations

The study was approved by the Norwegian Ethics Committee for Medical Research (REK

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 adult"
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		
Therapists must support each other	Risk of burnout syndrome	
Ward staff feel frustrated	Attitudes mirroring the marginalisation	

number 2011/879b) and followed the guidelines from the Helsinki Declaration. The participants received both verbal and written information on the study before consenting to participate.

Results

The professionals were asked to describe opportunities and challenges they experienced when working with addicted parents and their infant children. How did they understand the aims of the treatment, and their own roles as professionals, in preventing intergenerational transmission of SUD? In all three focus groups the participants were occupied with the difficulties of prioritising between different treatment aims and tasks. Besides this common feature, the themes that were emphasised were quite different in the three groups. The first group focused on issues related to patients practising skills for everyday life at the ward. The second group focused on the complexity of the patients' needs. In this group all members expressed quite critical viewpoints, requesting more cooperation between ward staff and therapists, and expressing a need for increased staff resources. The third focus group (the therapists) emphasised the need for therapists to support each other, and discussed how to regulate their own emotions during demanding treatment sessions. They emphasised collaboration within their own group. Taken together, the focus-group interviews revealed a tension between the perspectives and priorities of ward staff compared to those of the therapists.

Three dominating themes emerged from the transcripts: (1) "Rescue the child" versus "treat the adult", (2) Supporting the mothers – everyday life, routines and care, (3) A demanding line of work.

"Rescue the child" versus "treat the adult"

The timing of treatment approaches was 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 "*parents* 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 foci. Their foci were positioned along a continuum from (a) *rescue the child from difficult experiences* towards (b) *treat the adult 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' experience). Their main motivation for therapeutic work with SUD patients was to contribute towards positive development for the children.

> I decided to accept this position when I realised that it would be possible to build a treatment plan for the young children . . . We must prioritise the children's needs . . . To gain access to the children I had to connect with their parents. . . . "How will it affect your child if you keep thinking about substances?" . . . We need to focus mainly on parenting. (Therapist, new)

There were respondents with this position both among ward staff and therapists. However, they were all relatively less experienced in the addiction field. They 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.

> 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? (Ward staff, new)

Treat the adult. Professionals who regarded the addiction itself as the primary treatment focus, taking the treat-the-adult position, claimed that staff should take advantage of the child's being a unique motivational factor for the parents. They described becoming a parent as a "window of opportunity" for change, and felt that it was important to take advantage of the possibilities the pregnancy and the child offers. 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). These professionals argued that they were trying to help the parents to consider 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 children could motivate them to tolerate the strong emotions that emerged as they became abstinent.

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

> 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. . . . 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 in-patient stay. It must be terribly frustrating for them. (Ward staff, experienced)

These professionals, most with many years of experience of treating SUD patients, acknowledged that the mothers might have coping experiences when interacting with their child (i.e., the child responding to her, being able to satisfy her child's needs) 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 experience of failure.

> 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. . . . Parents cannot help their children before they are able to help themselves. (Ward staff, experienced)

These professionals wanted the parents first to cope with their own problems. Only after this had been achieved would they be able to offer security and structure for their child.

Different timing of approaches caused tensions. All the professionals shared the family-therapy perspective. In spite of this, there seemed to be at least two different interpretations of what should be the primary focus of the treatment: one on helping the mother to deal with her own disturbing thoughts, to increase her ability to regulate emotions, to overcome previous trauma experiences, and to create structure in everyday life (treat the adult). 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 (rescue the child). The different interpretations of the family-treatment approach caused tensions between the professionals. The second focus group included only experienced ward staff members. They expressed doubts about the "rescue-the-child" approach of the therapists, and tensions between themselves and the therapists were expressed. They felt their arguments were sometimes ignored by the therapists.

New principles meeting traditional treatment. Most therapists (the third focus group) 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 therapists being less experienced in traditional treatment principles for SUD patients. In the second ward staff group, all participants were experienced with SUD patients, and expressed frustration about the treatment focus of the therapists. The first ward staff group, however, comprised both new and experienced ward staff members. In this group the two treatment foci seemed to co-exist. No tension between treatment foci was expressed. Instead the members seemed to agree on a third focus, taking advantage of the present moment situations that could suddenly arise at the ward.

Supporting the mothers – everyday life, routines and care

Training for everyday life at the ward was a major topic, especially emphasised in the first focus group with ward staff. They 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 at 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.

> 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. (Ward staff, new)

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 how she thought the alliance contributed to one patient succeeding in treatment.

> 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. (Ward staff, new)

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 at the ward, opportunities arose where the staff could talk about impulse control and remind parents of their goal of becoming sober. Thus, through this approach they seemed to a certain degree to combine the aims of *rescuing the child* and *treating the adult*.

> 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?" (Ward staff, new)

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 at 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.

> 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 . . . 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, experienced)

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 quotation shows how they used present moments to train reflective functioning:

> "Mama, look at me now!" . . . Now he needs to "fill up his cup" . . . (Ward staff, new)
>
> "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? (Ward staff, experienced)

A demanding line of work

Exhausted by patients' 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.

> 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. (Therapist, new)

After sessions they needed to calm down, take care of themselves, and support each other. To care for themselves the therapists also expressed the need for working in teams during sessions.

> 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. . . . (Therapist, new)

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 SUD patients, whereas others described that working with addiction was less appealing. Some therapists expressed that they did not initially plan to work with SUD patients. They had been reluctant to work on the family ward, but had accepted the position because it provided an opportunity to work with small children.

Some professionals seemed to have attitudes towards this work which mirrored the social stigma patients with SUD meet elsewhere in society. These attitudes may reflect the marginalisation 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:

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

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

> 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. (Ward staff, experienced)

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 patients, with sudden changes in behaviour, strategies 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.

> 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 . . . (Ward staff, experienced)

Discussion

Therapists and ward staff at an in-patient family ward for dual treatment of parents with SUD and their unborn, infant, or preschool children, were asked to describe their work and how they understood their role in preventing intergenerational transmission of SUD. Three different themes emerged from focus group discussions: (1) "Rescue the child" versus "treat the adult", (2) Supporting the mothers – everyday life, routines and care, and (3) A demanding line of work.

To achieve abstinence and facilitate a well-functioning family, a range of issues need to be addressed in treatment. This gave potential for different priorities between professionals, and the three focus groups emphasised different tasks and challenges. The fact that the main viewpoints expressed in the three focus groups turned out differently may be caused by dominant voices making it difficult for others to express differing understandings or experiences (Parker & Tritter, 2006). We tried to prevent this by sorting therapists and ward staff into separate groups. On the other hand, it might have been even more difficult to express arguments that differed from their closest colleagues, at the same level of the organisational hierarchy. However, during the focus-group interviews we observed that all focus-group members expressed themselves and those who did not come forward of their own accord were especially invited to speak.

Different prioritising between treatment foci may explain the tensions found between professionals. Experienced ward staff 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 less experienced therapists were concerned about demanding treatment tasks and the need to support each other as therapists and to balance oneself emotionally. The differences may be understood as a result of the professionals' length of experience, as the more experienced professionals seemed to agree on the "treat-the-adult" perspective, whereas the newer professionals chose the "rescue-the-child" perspective. The focus group which was a mix of new and experienced ward staff members, chose to focus on everyday life at the ward instead.

Different treatment foci

Professionals chose different paths regarding the combination of the needs of the child and the adult. 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., 2010). 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 off from substance use, and of signalling that the SUD parent is of less interest as a patient, which introduces the danger of reinforcing the patient's already low self-esteem and feelings of stigma.

A review by Neger and Prinz (2015) concludes that dual treatment of SUD and parenting can 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 with no trauma-oriented treatment. Mayes et al. (2012) suggest that parental reflectiveness should first focus on thinking about their own development as parents. According to Neger and Prinz (2015), better outcome is found when SUD patients go through treatment that addresses psychological processes in the adult first, and afterwards learn to care for the child. Neger and Prinz (2015) and Mayes et al. (2012) seem to support the "treat-the-adult" approach.

While employees who emphasised interaction training were relatively new to the addiction field (3 weeks to 3 years), those who argued for prioritising fundamental psychological processes were experienced addiction workers (5–23 years). The different opinions could therefore be an expression of the phenomena of new treatment principles meeting tradition (Oreg, 2006). The lack of collaboration between ward staff and therapists might have led to a wider gulf between the two perspectives.

Whittaker et al. (2015) found anxiety related to helping both parents and children among practitioners working with families with parental addiction. The practitioners were unsure of their role and afraid of taking on responsibility for interventions. They described the families as difficult to engage and worried about lack of resources and support, but felt more reassured about the addiction treatment aimed at the parents. Discourses among professionals constitute and change institutions, the patients' identities, and social relations both inside and outside of the institution (Jorgensen & Phillips, 2002). If the discourse – to treat the adult or rescue the child – is acknowledged and reflected upon by professionals in dual treatment, 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.

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 and motivating parents to also continue structuring their everyday life after discharge from the family ward. The finding is supported by Weisner's (2010) research, which stresses 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 was the description of how the staff used present moments to facilitate growth in the SUD patients, concerning impulse control as well as sensitivity towards the child. This is in line with Stern (2004) who argues for the utilisation of present moment situations. The ward staff, in particular, used shared moments in the everyday life at the ward, to support parent–child interaction and interaction between co-patients. They used present moments to support the parents' reflective functioning (Slade, 2005), trying to demonstrate to the parents how their children signalled emotional, physical and social needs. Present moment situations were also used to reinforce new parenting skills, to achieve 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 the patients' belief in their ability to achieve an integrated "normal" family life outside the family ward, an aim previously identified as being of major importance for these families (Wiig et al., 2017).

By being trustworthy, predictable, available, and supportive, the professionals tried to build a therapeutic alliance with the parents, a major ingredient of any treatment. Facilitating the development of a therapeutic relationship is described as being particularly important to support mothers with SUD in their 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 an approach used in order to combine the focus on the child as well as the parent–child interaction, and the SUD adult. Through exploring present moment situations on the ward, the professionals were able to shift focus back and forth between the emotions and needs of the

child and the parent, and the interaction between them.

More collaborative work

SUD patients have multiple risk factors, and may have developed survival strategies that are a challenge for the professionals to understand and deal with during treatment. Prioritising and timing between different treatment aims in dual treatment may lead to an even more significant emotional burden. This may lead to the professionals feeling that their interventions are insufficient or inadequate and enhance emotional exhaustion. In general, high turnover rates have been found among clinical staff treating SUD patients (Young, 2015). This turnover has been linked to burnout syndrome (i.e., emotional exhaustion, cynicism or a diminished sense of efficacy) (Young, 2015).

Hood (2016) studied cooperation between service providers involved in the care of children and adolescents (child welfare, social services, education, healthcare and juvenile crime), and found that the staff felt pressure to adapt their roles and activities to the system they were part of. They sometimes renounced their own professional requirements. Hood's (2016) findings shed light on frustrations expressed by the ward staff in the current study. Sælør, Ness, Borg, and Biong (2015) found similar challenges in the working conditions of employees in addiction rehabilitation. These employees found their work organisation to be too rigid and restricted to allow for the flexibility and openness they considered necessary to maintain hope. Dual treatment includes additional and ambitious treatment demands, not only focusing on the SUD patient, but also on parenting and the welfare of the child. Professionals in dual treatment may therefore experience even higher demands than in traditional SUD treatment. It is not unlikely that this may be associated with increased emotional stress.

The tensions found between professionals may be understood as a deficit in collaborative practices which nourished subcultures, leading to increased polarisation between different treatment foci. When the aims and perspectives are both multiple and challenging, some degree of tension between professionals may be expected (Nes & Moen, 2010). Nes and Moen (2010) describe that a mixture of separate knowledges has to be negotiated, in order to integrate the different approaches. Robinson and Cottrell (2005), furthermore, argue that professionals need to appreciate each other's different competencies, and be aware of the strengths of individual colleagues. Hence, they may create a common language and perspective, and act in a complementary way. Suter et al. (2009) also found that collaborative practice requires that professionals comprehend their colleagues' roles and responsibilities, and that they communicate well. These are measures that may contribute to an integration of different perspectives among professionals, such as those found in the current study.

Strengths and limitations

The current study is a follow-up of a previous study where the understandings of mothers with SUD in treatment at an in-patient family ward was investigated. Having the perspectives of both patients and professionals strengthens the present study. An important limitation is, however, that patients and professionals from only one institution have been included. The findings may not be generalisable to other institutions offering dual treatment, and therefore only provide local descriptions. However, the review of Neger and Prinz (2015) indicates that tension between different treatment foci and timing of treatment approaches may be a relevant and significant discussion in the field of family treatment of SUD patients. The different priorities and the tension between staff members may be descriptions with relevance also for other professionals and institutions offering dual treatment of SUD, parenting, and the welfare of children, in SUD families.

Recruiting as many as 15 of 16 employees at this particular family ward was a strength of the study. The quality of the focus-group discussions seemed good, with all participants making themselves heard in the discussions, and relevant 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 is supposed to address the parents' SUD problems, the needs of the infant, and the family as a whole. This was described as a complex treatment, with many simultaneous tasks and aims. The staff often ended up choosing either addiction treatment or interaction training as their first priority. The different approaches appeared to create tensions between employees, and professionals expressed different attitudes towards SUD patients. Attitudes mirroring the marginalisation of SUD patients may be an obstacle towards reintegration of families into society, and different attitudes may further challenge collaboration between staff members. Additionally, they found the work to be emotionally demanding, which may also challenge employee collaboration.

However, the treatment at the family unit was also used to provide training in everyday routines and to utilise present moment situations therapeutically. The in-patient setting provided the opportunity for patients and staff to build therapeutic alliances, which enabled training in parenting skills, reflective functioning, structure, and the ability to resist cravings. The staff involved in this work seemed to be on the way to integrating the two different treatment foci, in a way that allowed for focus 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 at the unit for at least one year but need close follow-up care for many years afterwards. Although this is costly, it can be profitable, both financially and personally, if the cycle of intergenerational transmission of substance use problems is broken. It would be of interest for future research to interview professionals in the various services outside of the institution (child welfare, public health clinic, school, kindergarten, social services) to identify follow-up elements which contribute to good or unfavourable pathways over time for families with parental SUD.

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