Mothers with substance and alcohol abuse—support through pregnancy and early infancy

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Becoming a parent implies great changes in the lives of both mothers and fathers on many different levels. Preparing for parenthood may involve changes in housing, employment and social network, but the thought of being responsible for a baby also affects the self-image and the individual identity. For future mothers and fathers who have problems with abuse of alcohol and/or drugs, pregnancy may be regarded as a problem. However, pregnancy may also be a strong incentive for future parents to seek help to be able to stop using alcohol/drugs. To provide support for future parents who have problems with addiction to alcohol and/or drugs is a great challenge for professionals within health care as well as within social work. In this article, we will focus on the support given to pregnant women and mothers with young babies, at an antenatal and child welfare team in Gothenburg, specialised on working with mothers who abuse alcohol and/or drugs. The MBHV-team (Maternal- and child welfare health care team in Haga) in Gothenburg is one of few professional antenatal and child welfare care teams in Sweden that have the competence to provide such support to this group of women. The results presented in the article draw on a study of 17 women, who used the services of the MBHV-team during their pregnancy, and also during the first 6 months after their babies were born. The aim of the article is to account for how the women experienced the support they got during the time they used the services of the MBHV-team, and how they perceived the impact of this support on their perinatal experiences, and their ability to refrain from alcohol and/or substance abuse.

Antenatal care in Sweden

The Swedish antenatal care system was introduced in the 1930s. Antenatal care is organised within the primary health care system with the midwife as the primary caregiver. It is free of

charge, and is provided to all pregnant women in Sweden. Usually parents meet the same midwife during their antenatal visits. There is no routine visit to a medical doctor. If the midwife has concerns about the pregnancy, or the pregnant woman herself has a need or a wish to meet other professionals, the midwife will refer the woman to a unit with more specialized care (Hildingsson et al 2013). The first visit to the antenatal care usually takes place between the 6th and the 12th week of pregnancy. According to a national Swedish study, first time mothers reported on average 11 visits to the midwife at the antenatal clinic, and repeat mothers' averaged 9 visits. The majority of women were satisfied with the number of visits to the midwife (Hildingsson et al. 2002, 2005).

The MBHV-team

The team first started to give their services to pregnant women in 2007. The unit is a joint venture between the primary health care in Gothenburg and in south Bohuslän (county north of Gothenburg) and the clinic for treatment of drug- and alcohol abuse at Sahlgrenska University Hospital in Gothenburg. In the MBHV-team, the women have access to the services of midwives, nurses, one gynaecologist, one paediatrician and one social worker.

At their first contact with the MBHV-team, all women are informed of the structure used at the MBHV-clinic. This structure includes frequent visits of the women at the clinic, as well as regular urine tests, to check that the women refrain from using alcohol and/or drugs. However, albeit this fixed structure, all professionals strive at being as flexible and dynamic as possible, and adjust to every woman's individual needs and wishes.

Risks for children

If a woman abuses alcohol or drugs during pregnancy there is a risk for adverse perinatal outcomes for both mother and foetus and there is an increased risk for morbidity and mortality

for the mother, foetus and the newborn (Goodman & Wolff, 2013). Alcohol exposure in utero can cause long-term disability (Burns et al. 2013). Childhood is a critical period in life, and children's experiences during their first years are critical for their future. According to Killén (2009) there is probably no other risk factor that affects children more than parent's substance and/or alcohol abuse. Several studies that focus on the consequences for children of parents with alcohol and/or substance abuse show that the children are put at risk on several levels (for example: Backett-Milburn, 2008; Claezon, 1996; Barnard & Barlow, 2003). This does not only affect young children, but can also result in adverse life circumstances later in life. There is a four- to sevenfold increased risk of the existence of alcohol and/or substance abuse for young people whose parents have had addiction problems (Hjern et al. 2014). In comparison with the majority population, the risk to die a violent death is threefold and there is an increased risk for leaving school without passing grades for young people whose parents have had addiction problems (ibid.).

Pregnancy as 'turning point'

Women often interrupt or refrain from abuse of substances and/or alcohol during pregnancy. Trulsson (1997, 2003) and Skårner (2001) found that parenthood, for both women and men, is a powerful motivating factor for refraining from the abuse of substances and alcohol. In Radcliffe's (2011) study women reported that pregnancy or the birth of babies was a 'turning point', which made them re-evaluate their use of substances and their life stiles. There is evidence for positive effects of interventions in conjunction with substance and/or alcohol abuse during pregnancy and that pregnancy is a powerful motivating factor for women to interrupt their addiction while receiving social support and treatment focusing on both the addiction and on parenthood (Andersson et al. 2006).

Female perspective on substance abuse

According to Sheffel Birath and Borg (2011) a third of the patients within the addiction care are women. Developmental theories have specifically stressed mother's responsibility for their children (Kristjansson, 1999). Childhood and children's needs became, because of these theories amongst other reasons, strongly connected to how women understand motherhood (Elwin-Nowak, 1999). Addiction can make it difficult or impossible for women to take responsibility for their children and to care for them in a way that benefits their development. The responsibility for children is strongly connected to mothers, therefore women with a substance abuse are looked upon as more deviant than men. Thus, women have more barriers to overcome than men, and consequently the probability is lower that they receive care for their addiction (Trulsson and Segraeus 2011). These barriers are for example: lack of interventions for pregnant women and that women have a fear of being stigmatised which makes them trying to conceal their addiction and being reluctant to seek care. Some of the women in Dowdell's et als. (2009) study were scared of having their baby removed from their care. They tried to be "normal mums" and found accessing mainstream services hard. Goffman (1971) state that a requirement for stigmatisation is that there is a difference between the expected and the actual social identity, in this case the social identity as a parent. When an individual diverges from what is regarded as the normal pattern, insecurity is created as for identity and belonging. The prevailing conception in our society of what constitutes a good parenthood becomes the norm, which can imply negative self-perceptions for the individual parent. Women with substance and/or alcohol problems are often exposed to a "double oppression" and their special problems are emphasized because they do not behave according to the normal gender contract. The perception of a woman as a caring wife and mother forms a sharp contrast to that of a woman with alcohol and/or substance problems. Previous research shows that a mother with such problems is regarded as abnormal and negligent, a view of life and parenthood that the woman herself accepts. She often feels self-

contempt and she often puts the blame on herself. Thus, when in treatment, many women feel the need of compensating for a lack of self-confidence. “Becoming pregnant raises the need for a substance misusing woman to manage her identity in order to avoid the stigmatised figure of the junkie” (Radcliffe, 2011:986). How you treat another human being is intimately linked to the ideas you have of the person in question or perhaps rather what you take for granted concerning the group. Professionals are involved in processes and practices through which identities become established and have the power either to make a label stick or to support the creation of new identities (Radcliffe, 2011).

Services and support

Swedish research about support to parents with substance and alcohol related problems and their children within the antenatal and child healthcare is scarce. This is also the case when it comes to Swedish research about the combination of parenthood and substance/alcohol abuse (Andersson et al., 2006). There is a growing body of international research on treatment for alcohol and/or substance abusing pregnant women.

Several studies show that specialist multidisciplinary services that offer a range of support services promote the needed scope of care for both mothers and babies (Toner, 2008; Dowdell et al. 2009; Morris et al. 2012). An integrated antenatal and addictions treatment might improve both mother and baby outcomes (Mayet et al. (2008). Challenges when working in multi-agency environments can be: different policies, ways of working, philosophies and beliefs (Toner, 2008). According to Trulsson and Hedin (2004) Björkhagen Turesson (2001), Eriksson (1998) and Trulsson & Nötesjö (2000) early and comprehensive support during pregnancy have long term effects, as this reduces the women’s vulnerability in relation to their social situation and decreases the risk for relapse during the child’s first year.

Engagement of women as early as possible and continuity of care are important factors (Morris et al. 2011). According to Fridell (1996), a well functioning care organisation constitutes a high level of interaction between the client and the professional. Long-term contact creates an opportunity to build trusting relationships between midwives and the women and enables the midwife to better meet individual needs (Dowdell et al. 2009). Women need to be provided with clear information about what services and procedures they can expect (Radcliffe, 2011) and they benefit from comprehensive care and professional advocacy (Stone's, 2015).

The attitude of professionals has been found to be a key to how women respond to care (Morris et al. 2011). An equal partnership, a non-judgmental, warm and helpful attitude where the professional shows an interest in the woman's history and succeed in empowering the women to participation are factors promoting a successful treatment (Morris et al. 2011). A non-judgemental and non-confrontational treatment consisting of both individual and group talks are recommended (Sun, 2006; Tuchman, 2010). Professional's knowledge about how power operates is vital and allows processes where women can be empowered by professionals sharing knowledge about pregnancy, legal rights and procedures that might follow if a woman resists medical birthing practices (Fahy, 2002).

When interrupting an addiction, men and women frequently experience a lack of support from their social network as a result of old conflicts and broken relationships. Many women have to build a completely different life, new relationships and construct a new identity in order to in length be able to live a life free of drugs (Trulsson and Hedin, 2004). The women (who used illicit substances) in Dowdell et als. (2009) study tried to distance themselves from earlier friends who used drugs and found it difficult to create new supportive networks whilst the

women who had supportive networks were more likely to succeed in adapting to being a mother. Consequently, women are in in great need of support from professionals who can act as role models and help out in building new and mobilising old relationships (Trulsson and Hedin, 2004).

Requirements of organisations in order to meet the needs of these women and children are high. There are for example high demands on the organisational structure, continuity of staff, knowledge base and social skills of the professionals.

Methods

All the women in our sample were informed of the study by the staff at the MBHV-team. In all, 49 women, who were registered at the team during 2009-10-01 to 2010-09-30, were asked to participate in the study. 36 women agreed to participate, and out of these 17 were finally interviewed. While agreeing to participate, the women gave their consent for us to call them to give further information about the study, and to find a time for the interview. In this process, three women declined participation, due to lack of time. Three wanted us to get back to them later, but when we did so, it was never possible to find a time for the interview. Four cancelled planned interviews several times, and were not interviewed. The remaining nine possible informants never answered when we called. It is possible that these 19 women did not want to participate in the study in the first place, but found it hard to say no, when asked by the MBHV-team. The experiences of pregnancy, childbirth and parenthood may be difficult to share with researchers for this group of women, and we are very appreciative to those who took of their time to answer our questions.

The youngest of our interviewees was 21, and the oldest 40 at the time of the interview. The median age was 30. All of the women (except one who still hadn’t given birth) lived with their children who had been born during the time they used the services of the MBHV-team.

The children were around one year, or younger, when the interviews were performed. Five of our respondents lived together with the father of the child - two of these couples were married. 12 women were single mothers. For 12 women, this was their first child, but five already had children; two previously had one child, two women had two older children, and one had three. The children were present when most of the interviews were performed. In some cases this made it difficult to concentrate on the interview. Still, we found it to be an advantage to also having met the children, which gave us an opportunity to see how they related to their mothers. All of our respondents displayed pride and joy over their children. A more extensive account of the methods used is published in: Nordenfors, M. & Höjer, In (2012) Kvinnors erfarenheter av stöd från Mödra-Barnhälsovårdsteamet I Haga. FoU I Väst Rapport 4:2012. Länsstyrelsen Västra Götaland Rapport 2012:76.

Table 1

Reflections on the sample

Out of the in total 49 women who were asked to participate, we know that six declined to participate due to a difficult life situation, with relapses in substance/alcohol abuse, and/or child welfare assessments, with possible placements of the children in care (the remaining seven declined on other grounds). All the 17 women who participated in the study had a fairly stable life situation, and lived with their children. In order to get to know if the women who did not want to participate in the study were less positive to the support from the MBHV-team we asked four of them about their overall experiences of their contact with the team. All of them though, had overall positive experiences. Nevertheless, there is a possibility that our sample is biased, with a majority of participants who were doing fairly well and were less positive to the support from the MBHV-team.

Interviews

Our respondents could choose the place for the interview. Eight chose to do the interviews at the MBHV clinic, two interviews were performed at the Department of Social Work, University of Gothenburg, and five interviews were made at the homes of the respondents. Two interviews were performed over the telephone. We used a semi-structured questionnaire. Themes of the interviews were: Background, thoughts about the pregnancy, contact with the MBHV-team, support from parents, sisters and brothers, other support, addiction problems, parenthood, view of the child's needs, the future, questions related to specific methods used by the MBHV-team.

Data analysis

All interviews were recorded and transcribed. The interviews were analysed using *content analysis categorisation*. Examination of the data began with multiple readings of the interviews while making notes and identifying emerging themes and categories. Both similarities and differences have been of interest. A constructionist perspective also guided the analyses towards the women's experiences of who they had become in the meeting with the staff. We were interested in studying whether the support offered to the mothers and babies at the MBHV-team is perceived as part of a stigmatising process or if the support is designed in a way that breaks such a process and endorses the possibility of new identities?

Ethics

All women were informed of the study by the MBHV-team, both orally and with written material. We had no access to any individual data or any information about the women, until they gave their consent for us to call them. All women were informed that their participation was voluntary, and that they could end the interview at any point in time. They were also informed that they were anonymous and that the staff would not be informed of individual answers.

The Regional Ethic Board in Gothenburg has approved of the study.

Interviews with the staff

Two group interviews were performed with the staff at the MBHV-team. These group interviews were important for us to understand the background and the context in which the team worked. In this article we don't account specifically for the content of these interviews, but we use the information as a contextual frame for the interviews with the mothers.

Results

Initial ambivalence in relation to the pregnancy

At the first meeting with the MBHV-team there is an introductory information. If there is an early pregnancy, the staff is very explicit that the decision to continue the pregnancy must always be made by the pregnant woman. They provide accurate information on both alternatives – ending the pregnancy or continue – and are very careful to be as neutral as possible. If the woman decides to continue the pregnancy and accepts the conditions of the MBHV-team, they provide support on all levels. The quality of the support from the MBHV-team was of great importance for our interviewees. They felt that they could be open about their ambivalent thoughts, their worries and their fears.

Only three of our interviewees stated that they had planned their pregnancy. For the other women, the pregnancy was unplanned and unexpected. A majority were in an active phase of substance and/or alcohol abuse at the time of the pregnancy. Some women were in new relations when they found out that they were pregnant, and one did not know who was the father of her child (see table 1). Altogether, these factors contributed to a strong sense of ambivalence towards the pregnancy and the thought of future parenthood.

> *At first, I thought it was really difficult. I was just back from six months in rehab, and the first thing I did was to have a relapse. Two days later I found out I was pregnant, so it wasn't exactly what I had planned to do at that stage in my life. I was really worried, what with my drug problems and all, but I decided to set my mind to the positive things, and it has worked out really fine….* (Marie)

Three women had previously made abortions. All of these three stated that this had been such a negative experience that they could not bear the thought of having another abortion, and therefore had decided to continue the pregnancy even though their life situation was difficult.

Support

The mothers who receive support from the MBHV-team are a heterogeneous group and as a consequence the design of the support varies. There are though some general characteristics of the support that the women are offered and which they need to subject themselves to.

Frequent contact and control

Most women had been exposed to difficulties and were in need of special care. The professionals emphasised the importance of not putting too much stress on the women and instead ensured that their contact could advance at a calm pace. The professionals also emphasized the importance of a distinct structure in order to achieve the goal: to be free of substance and/or alcohol abuse, and they are very explicit when they explain the requirements for being admitted to a contact with the team.

Frequent and regular contact characterise the design of the support at the MBHV and agreeing to frequent contact with the MBHV-team is a prerequisite for being admitted to support from the team. Most of the women found it positive to meet frequently with their midwife or doctor, and said that this contributed to feelings of security, of being cared for, and that the chances of building positive relationships with the professionals were good. They emphasised the possibility to be able to get their questions answered and concerns stilled and most of them felt welcomed.

Several of our interviewees accentuated their personal need of structure and experienced that they benefitted from the element of control:

> *At this point, I didn't trust myself at all/../I did really weird stuff, and I liked the control, I needed someone to check what I did.* (Eva)

The control consists of for example regular check-ups and urine samples, to which the women have to submit. Gabriella described the control as helpful and sometimes a necessary prerequisite.

> *It has been great to see both the psychologist, the social welfare officer and the midwife so frequently. And the urine tests every week – I have been able to keep away from alcohol throughout the entire pregnancy.* (Gabriella)

All women had to provide urine samples one to three times a week (exceptions could be made). Some experienced this procedure as unnecessary, but said that they understood the purpose of it.

> *The urine tests – they worked as a kind of barrier…. Well, no matter how much you love your child, once a drug addict, always a drug addict, you have a certain way of thinking and a certain personality… Even if I haven't always liked the urine tests, I think subconsciously they stopped me. Even now I can feel that I don't want to deceive them- the staff at MBHV –team. They have given me such a lot of help, and I just can't let them down after all the support they have given me… I would be an idiot to start using drugs again … of course it is because of my daughter, but I think it was the urine tests that really did it.* (Dora)

For those who were used to providing urine samples in earlier settings it had become a habit, something one does and do not question. The professionals described the handling of the urine sampling as an important and difficult task and stressed the importance of the process being carried out in a good manner. Almost all of the women described that they thought this procedure was carried out in a good manner.

> *They just checked me - I didn't mind, it was nice – like going to the ladies with a friend.* (Eva)

For some of the women the sampling played the important role of proving that they were free from drugs. Only one of the interviewees, Rebecca , experienced the procedure as offensive:

It was awful. I felt as if I was a heavy addict.

Rebecca did not perceive herself as an addict and her description of her contact with the MBHV-team appears to be a struggle to defend herself towards a forced identity as a "drug-addict".

Availability

In contrast to other similar institutions, MBHV-team is characterised by high availability, which is of great importance as a way of alleviating anxiety and worries in order to support the women not to take up on substances and/or alcohol. As a consequence of the easiness for the women to get hold of the professionals, many of the women felt welcomed. Gabriella described how she one Friday morning felt anxious and sad and when she contacted the MBHV she was offered an appointment the same afternoon. She pointed out "otherwise the whole weekend might have been destroyed". Previously, alcohol "alleviated her condition for the moment", calling the MBHV-team was at that time a better alternative. On this occasion, the availability of the support worked as a substitute for alcohol for Gabriella.

According to the professionals, *time* is also connected to availability, and is a prerequisite for being able to provide the kind of flexible support offered. The MBHV- team has no waiting list and is able to meet with their patients within short notice. They also offer to do home-visits. Having access to support at short notice, and also to have access to advice when needed, were perceived as one of the most important positive experiences of the MBHV-team. Many of the women stated that this availability constituted an immense contrast to their previous experiences of support from general health care and other services, They were used to being put on waiting lists, and having to spend hours trying to get in touch with their social worker or doctor.

A holistic perspective

The MBHV-team offers a vast variety of support. Traditional maternity and child care such as medical care and controls, information about pregnancy, childbirth and so forth is the base. Beyond this the women described that they had received support with obtaining housing, with legal processes, transport, economy, contacts with authorities, counselling, acupuncture and so forth.

> *I had a disagreement with social services, and I came here and cried and didn't know what to do…. And she called my caseworker /…/they go the extra mile, they know about my personal problems, not only about my drug addiction and my son, but also about my housing situation, what other problems I have…* (Henrika)

Several of the women testified of the professional's holistic approach and the importance of the same. To receive support with basic functions such as housing and economy is a prerequisite for being able to deal with the challenges of addiction, parenthood and social relations.

All women received counselling concerning matters such as parenthood; addiction; parent-child relations and their own wellbeing; Pernilla told us about receiving help with handling anxiety.

> *How to cope with different problems, like anxiety… and other things/../That's why I used this service, because I got a lot of help with this, and I'm really grateful…..* (Pernilla)

Several of the women had contacts with other authorities such as the social welfare office and the mental health care. Coordinating these contacts was an important and appreciated part of the provided support, which often lead to speeding up otherwise protracted processes. Dora described how important such support had been to her:

> *… my midwife is a wonderful woman and she has really been there for me. She has called landlords and contacted socialworkers. I have had contact with the healthcare centre and the psychiatry. They* (all units) *have had contact between themselves. It has been great that they* (the MBHV-team) *established and kept in contact with all my service-units.*

Several of the mothers received help with contacts with social services, and also other services, such as establishing contacts with psychologist and pre-schools.

Trusting relationships/participation

There are many texts that emphasize the importance of the relationship between professionals and patients when working with different treatments, the relationship as a means to reach the purpose of the treatment. A good reception is a necessity for the midwife to be able to approach future parents (Agnetun and Danielsson, 2002). A member of the staff at the MBHV-team stressed the importance of creating a climate where the patient dares to be honest. This can mean that you have to progress slowly and refrain from certain questions, to be aware of how the woman feels, and meet each of the patients individual wishes.
Along with several others, Nina described the support as designed by her requests:

> *… they show respect for what you have experienced, they are understanding. /…/ I designed my contact with them, what I wanted. I was allowed to decide what I myself wanted from the contact. I think it is important for people, even with a heavy addiction, to be able to experience: here I have a say.*

This is a contrast to Nina's previous contacts with social services where she felt as if she had no control over the support and the treatment she received. She was not asked what kind of support she actually needed, and what support was helpful for her in her particular situation. The quotation testifies that the professionals succeed in mediating an empowering approach based on the perception that the patient has resources and is capable of defining his/her own

problems. Participation is about power relations, and having the possibility to have a say concerning the design of the support means to obtain power, which is a way to better inner strength and self-esteem.

The MBHV-team emphasises the importance of an informal and trusting relationship with the women, and many of our respondents highlighted how this approach made them feel safe and cared about.

> *When you are in this difficult situation, you are really sensitive. It was tough, sometimes I felt so sad, and just wanted to talk to someone who didn't give me a moral lecture… and I am still on my medication (Subutex), and what if this is damaging for the baby ….They had more knowledge and experience here, and they also made me feel as if I managed and did well…I didn't have to compare myself with other mothers, whithout drug addiction.*….(Ingela)

The permissive and non-judgmental attitude of the MBHV-team was perceived as a great asset for most of the women.

To be seen as the person you are and not being judged

Most women had positive experiences of how they had been treated. They had felt well received and the staff was perceived as being nice, kind, humble and human.

Many of our interviewees said that the professionals had listened to them and tried to understand them. They had got a personal reception and thought that the staff cared about them as individuals. Some of the women compared the contact with MBHV with other professional contacts and pointed out that previously they had felt a lack of commitment and personal involvement from the staff, whereas the MBHV-team really cared about them. To have positive feedback, and to feel "a bit smart", is an important part when meeting with the MBHV-team. Olivia said:

They care much more, and are easier to talk to. I never really had that kind of relationship with the other midwife (at the general antenatal services, our comment), *'cause I didn't see her that often. The thing is – at the MBHV-team, you meet so frequently, which makes it easier to have a very open relationship. And I actually never felt I needed to be ashamed of anything, and this was such a good feeling*

(Olivia)

Johanna told us how her contact with the MBHV-team encouraged her and increased her confidence. When she revealed negative thoughts about herself, they made her think differently, and focus on the positive things in her life.

It was not like "you are a bad person, you have led a bad life and now we have to control you", not at all. They had a positive attitude, which I really appreciated

(Johanna)

In the interview, Ingela underscored how much it had meant for her to be able to call someone who *"just listened, and didn't use any of that moral-talk"*. Furthermore, she also stressed the importance of "praise" – that the staff acknowledged and praised her for all her efforts, and accentuated how much she had accomplished.

If you are treated with mistrust you don't grow and it becomes difficult to create trust, rather one alienates from others. If you receive a personal response, are seen and acknowledged as a person worth respect the ability to grow enhances. The self-esteem of women with a substance and/or alcohol abuse is not seldom low, and connected to feelings of shame and guilt. Therefore, the non-judgemental attitude of the staff at the MBHV-team has been of great importance for many of our interviewees. Some of the women said that before they came to the MBHV team they feared that they would experience themselves as "the abusing mother". These fears were seldom fulfilled. Klara said she initially was afraid that she "would be a victim." Her experience was that she did not have major problems and was worried that

she would feel worse, as "someone who really has a problem" and that she would "be attributed a role as an addict." But that did not happen. She said that it probably had to do with the attitude of the staff and that "they know what they are doing." Ingela had left a long career as a substance abuse addict behind her and did not want to identify with her former life anymore. She emphasised the importance of the non-judgemental attitude of the MBHV-team:

> *At the other antenatal services they approached me differently – they identified me with my addiction problem - as if my problem was what identified me as a person. I didn't like that.* (Ingela)

Once she had started at the MBHV-team she felt that "it was very nice not being judged". She described that she had been able to be relaxed and say what she "feels and exactly what the situation was like," and "still not being judged." Nina said:

> *In the beginning I was an addict like any other, but as time passed, and everyone got to know me, it was almost as I was one of the gang sometimes. /.../ So, I became myself, I was not labelled at all, apart from being me.*

Dora said that she felt like "anybody, but in a positive way." As any mother anywhere, "they didn't care whether I've had substance abuse problems or not." Henrika said that she could be herself and she and Gabriella both experienced that they were treated for who they are.

Most of the women experienced that they had been met with a positive attitude and they did not feel abnormal, discriminated or judged.

There was one exception where one woman described that she did not identify as an addict before but felt that she was being judged as one when visiting the MBHV-team. This woman had an addiction to prescription drugs and did not agree with the professional's definition of her problems. In the beginning of the study the staff expressed an uncertainty about how to best support women with an addiction to prescription drugs.

To be considered normal, as anybody else is important. It is about getting away from an identity as an addict and to develop a new identity, of being a mother.

A 360° turn…..A different life

> *At first it was a bit of a chock – to quit smoking cigarettes, and give up my "normal" life – but in the end it was a positive change. I had to do a "360° turn…(Dora)*

Several of our interviewees told us how they had to change their life style as a consequence of their pregnancies. Having to give up drugs and alcohol, and even smoking, was not easy, for some it was a continual struggle.

> *I had a hard time during my pregnancy, I was really depressed, I felt sad and I was bored. I was a drug addict for many years, and to stop using drugs and trying to avoid relapses for such a long time was so hard. I felt as if I wasn't allowed to do anything* (Henrika)

As many of the women´s friends also were involved in substance abuse, the change of life-style could also include a break with their network. When all you did with your friends was to drink or use drugs together, the pregnancy made it hard, or impossible, to be part of the group of friends anymore.

> *I had a very intense life before I was pregnant, I was at the pub all the time, and the pregnancy meant a huge change for me. All my friends continued with their life, they didn't want to slow down because of me. I stayed at home, watching a film – it was hard to accept this change.* (Olivia)

In this situation, the support from the MBHV-team was particularly important. For Olivia, this support was crucial for the way in which she was able to go through her pregnancy without drinking.

> *… she was there, you could go there and just talk. She listened very well and praised me. She always asked what I did last weekend and "how did you feel when your*

friends were going out" and I said: "it's really tough, sometimes you just want to open a bottle of wine and accompany them". I felt so alone / ... / It might sound ridiculous, but when you sat there you needed that praise. It was actually important, because you could feel proud of yourself and you could feel that: "I can handle this". It's hard to explain but she was a huge support. (Olivia)

Like many others of our interviewees, Olivia found the support from the MBHV-team to be of great significance for the way in which she managed to go through with her pregnancy without any relapses. The way in which this support was given – accessible, with respect for the difficulties the women experienced and including praise – was of importance for the way in which the women could find their motivation to refrain from the use of drugs and/or alcohol.

Summary and conclusion

Research has shown that the stigma connected to being a female addict contributes to lower self-esteem, therefore it is of great importance that the support is designed in purpose of strengthening the patients self-esteem. The statements from the interviews give evidence that the MBHV-team often succeeded with this task. The women´s experiences indicate that the reception from the MBHV-team works well and they have no condemning attitude, which is an important part of the treatment (see e.g. Sun, 2006). Tuchman (2010) also emphasizes that when women tend to experience guilt and shame you cannot use methods that evoke these feelings, as for instance confrontation. It is a balancing act for the staff of the MBHV-team to see to the needs of these women by giving positive feedback and confirmation at the same time as they point out the risks that the foetus can have been exposed to and possibly is exposed to if the pregnant woman uses substances and/or alcohol. The staff has to choose between the risk of losing the possibility to give continuous support and create trust and the risks for the development of the child. In most cases they succeeded in this mission, but a few of our interviewees stated that they sometimes felt criticized and distrusted.

It is obvious that the non-judgmental and accepting attitude from the staff at the MBHV- team reduced the feeling of stigmatisation, guilt and shame that is often connected to mothers with substance and/or alcohol problems. Even the elements of control included in the MBHV-team's work is perceived as positive by most women, as it is connected to this non-judgmental attitude, with a foundation in a trusting relationship between the staff and the mothers. This positive and trusting relationship could in itself constitute a kind of control – some mothers stated that they couldn't bear the thought of letting the staff down by having relapses, or trying to fake refraining from using substances and/or alcohol.

How you treat another human being is intimately linked to the ideas you have of the person in question or perhaps rather what you take for granted concerning the group. The images of these women that the MBHV-team has formed differ from cultural ideas of women who have a substance and/or alcohol addiction and the women are described with a certain admiration. As Trulsson and Hedin (2004) point out it is of great importance to see the resources these women have and to value these resources. By looking at the stories of the interviewed women you see the attitude of the staff, how the staff manages to show respect and acceptance and where the women feel that they have a competence and ability of their own and know that they are accepted just as they are. Such an attitude will create good possibilities to support the mothers and make them experience increased self-esteem and obstruct stigmatizing processes. "Goffman (1959/1971) argued that the ability to present oneself as a moral actor is crucial in one's ability to play a part in social life and to ensure membership of social groups." (Radcliffe 2011, p 985).

We believe that the statements from our interviewees send a clear message to both antenatal and social services of the importance of a non-judgmental attitude, trust and a positive

relationship. Additionally, time and availability are crucial components to succeed with this mission. The organization of the MBHV-team is a prerequisite for the staff to be able to design support for mothers and children based on mothers' and children's needs. Having the opportunity to devote more time to each client create opportunities to build relationships with the mothers and to design support based on an assessment of the mother's whole situation.

Acknowledgements

We would like to thank The Swedish Council for Information on Alcohol and Other Drugs (CAN), the Primary Health Care in Gothenburg and the County Council of West Sweden who financed the study. Additionally, wt thank the staff at the MBHV team for their commitment; For helping us finding our respondents, for sharing their time with us to participate in group discussions and giving us continuous feedback in the design of the study. We would also like to thank all the mothers – and their children – who so generously shared their experiences.

Suggestions for future research

As mentioned in the methodology part, there is a risk that the 17 women we interviewed belonged to a group who did fairly well, and that we thus didn't collect any information from women who were doing less well, and also that we missed out on those who were more critical towards the professionals at the MBHV team. In future research it would be desirable to make efforts to also reach mothers with a more problematic life situation. Using an approach including the message that we need information from mothers with a variety of experiences to improve the way we work could possibly make this happen.

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