Struggling with parenthood after an upbringing with substance abusing parents

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LUND
UNIVERSITY

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Abstract

Objective: To investigate whether women and men raised in a family with substance abuse constitute a particularly vulnerable group of parents. A further goal is to gain a deeper understanding concerning the experience of growing up with substance abusing parents as well to explore in what ways it could influence one's own parenting.

Background: A history of family substance abuse can severely disrupt the caretaking abilities of parents in ways that can have far-reaching consequences and children growing up with insufficient parental care may incorporate this deficiency into their own parental behavior.

Methods: 197 parents from an IMH unit completed questionnaires assessing health problems as well as problems in their family of origin. In-depth interviews were conducted with 19 subjects who had grown up with substance abusing parents. Qualitative content analysis was used to analyze the data.

Result: In the total sample the mothers reported more symptoms of anxiety and depression than the fathers. Mothers raised with substance abusing parents had more mental health issues when compared with the rest of the mothers. Adults with such an upbringing reported a childhood with emotional abuse, trauma and parentification reinforced by lack of support and an own parenthood characterized by high degree of inadequacy and stress.

Conclusions: In the total sample, mothers were found generally to be vulnerable, but mothers who grew up with substance abusing families were found to be even more so. This might suggest that it could be important to include fathers in the treatment in order to strengthen the family's parenting function. It is also important to create routines and methods to identify these children and offer adequate support. Further it is important to develop treatment models to include transgenerational effects of growing up with substance abusing parents.

Key words: parenting, family of origin, substance abuse, child psychiatry, parentification, cross-sectional study, qualitative content analysis

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"…we who have hidden the larger part of our past. Who have lived with upside-down waves, with the wind whining on wind-still days and the rain pouring down on sunny days. Alcohol instead of presence. Drunkenness instead of reality. We, the family members, mourning alone. We who have fire-ants in our sleep at night."

…om oss som dolt den största delen av vårt förflutna. Som levt med felvända havsvågor, vinden vinande vindstilla dagar och slagregn soliga dagar. Sprit istället för närvaro. Rus istället för verklighet. Vi, de anhöriga, ensamsörjande. Vi med eldmyror i nattsömnen.

Susanna Alakoski: "April i anhörig-Sverige" 2015

To my dear parents, models of loving parenthood,
and to my beloved family, Ulf, Joel, Tomas and Erik,
who have given me the chance to practice parenting

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Abstract

Objective: To investigate whether women and men raised in a family with substance abuse constitute a particularly vulnerable group of parents. A further goal is to gain a deeper understanding concerning the experience of growing up with substance abusing parents as well to explore in what ways it could influence one's own parenting.

Background: A history of family substance abuse can severely disrupt the caretaking abilities of parents in ways that can have far-reaching consequences and children growing up with insufficient parental care may incorporate this deficiency into their own parental behaviour.

Methods: 197 parents from an IMH unit completed questionnaires assessing health problems as well as problems in their family of origin. In-depth interviews were conducted with 19 subjects who had grown up with substance abusing parents. Qualitative content analysis was used to analyse the data.

Result: In the total sample the mothers reported more symptoms of anxiety and depression than the fathers. Mothers raised with substance abusing parents had more mental health issues when compared with the rest of the mothers. Adults with such an upbringing reported a childhood with emotional abuse, trauma and parentification reinforced by lack of support and an own parenthood characterized by high degree of inadequacy and stress.

Conclusions: In the total sample, mothers were found generally to be vulnerable, but mothers who grew up with substance abusing families were found to be even more so. This might suggest that it could be important to include fathers in the treatment in order to strengthen the family's parenting function. It is also important to create routines and methods to identify children who grow up in substance abusing families and offer adequate support. Further it is important to develop treatment models to include transgenerational effects of growing up with substance abusing parents.

Svensk sammanfattning (Swedish summary)

Ett första syfte med denna avhandling var att undersöka om kvinnor och män som vuxit upp med missbrukande föräldrar och som vände sig till späd- och småbarnspsykiatrin för att få stöd i sitt föräldraskap var en speciellt utsatt patientgrupp, (studie I). Vi undersökte förekomsten av psykisk ohälsa och föräldrastress hos hela gruppen patientföräldrar som vände sig till den späd- och småbarnspsykiatriska enheten. För att undersöka dessa frågeställningar användes kvantitativ metod.

Ett andra syfte var att belysa erfarenheter och upplevelser från barndomen hos de patientföräldrar, som i den första delen av studien uppgivit att de vuxit upp med missbrukande föräldrar, och deras erfarenheter av och de utmaningar de nu upplevde i sitt eget föräldraskap, studie II. För att undersöka dessa frågeställningar användes kvalitativ metod.

Resultatet i den första studien (studie I) visade att kvinnorna som vuxit upp med missbrukande föräldrar var en extra belastad patientgrupp. De hade oftare symtom av depression och ADHD, oftare erfarenheter av eget missbruk och hade oftare varit med om traumatiska livshändelser jämfört med de kvinnor som uppgav att de inte vuxit upp med missbruk. För männen fanns ingen lika tydlig skillnaden mellan de som vuxit upp med missbruk och de som inte hade det.

I hela gruppen patientföräldrar som sökt behandling på späd- och småbarnspsykiatriska enheten var kvinnorna tydligt mer belastade av psykisk ohälsa än männen. De hade i jämförelse med männen betydligt oftare symtom av ångest, depression och ADHD. Kvinnorna hade även oftare varit med om traumatiska livshändelser och var mer drabbade av föräldrastress än männen.

I resultaten från den kvalitativa studien (studie II) som genomfördes med hjälp av djupintervjuer framkom att de kvinnor och män som vuxit upp med missbrukande föräldrar i mycket hög utsträckning varit utsatta för känslomässig misshandel och omsorgssvikt och att de inte haft någon att tala med om sin förälders missbruk. Det framkom vidare att intervjupersonerna under uppväxten upplevt starka känslor av övergivenhet och en stor brist på stöd. Majoriteten av dem hade utvecklat ett omhändertagandebeteende gentemot sin förälder till priset av att de samtidigt stängde av plågsamma känslor och tryckte bort egna behov, något som förstärkte deras känsla av övergivenhet.

De utmaningar föräldrarna beskrev handlade både om bristen på roll-modeller och om en vilsenhet i sitt föräldraskap. Vidare beskrev de en känsla av att ständigt vara i ”alarm-beredskap”. Utmaningarna som förälder handlade även om svårigheter att känna tillit till sig själva och till andra människor, att hantera negativa känslor gentemot sitt barn och att utmanas av starka känslor av skuld.

Slutsatser: Kvinnor som vuxit upp i hem med missbruk utgör en extra sårbar patientsgrupp inom späd- och småbarnspsykiatrin. Det är angeläget att identifiera dem och att utforma riktade behandlingsinterventioner. Mödrarna inom späd- och småbarnspsykiatrin verkar vara mer belastade av psykisk ohälsa jämfört med kvinnor i den allmänna befolkningen och mer än fäderna som ingick i undersökningen. Det är angeläget att screena för exempelvis depression, ångest och ADHD och att engagera moderns partner i behandlingen, då denne både kan utgöra ett stöd för kvinnan och ta en mer aktiv del i relation till barnet.

Vidare är det angeläget att personal inom skola, vård och socialtjänst kan hjälpas åt att se de barn som växer upp med missbrukande föräldrar och identifiera deras hjälpbehov. Dessa barn kan vara svåra att identifiera då ett brådmoget och, vid ett ytligt betraktande, kompetent beteende döljer deras svårigheter.

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List of papers

This thesis is based on the following papers, which will be referred to in the text by their roman numerals:

I. Tedgård E, Råstam M. *Vulnerable parenting among mothers with substance abuse in their family of origin: a cross-sectional comparative study of mothers in an infant and toddler program.* Springerplus. 2016 Sep 13;5 (1):1540. doi: 10.1186/s40064-016-3045-0. E Collection 2016. PubMed PMID: 27652113; PubMed. Central PMCID: PMC5020034.

II. Tedgård E, Tedgård U, Råstam M, Johansson BA. *Parenting stress in mothers and fathers in an infant mental health unit - a cross-sectional study.* Manuscript.

III. Tedgård E, Råstam M, Wirtberg I. *Struggling with one's own parenting after an upbringing with substance abusing parents.* International Journal of Qualitative Studies on Health and Well-Being. 2018 Dec;13(1):1435100.doi: 10.1080/17482631.2018.1435100. PubMed PMID: 29482480

IV. Tedgård E, Råstam M, Wirtberg I. *An upbringing with substance abusing parents - experiences of parentification and dysfunctional communication.* Accepted for publication in Nordic Studies on Alcohol and Drugs (2018)

Reprints of the papers were made by kind permission of the respective publishers.

Abbreviations

ADHD	Attention deficit hyperactivity disorder
ASQ	Attachment Style Questionnaire
ASRS	Adult ADHD Self-Report Scale
AUDIT	Alcohol Use Disorder Identification Test
QCA	Qualitative Content Analysis
CAP	Child and Adolescent Psychiatry
CAST	Children of Alcoholics Screening Test
COMP	Comparison group
DUDIT	Drug Use Disorder Identification Test
HADS	Hospital Anxiety and Depression Scale
IMH	Infant Mental Health
PTSD	Posttraumatic Stress Disorder
SPSQ	Swedish Parenthood Stress Questionnaire
SPSS	Statistic packages for social science
SUD	Substance use disorder
WMA	World Medical Association
WHO	World Health Organization

Introduction

The transition to parenthood is one of the most significant events in a person's life and involves emotional strains and a number of challenges (Deave & Johnson, 2008; Premberg, Hellström, & Berg, 2008). For most parents, whilst taking care of a small child is sometimes experienced as an overwhelming responsibility, it is also a source of joy and personal development. However, for some parents, being responsible for their child's welfare is felt as being too much and feelings of anxiety, despair and depression dominate their experience. When this is the case it may become a threat for the child, as she is extremely dependent on caregivers who are emotionally accessible if she is to develop in an optimal manner (Fearon, & Roisman, 2017; Verhage et al., 2016). One group of parents who run the risk of experiencing difficulties in their own parenthood are those who have grown up in a family that was characterized by heavy substance abuse.

Over the past twenty years, understanding of infants' neurological vulnerability has increased. Research has shown that the child's developing brain is extremely sensitive and that the period in which growth and plasticity are greatest is from the third trimester of pregnancy to when the child is approximately three to five years old (Wachs, Georgieff, Cusick, & McEwen, 2014). Three factors that are important for the development of the brain during this period are: firstly, the ability to reduce toxic stresses and their somatic consequences; secondly, access to strong social support and attachment and thirdly, the provision of optimal nutrition (Wachs et al., 2014). A Danish study (the Copenhagen Child Birth Cohort CCC 2000) shows that 16 to 18% of eighteen-month-old infants reveal diagnosable mental health problems. The study suggests that one key risk mechanism associated with emotional and behavioural disorders is the presence of relationship disorders between parent and child that were found in 8.5% of the population studied (Skovgaard et al., 2007). Such findings suggest that it could be important to offer support to families in this kind of psycho-social risk zone, especially where the children are in the sensitive developmental period (0 to 5 years), as early disturbances may result in long-term negative consequences not only for the individual's mental health but also for her future education and work-life (Walker et al., 2007).

Short historical background

Infant psychiatry was introduced in Sweden in the 1980's. The experience gathered from the treatment of pre-school children had identified the need to offer psychotherapeutic help to families with even younger children. Interest in developing treatment methods for families with infants was widespread and in the beginning of the 1990's there were 31 such units (Socialstyrelsen, 1993). It could be child psychiatry, social welfare, Primary Care or a mixture that assumed organizational responsibility for these programs (Broberg, Risholm Mothander, Granqvist et al., 2008). Support for treatment interventions was provided by more sophisticated research into the development of the child's brain (Schore, 1994; Siegel, 1999), studies concerning the effects of post-partum depression and the goals of the World Health Organization (WHO) concerning public health and prevention: "*Psychosocial and cognitive development of babies and infants depends upon their interaction with their parents. Programs that enhance the quality of these relations can improve substantially the emotional, social, cognitive and physical development of children. These activities are particularly meaningful for mothers living in conditions of stress and social adversity*" (WHO, 2001).

Three international research bodies were established during the 1980's, each with a different focus: The Marcé Society for Perinatal Mental Health (https://marcesociety.com"), that concentrates on mental health and sickness during pregnancy and the infant period; The World Association for Infant Mental Health (WAIMH; https://waimh.org) that focuses on infant mental health and the International Attachment Network (IAN; www.ian-attachment.org.uk) that is centred on the significance of the attachment system. Today, extensive cross-disciplinary research is carried out in these areas and the different bodies arrange regular international conferences.

Whilst our knowledge today is greater than ever before concerning both the vulnerability and the potential of the infant, societal development in Sweden has meant that many of the infant programs that offered help to families most in need have been shut down. Resources have instead been directed to treatment programs for older children and their families (Broberg et al, 2008). However, in the period 2017-2018 The National (Swedish) Board of Health and Welfare (*Socialstyrelsen)* carried out a survey of existing infant programs and noted that interest in the development of effective treatment models for families with infants has increased.

After many years of practicing psychotherapy with families with small children and with parents who fought to cope despite the burden of what they experienced as their own inadequate parenting skills, the desire grew to understand more about the complex process of becoming a parent. For example - what specific kind of help do newly-become mothers or fathers need in order to become competent parents even

if their own parents had been negative role-models, often absent because of a heavy substance abuse?

This thesis analyses the information obtained from interviews with and self-report questionnaires obtained from parents who attended an infant and small child unit within the Child and Adolescent Psychiatry (CAP) in Malmö, Sweden. The thesis is about the parents and their own families of origin, the prerequisites for parenting, and some background factors that can impair the process of becoming a parent. The thesis begins with a summary of some of the theories that help us to understand the relationship between the small child and her parent. This is followed by identifying and describing some factors that may negatively affect parenting, for example, an upbringing with substance-abusing parents. In the final section, the results from two studies are presented: the first with a quantitative design, and the second with a qualitative design. For the reader's sake, perhaps some negative disclaimers should be noted here: the increasing amount of research on genetics and other neurobiological factors that interact with the environment in the development of parent-child interaction is of great importance, but does not lie within the scope of this thesis. Also, no attempt is made to examine the uni-directional influence of the child on the parents, and there are no instruments used to assess parental influence on the development of the child: the focus is on how parents in an infant psychiatric setting rate their own psychological health and how parents with an upbringing with substance abusing parents experienced their childhood, and how that experience influences them as they become parents themselves.

Background

Some theories of the relationship between the small child and her parents

Attachment theory

Attachment theory (Bowlby, 1980) describes the emotional tie or bond that the infant develops with her parents (or other primary caregivers) under her first year. (Here we use the word "parents" for the sake of simplicity: primary caregivers are normally parents, but do not need to be.) This tie creates the possibility for the child to develop both a sense of security and an exploratory behaviour. Attachment is viewed as an evolutionary function that is necessary for the child's survival, and as such is - under normal circumstances - biologically steered and therefore "compulsory" in nature, which means that the child cannot choose to not become attached to her parents. The internal attachment system of the child is activated whenever the child experiences fear or stress and as a consequence desires to be united with the attachment figure. For the attachment tie to have the most positive results, the child needs sensitive and attentive caregivers who can interpret and respond to her different signals and who understand the intentions behind her communicative behaviour (Fonagy, Steele, Steel at al., 1991; Slade, Grienenberger, Bernbach et al., 2005; Sroufe, Egeland, Carlson et al., 2005). The quality of the attachment bond is dependent on the parent's ability to encourage independence and curiosity in safe contexts, and provide safety and comfort in frightening situations (Cassidy, 2008).

The nature of the interaction between child and parent influences the way in which the child conceptualizes the nature of the world and how it works, as well as the development of what are known as "internal working models". The theory suggests that the child who receives sensitive care in the sense that her needs are understood, affirmed and satisfied will tend to develop internal representation of herself as a good person and of the world as a good place. Under such conditions the child develops what is known as a "secure attachment" (Bowlby, 1980). But inadequate caring seriously threatens not only the development of a secure attachment bond but also the learning of many strategies that are important for competent interaction with

others, and the child may develop what is known as an "insecure attachment" (Groh, Fearon, Ijzendoorn et al., 2016; Solomon & George, 2011). Children who develop an insecure attachment bond learn to either repress their emotional needs or to adapt to parents who are not available when they need support. The kind of attachment relationship that is judged to be the most problematic is the one in which the primary caregiver is a frequent source of threat and who stimulates fear and anxiety in the child. Thus, when the child's attachment system drives her to seek security with her parents, the nearer she approaches them the more anxious and afraid she becomes. The child runs the risk of finding herself in an impossible conflict situation and as a result may develop what is known as "disorganized attachment" (Groh et al., 2016; Solomon & George, 2011; Cassidy, 2008).

Disorganized attachment may develop in families where there are serious care deficiencies that are a result of physical, emotional or psychological abuse that may or may not be coupled with mental illness and/or substance abuse. Disorganized attachment may also develop in families where there are no apparent serious care deficiencies, but where the parents have difficult, unresolved problems that are activated in interaction with their own child. The expressed needs of the child may stimulate and fill the parents with feelings of fear and anxiety and even anger, and in such cases it may be difficult for the child to use her parents as secure and safe attachment persons (Hesse & Main, 2006; Solomon & George, 2011). This risk increases if the parent has learned and internalized a pattern of insecure attachment that steers her way of relating to others (Jones, Cassidy, & Shaver, 2015).

Affect regulation

The emotional development of the child is to a great extent dependent on the parent's patterns of caring and the emotional climate in the family (Bariola, Hughes, & Gullone, 2012; Bridges, Denham, & Ganiban, 2004; Zeman, Cassano, Perry-Parrish et al., 2006). A part of the socializing process between parent and child is the direct and indirect teaching and learning of affect regulation (Zeman et al., 2006). Morris et al. use a three-part model to describe the development of emotional regulation (Morris, Silk, Steinberg et al., 2007). The first part describes how the child learns through observational learning, modelling and social referencing. In the pre-language stage, it is interesting to hypothesize in what way mirror neurons (the "neuronal mirroring system") might play a role (Marshall & Meltzoff, 2011). The second part consists of the collected history of experiences of interactions with her parents that the child has participated in that are relevant for understanding and regulating affect. Here, the parents' mentalizing ability is important, in that it will help them to understand what the child's intentions might be when she displays affective behaviour and thus help them to mirror, identify and affirm her expressed emotions whilst more easily distinguishing her feelings from their own (Fonagy,

Gergely, Jurist et al., 2002). The third part consists of the emotional climate in the family which includes not only the attachment relationship that exists between parent(s) and child, but also between the parents (Morris et al., 2007). In order to develop effective affect regulation, the child is dependent upon receiving sensitive support and children who have a secure attachment system learn more adaptive emotion regulatory strategies than those who have an insecure attachment system (Mikulincer, Shaver, & Pereg, 2003).

The ability to regulate emotion influences the ways in which the individual seeks to create and maintain relationships (Koole, 2009) and children who have difficulties in this area run a higher risk of developing either aggressive or anxiety-laden behaviour in social contexts (Cumberland-Li, Eisenberg, Champion et al., 2003; Frick & Morris, 2004; Howe, 2005; Silk, Steinberg, & Morris, 2003). Having difficulties with emotion regulation has been shown to have a correlation with different types of mental disorders such as generalized anxiety disorder (Etkin, Prater, Hoeft et al., 2010), depression (Aldao, Nolen-Hoeksema, & Schweizer, 2010) and substance use and abuse (Li & Sinha, 2008).

Parentification

Children who become stressed or anxious but who cannot turn to their parents to find the comfort needed to be able to calm down and feel safe run the risk of experiencing long periods of stress. In those cases where, as was noted above, it is the parents themselves who are the source of threat and danger, attempts to approach them, instead of providing comfort, may instead result in increased stress and anxiety (Bowlby, 1982; Solomon & George, 1999; Solomon & George, 2011). Such relationships may result in the child developing a chronic state that consists of being hyper-aroused with a highly dysregulated emotional state that is difficult to manage (Howe, 2005). However, with increasing maturity, most children develop different strategies to manage the relationship and minimalize stress. One such strategy involves the child taking responsibility both for herself and for the others in the family, and she behaves as if she were the parent, either through "compulsive self-reliance/controlling/punishing behaviour" or by "compulsive caregiving/caring and helpful behaviour" (Bowlby, 1988; Jacobvitz, Riggs, & Johnson, 1999; Solomon & George, 2011; Teti, 1999). Both sets of behaviour can be understood as a sign that the child cannot express her own helplessness and anxiety to her parents with any hope of receiving comfort and instead learns alternative ways to take care of her own needs (and/or even her siblings and parents) (Solomon & George, 2011).

Towards the end of the 1970's the term "parentification" was introduced into the therapeutic literature, and one definition was "*parentification implies the subjective distortion of a relationship as if one's partner or even children were his parent*" (Boszormenyi-Nagy & Spark, 1973). The concept has been refined and developed

since then in its application to child development. One established definition is: "*…parentification in the family is a functional and/or emotional role reversal, in which a child in response to an adult´s abdication of parental responsibility, reacts by sacrificing his or her own needs for attention, comfort and guidance in order to care for the logistical, emotional and self-esteem needs of a parent"* (Chase, Deming, & Wells, 1998). This definition focuses on two aspects of role-reversal. Firstly, "logistical/instrumental parentification" that involves the child taking over practical tasks such as taking care of her siblings and doing household tasks. Secondly, "emotional parentification" that influences the child's development in more serious ways and involves the child in taking responsibility for her parents' or siblings' feelings - for example by taking on the role of being their friend, providing a buffer in parental conflicts, supporting her siblings, trying to protect one of the parents from physical abuse by the other and even becoming a sexual partner (Jurkovic, 1997; Pasternak & Schier, 2012). Two different variations of emotional parentification - besides taking direct responsibility for the emotional well-being of parents or siblings - can be that the child either becomes a scapegoat who is seen the cause of other family members' misfortunes or becomes the "perfect" child who is never the source of any trouble and who never makes any demands on her parents (Haxhe, 2016). No matter which strategy the child develops, one probable consequence for her is the development of a fragmented and confused idea of self that may result in difficulties with emotional self-regulation – the consequence of the discrepancy between the adopted strategy that creates the appearance of her as being a "competent self" in relation to her parents or siblings whilst actually being an immature person who lacks the means to regulate her own fears (Cicchetti, 2016; George & Solomon, 2008); Emotional parentification can be viewed as one possible effect that is caused by a specific combination of family dynamics and family relationships that together constitute a severe form of neglect, in which the child's basic physical, emotional and psychological needs of care and affirmation are poorly recognized and certainly not satisfied (Hooper, 2007; Jurkovic, 1997; Schier, Herke, Nickel et al., 2015). Emotional parentification may also be associated with the emergence of difficulties when the child grows up and becomes a parent herself (Byng-Hall, 2008; Haxhe, 2016).

Social referencing and dysfunctional communication

In the daily interaction between parent and child, the child is often dependent upon her parent's help to interpret and make sense of her perceptions and her experience. This help usually occurs in the context of "social referencing", where the child attends to her parent's affective response and communication concerning an experienced phenomenon in order to understand what is happening (Walle, Reschke, & Knothe, 2017). The parent's response to the jointly perceived event

signals and offers important information to the child that can help her distinguish between, for example, which potential threats are in fact dangerous and which are not.

A parent who abuses alcohol and/or drugs and denies his addiction insists on a "conspiracy of silence" that effectively blocks all attempts to talk about the addiction and its consequences (Kroll, 2004). Such a person may also insist on ignoring catastrophic events that are often a part of subtance abuse, a behaviour that will tend to create confusion for the child. As a result, the rule that insists on denial will create distortions in the child's cognitive maps of the world and thereby also influence the nature of her emotional responses (Staf & Almqvist, 2015). The parent who denies or refuses to comment on dramatic events in the family makes it hard for her child to understand and to trust her own perception. The child is left to her own devices to make sense of and handle frightening experiences that may result in the child assuming responsibility for what has happened. The child might become alienated from herself or develop other types of dissociated states (Byun, Brumariu, & Lyons-Ruth, 2016; Dutra, Bureau, Holmes, et al., 2009; Narang & Contreras, 2005; van Ijzendoorn & Schuengel, 1996). Silence and denial may also have a negative influence on the child's internalized image both of her family and of herself.

Adverse Childhood Experiences

Child maltreatment is defined as "acts of commission or omission by a parent or other caregiver that result in harm, or threat of harm to a child" (Gilbert, Widom, Browne, et al., 2009) and can take many forms. Felitti et al.'s definition of child maltreatment or Adverse Childhood Experiences includes: *sexual abuse*, which means involving a child in sexual activities which she cannot fully understand and is therefore unable to agree to in any meaningful way; *emotional abuse*, which means that the child is the target for threats and antipathy and is mocked and humiliated and *physical abuse*, where the child is consciously made the target for violent behaviour, resulting in physical damage. Two additional aspects of Adverse Childhood Experiences are *physical neglect*, which is said to occur when the child's physical needs of for example food or health care are not satisfied and *emotional neglect*, which means that the child does not receive affirmation for her emotions or her way of being in the world – that she is not offered messages that she is liked and is of worth (Felitti et al., 1998).

It is well-documented that the abuse of children involves severe negative consequences for a child's development (Hussey, Chang, & Kotch, 2006; Lansford, Miller-Johanson, Berlin et al., 2007; Villodas, Littrownik, Thompson et al., 2015) and strongly correlates with mental illness, substance abuse and poor responsiveness to treatment (Finkelhor, Turner, Hamby et al., 2011; Nanni, Uher, & Danese, 2012).

Adults who were the victims of different forms of abuse as children run a greater risk of developing a number of different medical problems (Felitti et al., 1998; Gilbert et al., 2009). The term "developmental trauma" is used when a child has been the victim of interpersonal victimization in the form of physical violence, emotional abuse and impaired caregiving over a long period of time, but the necessary criteria for the diagnosis of posttraumatic stress disorder (PTSD) are not met. Instead, the child presents other kinds of psychiatric symptoms such as affect regulation problems, behavioural dysregulation, and cognitive and consciousness problems (D'Andrea, Ford, Stolbach et al., 2012). As a diagnosis, "developmental trauma disorder" can be difficult to establish and it is therefore important to develop and validate diagnostic instruments in order to be better able to understand the complexity of the child's presenting symptoms (Denton, Frogley, Jackson et al., 2017).

It is important to note that children who have been the victims of Adverse Childhood Experiences and psychological trauma have a higher risk of suicidal behaviour (Hardt, Bernert, Matschinger et al., 2015; Park, Hong, Jeon et al., 2015; Tunnard, Rane, Wooderson et al., 2014) throughout their lives (Behr Gomes Jardim et al., 2018; Hardt et al., 2015) and are often difficult to treat (Hovens et al., 2010; Nanni et al., 2012).

Recent research about children who are the victims of abuse and neglect has been more focused on the bidirectional influences between the individual's social environment and her biology rather than on which psychiatric diagnoses she might develop (Finegood & Blair, 2017). This focus includes the relationship between childhood abuse and neglect and how this influences the individual's ability to regulate stress. The learned responses and the adaptive behaviour that the child develops to manage stressful and threatening life experiences that she experiences are presumably the most functional that she could manage at the time, but in the long-term they can be a negative influence on the individual's ability to manage stress (Alink, Cicchetti, Kim et al., 2012; Jaffee, Caspi, Moffitt et al., 2004; Koss, Hostinar, Donzella et al., 2014) and may inhibit the capacity for future learning (DeSteno & Schmauss, 2009).

Resilience

As noted above, many children who face Adverse Childhood Experiences may be at greater risk for subsequent failures and maladaptation over time, but not all children who endure Adverse Childhood Experiences develop behavioural or mental health problems (Woodruff & Lee, 2011). Instead, some children reveal resilience, which is defined as the ability to respond adaptively to serious adverse experiences (Afifi & MacMillan, 2011; Werner, 2005). In a review carried out by Afifi & MacMillan (2011) the factors that seem to correlate with the presence of

resilience are divided into three categories – individual, family and community. Important *Individual factors* include personality traits, intellect, self-efficacy, coping, appraisal of maltreatment, life satisfaction, self-control, cooperation, assertion, responsibility (Lansford, Malone, Stevens et al., 2006) and an ambition to create a better life than their parents have had (Werner & Johnson, 2004). *Family factors* that can have a decisive importance include family coherence, stable caregiving, parental relationships and spousal support (Afifi & MacMillan, 2011). *Community level factors* include peer relationships, non-family member relationships, non-family member social support and religion (Afifi & MacMillan, 2011). That school can be an important factor in supporting individual development is becoming more and more obvious in our post-modern society (Berlin, Appleyard, & Dodge, 2011; Werner, 1993; Vinnerljung, Lindblad, Hjern et al., 2010). The ability to seek and receive help seems to be an especially important factor in terms of coping when children who have experienced abuse become parents (Egeland, Jacobvitz, & Sroufe, 1988; Egeland & Kreutzer, 1991). When the resilient child herself becomes a parent, factors such as having had a sensitive mother, being socially competent, and establishing a satisfactory partner-relationships are of special importance in becoming parents who are able to function in a satisfying and competent way (Conger, Schofield, Neppl et al., 2013; Raby, Steele, Carlson et al., 2015).

Some factors that challenge parenting

Parenting stress

Parenting stress, defined as *"the disparity between the perceived demands of parenting and the resources parents have available to meet those demands"* (Abidin, 1992), can significantly influence a parent's caregiving ability (Le, Fredman, & Feinberg, 2017). The degree of stress can be thought of as a function of the parent's affective and cognitive resources and how the child develops and behaves (Essex, Klein, Cho et al., 2002; Ostberg, Hagekull, & Wettergren, 1997). Social context can also be important as described in a recent Swedish study which found that fathers who shared parental leave equally with their partners were less affected by perceived parenting stress than those who shared parental leave unequally (Lidbeck, Bernhardsson, & Tjus, 2018). Studies of parenting stress in mothers, who generally experience higher stress levels than men (Hildingsson & Thomas, 2014; Milgrom & McCloud, 1996), show that high levels of perceived parenting stress were associated with depression (Andersson & Hildingsson, 2016; Saisto, Salmela-Aro, Nurmi et al., 2008), perceived high workloads and lack of social support (Östberg & Hagekull, 2000). These are all factors that negatively affect the mother's ability to show responsiveness and sensitivity in relation to the child and also affect her self-image as a parent (Abidin, 1992; Gelfand, Teti, & Fox,

1992; Whiteside-Mansell, Ayoub, MaKelvey et al., 2007). There is an increased risk that parenting stress affects a parent's interaction with her child and in the long term this will also influence the child's development (Costa, Weems, Pellerin et al., 2006). A recent, relatively large Korean study found that paternal involvement reduced maternal parenting stress and this in turn was associated with positive infant neurological development. There was an even stronger direct effect of paternal involvement on infant neurodevelopment (Kim, Kang, Yee et al., 2016). Another study highlighted the gender differences regarding parenting stress. For mothers, parenting stress was explained by factors related directly to mother-infant interaction, while for fathers it was explained by the mediating role of maternal depression and conflicts with the spouse (Gutierrez-Galve, Stein, Hanington et al., 2015).

Mental health problems

An affective disorder in either parent is the most common mental health problem during pregnancy and the postnatal period. It can interfere with parenting quality and increase the risk of children developing cognitive, behavioural and psychomotor development problems (Kingston, Kehler, Austin et al., 2018; England & Sim, 2009; Goodman, Rouse, Connell et al., 2010; Kingston, Tough, & Whitfield, 2012; Murray, Arteche, Fearon et al., 2011) all of which also increases susceptibility to psychopathology (Apter-Levy, Feldman, Vakart et al., 2013; Matijasevich, Muray, Cooper et al., 2015; Murray et al., 2011; van der Waerden, Galéra, Larroque et al., 2015). Post-partum depression is the most prevalent maternal psychiatric disorder occurring in 10 to 15 % of women (Munk-Olsen, Laursen, Pedersen et al., 2006; Reck, Struben, Backenstrass et al., 2008). Studies have shown that maternal depression reduces maternal sensitivity and increases intrusiveness and may create long-term negative consequences, not limited to the infancy period (Apter-Levy et al., 2013; Pratt, Apter-Levi, Vakart et al., 2015). Maternal depressive symptoms have also been associated with family disorganization, indexed by role confusion between parent and child, disorganized activities, and disruptions to multiple aspects of family life (Foster, Webster, Weissman et al., 2008; Keren, Dollberg, Koster et al., 2010).

Most research in this field focuses on the impact of maternal insufficiency on parenting, with some exceptions. Studies indicate that 6 to 10% of fathers suffer from depression in the postnatal period (Giallo, D'Esposito, Cooklin et al., 2014; Massoudi, Hwang, & Wickberg, 2016; Paulson & Bazemore, 2010). A Swedish study found an association between the occurrence of depression in the father and a low level of education, earlier depressive periods, stress-filled life events and problems in partner relationships (Massoudi et al., 2016). Depressed fathers were found to be more withdrawn, less emotional and to communicate less with their

child and these factors were associated with a negative influence on the child's development. (Bronte-Tinkew, Moore, Matthews et al., 2007; Giallo, D'Esposito,Christensin et al., 2012; Sethna, Murray, Netsi et al., 2015; Sethna, Perry, Domoney et al., 2017; Wilson & Durbin, 2010). A positive correlation has been found between depression in the mother and depression in the father (Paulson & Bazemore, 2010). There are also indications that depression in the father can lead to depression symptoms in the mother, but not vice versa (Paulson, Bazemore, Goodman et al., 2016). Most of the association between postnatal depression in fathers could be explained by the mediating role of family environment, whereas the association between depression in mothers and children appears to be better explained by other factors, including for example direct mother-infant interaction (Gutierrez-Galve et al., 2015). However, it would seem probable that psychological disturbance in either or both of the parents and/or in the couple's well-being may cause disruptions to family processes (Korja, Piha, Otava et al., 2015) and the mother–child and father–child relationships will mutually influence each other (Cummings, Merrilees, & George, 2010; Lamb, 2010).

Lack of social support

Several decades of research point to the importance that social relationships and social support have for the development of both physical and mental health (Thoits, 2011). Longitudinal data from the U.S. Fragile Families and Child Wellbeing Study (Turney, 2013) suggest that mothers' perceptions of instrumental social support are positively associated with children's overall health.

Social support takes a number of forms and those which are most frequently mentioned are emotional, informational and instrumental. *Emotional support* consists of messages that express love, caring, sympathy and esteem. *Informational support* contains information, advice and feedback that make it easier for the person receiving it to cope with difficult situations. *Instrumental support* is concrete, practical help in a difficult situation (House, Kahn, McLeod et al., 1985). Social isolation or the absence of social support during pregnancy is a risk factor for mental disturbance after the birth of the child (Nielsen Forman, Videbech, Hedegaard et al., 2000; Séguin, Potvin, St-Denis et al., 1999) and several studies emphasize the importance of the social network as a protective factor in reducing the risk of post-partum depression (Surkan, Peterson, Hughes et al., 2006; Webster, Nicholas, Velacott et al., 2011; Xie, He, Koszycki et al., 2009). This protection applies no matter what form of family the woman lives in (Reid & Taylor, 2015).

Trauma

Exposure to trauma, both in childhood and adulthood, increases the risk of a wide range of mental health problems across the life span, including PTSD (Breslau, Chilcoat, Kessler et al., 1999). People who have been exposed to trauma may experience more problems when they become parents (Cohen, Hien, & Batchelder, 2008). Difficulties which have been noted include lower satisfaction in being a parent, which may include a negative picture of the child which in turn may generate aggression and emotional numbing in the relationship (Lang, Gartstein, Rodgers et al., 2010; Ruscio, Weathers, King et al., 2002; Thakar, Coffino, & Lieberman, 2013) that increases the risk of child abuse (Kalebić Jakupčević & Ajduković, 2011; Schaeffer, Alexander, Bethke et al., 2005). Studies indicate that poor trauma recovery may result in a parent being more emotionally unavailable (measured in terms of posttraumatic symptoms and inadequate care-giving behaviour) and that this in turn may have a strong impact on their children's development (Almqvist & Broberg, 2003; Lambert, Holzer, & Hasbun, 2014; Lehrner & Yehuda, 2018; van Ijzendoorn & Sagi-Schwartz, 2008).

Attention deficit hyperactivity disorder (ADHD)

There are a number of different diagnostic categories for neuropsychiatric disabilities: here we shall focus on adults who suffer from ADHD. Besides attention deficiency, many also have a poor short-term memory and weak impulse control, both of which are factors that influence academic, vocational, and relationship functioning (Safren, Sprich, Cooper-Vince et al., 2010). Studies show that parental conflict and divorce are more common in couples where one or both suffer from ADHD than in couples where neither has this kind of difficulty (Williamson & Johnston, 2017; Wymbs, Dawson, Egan et al., 2017). When one or both parents suffer from ADHD, this increases the risk of generating disorganization and chaos in the family, coupled with less monitoring of the child's behaviour, less effective problem-solving in child-rearing, and more inconsistent and over-reactive disciplining (Johnston, Mash, Miller et al., 2012). A recently published review notes that the parenting style of adults with ADHD is characterized as being both harsh, particularly with daughters who exhibit the same problems, and lax (Park, Hudec, & Johnston, 2017). It has been suggested that the dual diagnosis of substance abuse and ADHD carries an added risk for the development of negative parenting (Johnston et al., 2012).

A systematic review finds that there are links between disruptive behaviour disorders (including ADHD) in children and early life factors such as maternal stress and anxiety, parental stress and parental styles (Latimer, Wilson, Kemp et al., 2012).

Substance abuse

Parental substance abuse can severely disrupt parents' caretaking abilities and is often associated with family dysfunction, as the parenting skills and behaviours of adults with such problems are significantly impaired (Howe, 2005; Locke & Newcomb, 2004). Substance abusing parents can frequently be neglectful, abusive, unreliable and emotionally unavailable for their children (Chassin, Rogosch, & Barrera, 1991; Velleman, Templeton, Reuber et al., 2008). There is a greater risk that the upbringing of children whose parents have an active substance abuse will be characterized by unpredictability, a high degree of stress and situations in which the parents are experienced by the child as frightening (Burnett, Jones, Bliwise et al., 2006; Ross & Hill, 2004).

The influence of parents' substance abuse on the health of their children is far-reaching including a risk for foetal alcohol syndrome (Anda, Whifield, Felitti et al., 2002; Bakoyiannis, Gkioka, Pergialiotis et al., 2014; Balsa, Homer, & French, 2009; Elkins, McGue, Malone et al., 2004; Rangmar, Hjern Vinnerljung et al., 2015; Velleman et al., 2008). Further, growing up with substance abusing parents is associated with increased aggressiveness and stress sensitivity in the affected offspring (Dube, Anda, Felitti et al., 2001; Elkins et al., 2004). Studies have found links between parental substance abuse and anxiety and affective disorders in the child (Chen & Weitzman, 2005; Foley, Pickles, Rutter et al., 2004; Hill, Shen, Lowers et al., 2008; Kelley, Pearson, Trinh et al., 2011) as well as an increased risk of developing substance abuse of their own (Buu, DiPiazza, Wang et al., 2009; Johnson & Leff, 1999; Kendler, Ohlsson, Sundquist et al., 2015; Yule, Wilens, Martelon et al., 2013). Daughters of mothers with alcohol abuse seem to be at greater risk of developing adult mental health problems than male children (Morgan, Desai, Potenza, 2010; Pearson, D'Lima, & Kelley, 2012).

Offspring of parents with substance abuse have an increased risk of ADHD (Knopik, Heath, Jacob et al., 2006), especially children in families with multiple cases of substance use disorder (SUD) (Hill et al., 2008). Numerous studies have demonstrated a considerable overlap between ADHD and SUD (Capusan, Bendtsen, Marteinsdottir et al., 2016; Iacono, Malone, & McGue, 2008; Lee, Humphreys, Flory et al., 2011; Wilens, Martelon, Joshi et al., 2011; Young, Friedman, Miyake et al., 2009) and according to a meta-analysis review of ADHD prevalence in substance abuse populations almost one in four individuals with substance abuse has ADHD (van Emmerik-van Oortmerssen, van de Glind, van den Brink et al., 2012).

Treatment within Infant Mental Health Services (IMH)

One of the basic goals of the treatment offered by the IMH unit is to help parents to help their children, and it can be said that it is the interaction between them that is the "real" patient. In order to be able to offer support to vulnerable parents, a number of different treatment models have been developed within IMH services. Typically, these treatment models offer interventions designed to support parental development in two areas: firstly, to develop greater sensitivity for their child's needs and secondly, to increase their ability to reflect over their child's expressed affect and intentions. Another common intervention goal is to support the interaction between parent and child so that the child can develop a secure attachment to her parents. Clinical work typically focuses on one or more of three main areas. The first area examines interaction between the child and the parent and the therapist will provide the parents with the possibility to explore their child's temperament and personality and to experience different responses from their child. The second area consists of three themes: helping parents to explore their inner representations of their child, to help them to increase their own affect regulation and finally to explore any feelings of guilt and/or traumatic experiences that may influence their parenting ability. The third area usually consists of a discussion with the parent(s) (and possibly other important caregivers) where the theme is the child's needs and how her development can be supported. When there are two or more parents or caregivers then one focus will be how they can support each other to support the child (Brodén, 1992). A number of intervention methods have been developed, amongst them different types of video-feedback. One example is Video-feedback Intervention to promote Positive Parenting (VIPP) (Juffer, Bakermans-Kranenburg, & Ijzendoorn, 2008), another is Marte Meo (Vik & Rohde, 2014; Wirtberg, Petitt, & Axberg, 2013) and a third example is Circle of Security (Cooper, Hoffman, Powell et al., 2005). In all three examples, interaction between parent and child is filmed. The film is then analysed and examined in different ways together with the parents in order to provide them with constructive feedback.

The importance of taking the family's social context into account in the treatment process is noted by Morris (Morris, Robinson, Hays-Grudo et al., 2017). The authors identify a number of factors which have significance for treatment and these are described in Fig. 1 below. They identify the importance of paying attention to the family's emotional climate and structure, the parents' psychological well-being, their personal experience of abuse and neglect and the child's sex, age and temperament.

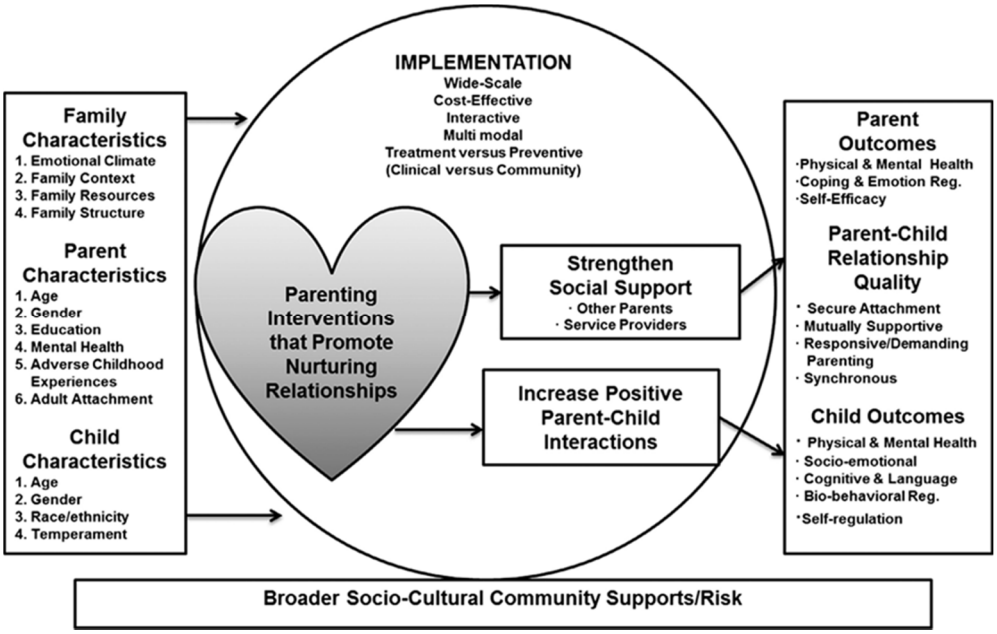

Figure 1.
Building early relationships model of change (Morris et al., 2017). Printed with permission from the author.

The development of parenthood

In summary, we can state that parenting is a product of many different factors, of which only a few are discussed here. Forces within the individual parent(s), the individual child and the social context in which they find themselves all influence the ways in which parenthood develops. Jay Belsky described the different determinants for parenthood which have been the starting point for many research projects in this area (Belsky, 1984). In a recent article (Taraban & Shaw, 2018) a revised and updated model of the different elements of parenthood is presented. The model contains a description of how parenthood is constructed partly from the qualities possessed by the parents, e.g. developmental history, cognitions and personality, partly from the child's constitution and her stress-regulating abilities, and partly from the influence of the social environment the family lives in e.g. social support and culture. The model also identifies the importance of the interaction between these three main sets of elements. Together they build a base for parenthood.

Daniel Stern (Stern, 1995) suggests that one important aspect of the development of parenthood is the psychological changes which both men and women experience –

assuming that they wish to become parents. These internal changes are described under four major themes. The first ("The life-growth theme") includes all that is needed in order to ensure the survival of the child; the second ("The primary relatedness theme") is the formation of a deep emotional relationship to the child; the third ("The supporting matrix theme") is the establishment of a benign, protective network to help the parent achieve the first two themes and the fourth ("The identity reorganization theme") is the need to develop an identity as a parent.

One important quality required to be able to develop a deep emotional relationship with the child is that of sensitivity – in particular to be able to attune to and affirm the child's communication. This helps the child to develop appropriate self-regulation, a sense of security, and an organized attachment (Fearon & Roisman, 2017; Verhage et al., 2016). The development of the child is dependent on the parents' ability to have a realistic view of what a child can handle, to prioritize the child's needs above their own needs and their ability to handle their own pain and frustration without burdening the child with them (Killén, 2002).

Another factor that influences the development of parenthood is the quality and nature of relationships that existed in one's family of origin (Solomon & George, 2011). One of the most significant predictive factors for the nature of an individual's parenthood is the quality of the caring that her own parents provided (Anda, Felitti, Bremner et al., 2006; Conger, Belsky, & Capaldi, 2009; Main, Kaplan, & Cassidy, 1985; Meins, 1999; Slade, Grienenberger, Bernbach et al., 2005).

Parents who view their own early caregivers as hostile and insensitive are more likely to provide a more insecure environment for their own children (Liotti, 2004; Solomon & George, 1999; Solomon & George, 2011). The parent's ability to give adequate care can be compromised for a variety of reasons. Substance abuse in the family of origin is one factor that can negatively affect parenting behaviour (Howe, 2005; Locke & Newcomb, 2004). The offspring of parents with serious substance abuse problems face, as described above, an accumulation of risk factors because of biological, psychological, social and environmental vulnerability. However, with few exceptions (Wiig, Haugland, Halsa et al., 2017) the research is relatively scarce on children of substance abusers and the challenges they face when they themselves become parents. The present study helps expand this issue by exploring the experience of mothers and fathers growing up with parents with SUDs and subsequently becoming parents.

Aims

The overall aim of this thesis was to investigate if parents who were raised in a family with substance abuse and were then referred together with their infant/toddler to an outpatient IMH unit for treatment constitute a particularly vulnerable group of patients. A further aim was to gain a deeper understanding of the experience of growing up with substance abusing parents as well as to explore in what ways it could influence one's own parenting.

The aims of Study I (Paper I, II) were to investigate parents with and without substance abuse in their family of origin regarding psychosocial background factors and investigate how parents in an infant psychiatry setting rate their own psychological health, examine predictors for parenting stress and also to identify gender differences.

The aims of Study II (Paper III, IV) were to explore common key elements in the descriptions of the informants' upbringing with substance abusing parents. How did they feel that their parents' substance abuse had influenced them? How did they describe the challenges in their own parenthood? What were their main concerns in their role as a parent with the background of growing up with substance abusing parents?

Overview of the four papers presented in this thesis

Paper	Participants	Data collection	Analysis
I	129 mothers	Background data Self-report questionnaires	Pearson's chi-square test Fisher's Exact Test Student's T-test
II	197 parents (129 mothers 68 fathers)	Background data Self-report questionnaires	Pearson's chi-square test Fisher's Exact Test Student's T-test Linear regression
III	13 mothers 6 fathers	Qualitative interviews with parents Self-report questionnaire	Directed Qualitative Content Analysis
IV	13 mothers 6 fathers	Qualitative interviews with parents	Directed Qualitative Content Analysis

Methods

Subjects of Study I (Paper I, II)

During the study period from May 1, 2011, to May 1, 2013, a total of 177 families were admitted to the clinic. Exclusion criteria were severe mental illness (psychosis or severe depression with hospitalization; n=9) or inadequate knowledge of the Swedish language (n= 9), leaving 159 families eligible. Nine families declined participation, and a further 18 failed to complete the questionnaires. A total of 132 families participated in the study. In 65 families, we have data from both parents, in 62 families only from the mother, and in five families only from the fathers. See flowchart figure 2 and table 1.

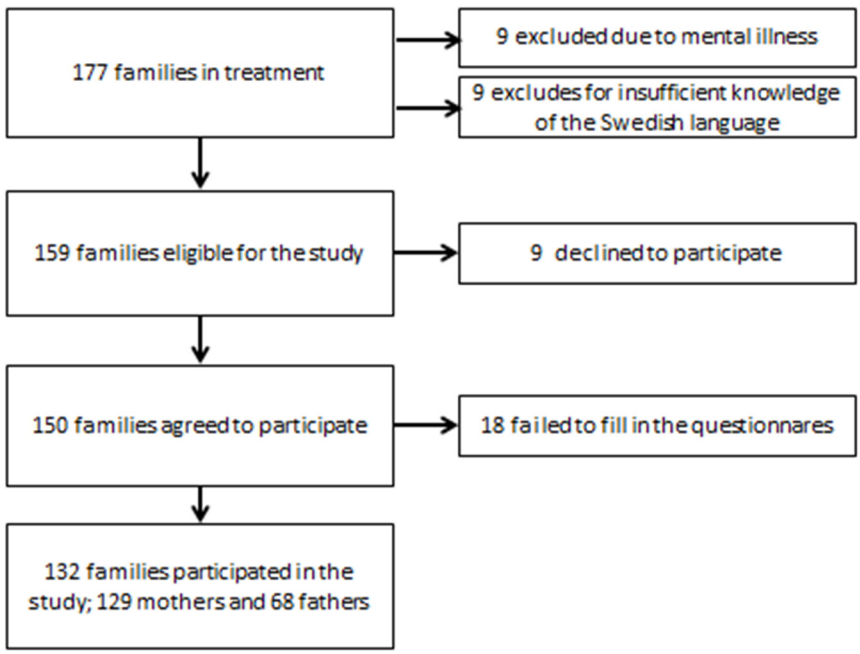

Figure 2
Flowchart

Background characteristics of the study sample Study I (Paper I, II)

Table 1
Demographic characteristics for women and men (n=197)

	Women n = 129	**Men = 68**	**p value**
Median age of parent, (years)	32 (range 19-46)	34 (range 18-47)	
Primiparous	86 (67%)	45 (66%)	.945 [a]
Median age of child (months)	9.0 (range 1-48)	10.0 (range 2-48)	
Married/cohabitating	108 (84%)	64 (94%)	.048 [a]
Educational background			.449 [a]
Elementary ≤9 years	10 (8%)	9 (13%)	
Secondary 10-12 years	50 (39%)	26 (38%)	
College/university >12 years	69 (53%)	33 (49%)	
Unemployment	24 (19%)	11 (16%)	.654 [a]
Ethnicity			. 249 [a]
Swedish origin	86 (67%)	53 (78%)	
European origin, other than Sweden	30 (23%)	11 (16%)	
'Outside Europe' origin	13 (10%)	4 (6%)	

[a] Pearson's chi-square test

Subjects of Study II (Paper III, IV)

From the total sample of 197 parents from the clinic who were screened by self-reports for sociodemographic and psychosocial data, a sub-sample of 53 parents reported that they had grown up in a family with substance abusing parents. From that sample, 29 parents who had concluded treatment were consecutively asked if they would participate in the study. Four parents declined, due to lack of time and/or a desire not to revive painful memories and two could not be reached by telephone. 23 persons agreed to participate and of those four did not show up for the interview, giving no explanation. The final sample consisted of 19 informants (13 mothers and 6 fathers) whose children were between 1 and 5 years old at the time of the interview. Table 2

Table 2.
Sociodemographic characteristics of the sample (n=19).

	Women	**Men**
	n = 13	**n = 6**
Age of parent (years)	21-40	27-40
Primiparous	7	5
Age of child (months)	12-60	12-48
Married/cohabitating	9	4
Educational background		
Elementary <9 years	1	1
Grammar/secondary 10-12 years	7	4
College/university >12 years	5	1
Unemployed	1	1

Instruments in Study I (Paper I, II)

A *self-report questionnaire* was designed by the research group for the present study with questions pertaining to sociodemographic and psychosocial risk factors, such as traumatic life events and somatic and psychiatric disorders, including substance abuse in the subjects and in their family of origin. The questionnaire included 13 questions, and the participants were asked to provide a more detailed answer to any initial positive responses (e.g. "Did you or any family member in your family of origin suffer from substance abuse problems (alcohol, prescribed drugs, illegal drugs)? If yes, what kind?") for more details see (Tedgard & Rastam, 2016).

The Hospital Anxiety and Depression Scale *(HADS)* has been shown to be valid and reliable in medical practice and research (Snaith, 2003; Zigmond & Snaith, 1983). The HADS is a Likert-style questionnaire consisting of 14 items (seven for anxiety and seven for depression). The score ranges from 0 (no anxiety) to 3 (greatest anxiety) for each question (Zigmond & Snaith, 1983). The ranges of scores used to define cases are as follows: 0-7, normal; 8-10, mild disorder; 11-14, moderate disorder; and 15-21, severe disorder (Bowling, 2005; McDowell, 2006; Snaith, 2003). A cutoff score of ≥ 8 was used in the present study (Bjelland, Dahl, Haug et al., 2002). The results were compared with the Swedish norm (Lisspers, Nygren, & Söderman, 1997). Previous studies have supported the two-factor model used in this study (Helvik, Engedal, Skancke et al., 2011; Norton, Cosco, Doyle et al., 2013).

The Alcohol Use Disorders Identification Test *(AUDIT)* is an internationally well validated questionnaire assessing alcohol consumption (Saunders, Aasland, Babor et al., 1993). We used the Swedish version of the AUDIT. The AUDIT consists of ten questions, each of which is scored from 0-4 points, so the maximum score is 40. It contains questions relating to the level and frequency of alcohol consumption, heavy drinking, drinking behaviour, and alcohol-related problems. Harmful use of alcohol is indicated by a score of 6-13 points for women and 8-15 points for men, and alcohol dependence is indicated by a score ≥ 18 points. The recommended cutoff scores used in this study were ≥ 6 for women and ≥ 8 for men (Berman, Wennberg, & Källmén, 2012).

The Drug Use Disorders Identification Test *(DUDIT)* is a validated questionnaire evaluating the use of illegal drugs (Berman, Bergman, Palmstierna et al., 2005). Patients at risk of drug use were identified using the Swedish version of the DUDIT. The instrument consists of eleven items designed to assess the consumption patterns of illicit drugs and associated problems. The first nine items are scored on a five-point scale ranging from 0 to 4, and the final two on a three-point scale with the values 0, 2, and 4. The total score therefore ranges from 0 to 44, with higher scores suggesting a more severe drug problem. The DUDIT cutoff score for any type of problematic use (i.e., harmful use, substance abuse, or dependence) is generally recommended to be ≥6 for men and ≥2 for women. The following risk levels are suggested for the DUDIT scores: no drug-related problems (total scores 0-5 for men /0-1 for women), possible drug-related problems, i.e. risky or harmful drug habits that might be diagnosed as substance abuse/harmful use or dependence (6-24 for men /2-24 for women), and probable heavy dependence on drugs (scores ≥ 25).

The ASRS v. 1.1 Adult ASRS Full Edition *(WHO Adult ADHD Self-Report Scale*) is the WHO's self-report rating scale for adult ADHD (Kessler, Adler, Ames et al., 2005). The scale consists of 18 items that are consistent with the *DSM-IV* diagnostic criteria for ADHD symptoms. Items 1 to 9 (Part A) concern symptoms of inattention, and items 10 to 18 (Part B) symptoms of hyperactivity or impulsivity. The internal consistency of the ASRS in this dataset on the basis of Cronbach's alpha was .86 for Part A and .86 for Part B. ADHD symptoms were assessed using the Swedish version of the 18-item ASRS, using the cutoff level of ≥ 24.

The Swedish Parenthood Stress Questionnaire (SPSQ) (Östberg et al., 1997) is based on the Parent Domain of the Parenting Stress Index (Abidin, 1995). The SPSQ measures parenting stress and comprises 34 items divided into five subscales: *incompetence, role restriction, social isolation, spouse relationship problems, and health problems.* The *incompetence* subscale covers general experiences of caregiving, feelings of incompetence in the parental role, and difficulties of parenthood. The *role restriction* subscale describes narrowing of interests and activities due to parental responsibilities, e.g. *"Since I had children, I have almost*

no time to myself". The *social isolation* subscale focuses on social contacts outside the family, e.g. *"When I get into a problem situation with the children, I have many people I can turn to for help and advice"*. *Spouse relationship problems* concern social experiences with the partner within the family. The final subscale, *health problems*, concentrates on physical fitness, infections and fatigue caused by the demands of parenthood (Östberg, Hagekull, & Hagelin, 2007). Together, these five subscales form an overall parenting stress score. The response options range from 'strongly agree' to 'strongly disagree' and are scored on a Likert-type scale from 1 to 5. Higher scores indicate more stress. The instrument has been validated in several studies, has shown good psychometric properties (Östberg, 1998; Östberg et al., 1997) and shows stability over time (Lagerberg, Magnusson, & Sundelin, 2011; Östberg et al., 2007). In this study, the results are compared with the results from a Swedish normal community sample (Östberg, 1998). No cutoff scores of clinical significance have been established, but in previous research, items scored as a 4 or a 5 have been considered problematic (Johansson, Svensson, Stenström et al., 2017).

Instruments in Study II (Paper III)

***The Attachment Style Questionnaire*, ASQ** (Feeney, Noller, & Hanrahan, 1994) has been translated into Swedish (Håkansson, & Tengström, 1996) and contains 40 items. ASQ is used to evaluate common themes in attachment theory such as trust, dependence and self-reliance in relationships in general (Feeney et al., 1994), as well as measuring basic personality factors such as the ability to have intimate and romantic relationships (Roisman, Holland, Fortuna et al., 2007). The questions in ASQ can be analysed in two separate factors (secure and insecure attachment) but can also be analysed on the basis of a three-factor structure in line with Hazan's and Shavers's (1987) conceptualization of attachment (secure, anxious and avoidant)(Hazan & Shaver, 1987). ASQ answers range from 1 (totally disagree) to 6 (totally agree). Feeney et al (1994) reported internal consistencies for the English version and found adequate Cronbach's alphas for the sub-scale security (.83), avoidance (.83) and anxiety (.85). The test-retest reliability over a period of approximately ten weeks was 0.74, 0.75 and 0.80 for the three subscales. The internal consistency for the three subscales in the Swedish version is in the same range as for the English original version (Håkansson, & Tengström,1996).

SPSQ, HADS, AUDIT, DUDIT, ASRS and ASQ have all been validated for the Swedish population.

Procedure

Study I (Paper I, II)

The study focused on self-reported data from women and men participating with their children (median age 10 months) in an IMH program in a specialized outpatient infant and toddler psychiatric clinic in Sweden. They were treated in the unit because of deficient parenting behaviour and dysfunctional patterns of interaction with their child. All participants were referred for treatment either through self-referral (60%) or through referral by a doctor or nurse from primary care, adult psychiatry, or the paediatric clinic. Parents diagnosed with intellectual disabilities were not treated at the unit. The data were collected before the start of the intervention. The data are stored in a database titled 'Factors Important for Parenting' at the Skåne County Council. The questionnaires were administered by an experienced administrator. At admission, the parents were informed about the study by the administrator and if they agreed to participate in the study, she collected the consent forms.

The administrator was then responsible for the distribution and collection of the instruments that were used.

Study II (Paper III, IV)

The subjects were invited by letter that also contained information concerning the study. A week later they were contacted by phone by the interviewer and asked if they would like to participate. All participants gave their written consent including permission both to use information from the self-reported data from study I and to tape record the interviews. The subjects received two cinema tickets as a compensation for participating. None of the participants were partners with each other and none of the participants have received treatment from or had previous contact with the psychologist (ET) who carried out the interviews. The in-depth interviews were conducted after the families had finished treatment at the IMH unit.

Analytical methods Study I (Paper I, II)

Statistical analyses were performed using the IBM SPSS software package for Windows. Differences were regarded as significant when the p-value was less than 5% ($p<.05$). We did not perform any analysis of mass significance (e.g. Bonferroni-Holm test).

Comparison between groups (Paper I, II)

Pearson's chi-square test

The chi-squared test is a non-parametric test used to determine whether there is a significant difference between the expected frequencies and the observed frequencies in one or more independent categorical variables. It compares the frequency of cases found in the various categories of one variable across the different categories of another variable. This method was used as part of the analysis in Paper I and II to determine possible significant differences between parents with and without substance abuse in their family of origin.

Fisher's exact test

The Fisher's exact test is used to determine if there are non-random associations between two categorical variables. It is more accurate than the Pearson's chi-square test when the expected numbers are small. It was used in Paper II to check for possible differences between fathers with and without substance abuse in their family of origin and their own prior substance abuse.

Independent samples Students t-test

The independent samples Students t-test can be used to compare mean scores on continuous variables for two independent groups. It assumes approximately normal distribution of the dependent variable and homogeneity of variance between groups. Normal distribution is less important in samples bigger than 30. This method was used as part of the analyses in paper I and II.

Correlation analysis (Paper II)

Linear regression

Linear regression is a method of exploring the relationships among, and testing hypotheses about, a dependent variable and several independent variables. It was used to analyse variables and interactions that predict parenting stress, including symptoms of depression, anxiety, divorce in family of origin, and traumatic life experience.

Analytical methods Study II (Paper III, IV)

Measures

The main methodological approach was qualitative – meaning that focus was on describing and understanding the life stories told at the interviews (Hyden, 1997; Launer, 2002). The study had both a retrospective quality design using in-depth interviews that focused on the subject's upbringing and a questionnaire with a cross-sectional design that measures current attachment style.

In-depth interview (Paper III, IV)

The in-depth interviews were conducted between May 2012 and June 2013. A semi-structured interview guide was used in order to access many different aspects, while at the same time ensuring that everyone was asked the same key questions. The guide contained questions regarding experiences from childhood and included: family climate, relationship to parents, network and school. There were also questions concerning the present, and these included their own experience of being a mother or a father. The subjects were free to express themselves and to associate in different directions to the open-ended questions, and efforts were made to get small narrative examples that illustrated the answers, in order to enhance understanding. The interviews lasted from 90 to 150 minutes. Each interview was tape-recorded after obtaining permission from the informants. Before the data analysis started the interviews were transcribed verbatim.

The questions asked focused to a large degree on the past and when asking people to recall the past there is usually no way of controlling "the facts". The data collected are accepted as the memories and experiences that the women and men have of their childhood and upbringing. It is assumed that their recollections of historical events, recalled in response to the retrospective questions of the interviewer, are influenced by the narratives they have in the present (Kvale & Brinkmann, 2009).

Data Analyses Study II (Paper III, IV)

Directed Qualitative Content Analysis (Directed QCA) was used to identify, classify and code the themes and patterns of the interview data (Graneheim & Lundman, 2004; Hsieh & Shannon, 2005; Sandelowski, 2000). With Directed QCA an analysis starts with a specific theory or with relevant research findings that are used as a guide for the initial codes that are selected (Graneheim, Lindgren, & Lundman, 2017). In this study the research findings presented in the introduction were used as a starting point. Directed QCA differs from some other qualitative methods (e.g.

grounded theory) in that it is more structured and involves inductive, deductive and adductive approaches (Krippendorff, 2013; Pisarik, Rowell, & Currie, 2013).

The aim of directed QCA is to present a thick description of the informants' own stories (Graneheim & Lundman, 2004; Hsieh & Shannon, 2005). The inductive approach, also called data-driven (Schreier, 2012) or text-driven (Krippendorff, 2013), is characterized by a search for patterns. During the analysis, based on answers containing feelings, reflections and memories as described in the texts, the researcher looks for similarities and differences in the data, which are described in categories and/or themes on various levels of abstraction and interpretation. Keeping as faithful as possible to the data is considered crucial, even if all analysis infers some degree of interpretation. The researcher moves from the data to a theoretical understanding – from the concrete and specific to the abstract and general (Graneheim et al., 2017). Using a deductive approach, also called concept-driven (Schreier, 2012), researchers test the implications of existing theories or explanatory models about the phenomenon under study against the collected data.

After careful reading of all the interviews many times, the text was − with an inductive starting point − divided into "meaning units", which are those parts of the texts that relate to the aims of the study. All meaning units were then condensed, while care was taken to preserve the original content. The condensed meaning units were given codes. The codes were then grouped into sub-categories and thereafter to mutually exclusive categories, depending on similarities and differences in content. The emerging categories were then closely examined and discussed by the research team and reorganized until consensus was reached. Finally, we searched across categories to identify recurring regularities that could be expressed as themes.

The first author (ET) performed the analysis throughout the whole analytical scheme, and the last author (IW) participated in all steps after the coding process. The analytical process had a continual back-and-forth movement between the emerging categories and the original parts of the text in order to secure trustworthiness and a comprehensive understanding of the material. In addition to the inductive-analysis of the transcribed interviews, items from the "Parentification Questionnaire" (Jurkovic, &Thirkield, 1998) were used to analyse the same interview material so that the theoretical method (Directed QCA) was complemented by a more deductive approach in order to obtain a more complete understanding by analysing specific aspects of the material – for example their experience of role reversal regarding responsibilities in the family. Examples of the items that were applied to the interview material include: "In my family I often made sacrifices that went unnoticed"; "I often felt more like an adult than a child in my family" and "At times I felt I was the only one my mother or father could turn to". This approach implies continually moving back and forth between inductive and deductive approaches − from theory to data and back again (Graneheim et al., 2017).

Validity and quality of the qualitative analyses

Ensuring validity in a qualitative study is a constant process throughout every stage of the research project. Constant scrutiny is required to ensure that the study maintains high quality and generates relevant knowledge (Kvale & Brinkmann, 2009; Yardley, 2017). This applies not only to the design of the study, but also to the choice of methods and to the procedures that are followed for the collection and analysis of data (Lawrence, 2015). Finally, every stage in the process is described in a clear and methodical manner. One way to describe and evaluate the quality of qualitative research is to see that sufficient care has been taken in four important dimensions: commitment and rigor, sensitivity to context, transparency and coherence and finally impact and importance (Yardley, 2017). *Commitment and rigor* were observed and followed for example in the way in which the population was selected. One of the first steps was to maintain a double-check on the information received in the preliminary enquiry (as to whether the potential participant had grown up with substance abusing parents) by first writing to the potential participants, and then by taking telephone contact with them. *Sensitivity to context* was followed by examining every response made by the participants and trying to understand it in its own terms, rather than using a pre-prepared coding system. In dealing with the interview material, *transparency* was created by describing every step of the process so that the reader can understand the way in which the material is analysed and interpreted. Finally, as regards *impact and importance* - at the present time knowledge is rather limited concerning how being raised in a family where substance abuse is present affects the development of parenting skills. It is important to know more, as so many families are potentially affected.

Ethical considerations

All procedures performed in the present study were in accordance with the ethical standards of the institutional research committee and with the 1964 Helsinki declaration as developed by the World Medical Association (WMA) which are a set of ethical principles for medical research involving human subjects, including later amendments. Ethical approval was obtained from the Regional Ethics Committee in Lund, Sweden (Dnr 2011/193).

All participants were given written and oral information about the studies and had the opportunity to ask questions before agreeing to participate. They were informed of their right to withdraw from the studies at any time, without giving any reason, and that this would not have any consequences for the treatment. All participants gave their written consent.

In order to protect confidentiality, all statistical analyses were performed on coded data files. The tape-recorded interviews and the interview transcripts were also coded, and the code keys were stored separately from the research data.

In Paper I and II the self-reporting questionnaires were administered by an administrator before treatment commenced. None of the therapists were allowed to access the information obtained from the questionnaires in order to ensure that it would not influence the therapeutic alliance or the construction of treatment strategies.

In Paper III and IV selected parents were informed by letter that we wished to interview them because in the questionnaire they had reported that they had grown up with substance abusing parent(s). They were also told that the interview would focus on difficult and possibly painful material from their childhood.

All but one of the interviews were carried out on the institution's premises, a decision based on the premise that the informants would thus be in familiar but not personal territory. In consideration of the possibility that the informant might experience problems after the interviews they were offered the chance to be referred for further counselling. One of the participants used that opportunity.

Results

Study I Self-reported psychiatric symptoms at admission (Paper I, II)

Gender differences in terms of sociodemographic and psychosocial data

The female participants were aged between 19 and 46 (median age 32 years; SD 5.28), and the male participants were between 18 and 47 (median age 34 years; SD 5.75). Being a single parent was more common among the mothers (16% vs. 6%, p=.048). Of the 129 women in the sample, 104 (81%) had anxiety symptom scores that were above the above recommended cutoff (≥ 8), compared with 34% of the fathers (p<.001). The mothers were also more affected by symptoms of depression (40% vs. 16% p=.001), parenting stress (3.13 vs. 2.67 p<.001) and had experienced trauma more often (64% vs. 37% p=.001) when compared with the fathers. The traumatic life events most frequently reported by the mothers were severe physical abuse, sexual abuse, and death in the immediate family. For the fathers, it was severe physical abuse and death in the immediate family, see Table 3.

Table 3.
Summary of statistics for health measures and demographic characteristics (n=197)

	Mothers n = 129	**Fathers n = 68**	**p value**
Upbringing with substance-abusing parent	35 (27%)	18 (27%)	.896 [b]
Symptoms of depression	52 (40%)	11 (16%)	≤.001 [b]
Symptoms of anxiety	104 (81%)	23 (34%)	≤.000 [b]
Symptoms of ADHD	26 (20%)	9 (13%)	.209 [b]
AUDIT	11 (9%)	10 (15%)	.188 [b]
DUDIT	11 (9%)	2 (3%)	.127 [b]
Experienced traumatic life event	77 (60%)	25 (39%)	≤.001 [b]
Parenting stress	3.13 (SD 0.6)	2.67 (SD 0.6)	≤.000 [a]

a T-test, b Pearson's chi-square test

Parenting stress in the clinical group compared to the normal Swedish population

The mean score on the parenting stress questionnaire (SPSQ) was 3.13 for the mothers and 2.67 for the fathers. All the results for the mothers on the parenting stress questionnaire were significantly higher (p=.000) than the norm for Swedish women (Östberg, 1998). The results for the fathers were also significantly higher than the norm for Swedish fathers (p=.000) (Hildingsson & Thomas, 2014).

Substance abuse in parents in the family of origin (Paper I, II)

Of the participating parents, 35 (27 %) of the women and 18 (27%) of the men reported that they were raised in families with substance abuse. These two groups constituted the index groups (see table 4). Alcohol abuse was the most common form of substance abuse. The COMP groups consisted of 91 women and 50 men who stated that there was no alcohol and/or drug abuse in their family of origin.

Table 4.
Substance abuse in the family of origin (n=53).

	Index women	**Index men**
	n = 35	**n = 18**
Childhood in which both parents had substance abuse	10	2
Childhood in which mother had substance abuse	10	3
Childhood in which father had substance abuse	15	13

In the index group of women there were significantly more single mothers and a higher incidence of prior personal drug abuse. It was also more common that the women with an upbringing with substance abusing parents had more symptoms associated with depression and ADHD, more experiences of traumatic life events and a history of divorce in the family of origin compared with the COMP women, see Table 5.

The index group of men had a lower level of education, more often a history of divorce in the family of origin and reported higher number of traumatic life events compared with the COMP men. See table 6. The men reported being the victims of rape, assault and violence in combination with alcohol/drugs.

Table 5
Demographic characteristics and health measures for Index women vs COMP women (n=129)

	Index women n = 35	**COMP women n = 91**	**p value**
Median age of parent, (years)	31(range 19-40)	33 (range 20-46)	
Primiparous	23 (66%)	62 (67%)	.919 [a]
Median age of child (months)	11(range 2-48)	8 (range 1-48)	
Married/cohabitating	25 (74%)	82 (88%)	.045 [a]
Educational background			.200 [a]
Elementary ≤9 years	5 (14%)	5 (5%)	
Secondary 10-12 years	14 (40%)	35 (38%)	
College/university >12 years	16 (46%)	53 (57%)	
Unemployment	9 (26%)	15 (16%)	.226 [a]
Ethnicity			.203 [a]
Swedish origin	19 (54%)	66 (71%)	
European origin, other than Sweden	11 (32%)	19 (20%)	
'Outside Europe' origin	5 (14%)	8 (9%)	
Parents in original family divorced	23 (66%)	36 (39%)	.006 [a]
HADS Symptoms of depression	19 (54%)	33 (36%)	.043 [b]
HADS Symptoms of anxiety	29 (83%)	75 (81%)	.775 [a]
ASRS Symptoms of ADHD	11 (31%)	13 (14%)	.024 [a]
AUDIT Alcohol use last 12 months	5 (14%)	6 (7%)	.165[a]
DUDIT Drug use last 12 months	6 (18%)	5 (6%)	.041[b]
Experienced traumatic life event	28 (85%)	49 (56%)	.004[a]
Parenting stress	3.23 (SD 0.5)	3.10(SD 0.6)	.150[c]

[a] Pearson's Chi-Square test [b] Fisher's Exact Test [c] T-Test

Table 6
Demographic characteristics and health measures for Index men vs COMP men (n=68)

	Index men n = 18	**COMP men n = 50**	**p value**
Median age of parent, (years)	32 (range 18-43)	35 (range 23-47)	
Primiparous	13 (72%)	32 (64%)	.527 [a]
Median age of child (months)	10.0 (range 3-48)	10.5 (range 2-48)	
Married/cohabitating	16 (89%)	48 (96%)	.272 [a]
Educational background			.004 [a]
Elementary ≤9 years	5 (28%)	4 (8%)	
Secondary 10-12 years	10 (55%)	16 (32%)	
College/university >12 years	3 (17%)	30 (60%)	
Unemployment	5 (28%)	6 (12%)	.119 [a]
Ethnicity			.464 [a]
Swedish origin	15 (83%)	38 (76%)	
European origin, other than Sweden	3 (17%)	8 (16%)	
'Outside Europe' origin	0 (0%)	4 (8%)	
Parents in original family divorced	11 (61%)	16 (32%)	.030 [a]
HADS Symptoms of depression	4 (22%)	7 (14%)	.437 [a]
HADS Symptoms of anxiety	9 (50%)	14 (28%)	.102 [a]
ASRS Symptoms of ADHD	1 (6%)	2 (4%)	.783 [a]
AUDIT Alcohol use last 12 months	1 (6%)	9 (18%)	.201[a]
DUDIT Drug use last 12 months	2 (11%)	0 (0%)	.067 [b]
Experienced traumatic life event	15 (83%)	10 (20%)	<.001[a]
Parenting stress	2.76 (SD 0.6)	2.64 (SD 0.6)	.421[c]

[a] Pearson's Chi-Square test [b] Fisher's Exact Test [c] T-Test

Perceived parental stress (mothers) (Paper II)

For the women in the Index group symptoms of depression predicted a high score of parental stress and for the women in the COMP group symptoms of both depression and anxiety predicted a high score in the SPSQ. See Table 7.

Table 7
Summary of regression analysis for variables predicting parental stress for all women and subgroups Index women and COMP women (*N*=129)

Variable	All women (*N*=129)			INDEX women (*N*=35)			COMP women (*N*=94)		
	β	SE β	sign	β	SE β	sign	β	SE β	sign
HAD Anxiety	.367	.119	.002	.415	.211	.060	.350	.145	.018
HAD Depression	.574	.091	.000	.435	.170	.016	.659	.112	.000
Traumatic life event	.107	.089	.233	-.175	.215	.424	.163	.103	.116
Divorce in family of upbringing	-.103	.087	.238	-.198	.178	.275	-.038	.106	.718
	R^2 .381			R^2 .341			R^2 .419		

Perceived parental stress (fathers) (Paper II)

Among fathers in the Index group symptoms of anxiety predicted a high score in the SPSQ. For fathers in the COMP group symptoms of depression predicted a high score in the SPSQ. See table 8

Table 8
Summary of regression analysis for variables predicting parental stress for all men and subgroups Index men and COMP men (*N*=68)

Variable	All men (*N*=68)			INDEX men (*N*=18)			COMP men (*N*=50)		
	β	SE β	sign	β	SE β	sign	β	SE β	sign
HAD Anxiety	.091	.136	.505	.569	.256	.045	-.107	.181	.557
HAD Depression	.623	.176	.001	.486	.293	.121	.622	.223	.008
Traumatic life event	.100	.123	.419	-.191	.319	.559	.056	.179	.756
Divorce in family of upbringing	.025	.127	.845	-.005	.227	.981	.122	.178	.496
	R^2 .261			R^2 .561			R^2 .190		

Results Study II (Paper III, IV)

Results pertaining to some background factors from self-reports in Study I

At the time of the interviews, only two were unemployed, all had their own home, and almost all had finished high-school or post-secondary studies. Thirteen of the subjects lived together with the parent of their child. Mental health problems that they had experienced during childhood – mostly in the form of depression and anxiety – were often still present at the time they began participating in the program and influenced their parenting abilities in a negative manner. A few had been in psychotherapy before entering the family program.

Experience of a childhood with substance abusing parents

Family climate and prevalence of abuse and neglect

Almost all of the informants had been the victims of emotional neglect and had suffered emotional abuse and many described being physically abused. Most of the interviewees described their parents to be unpredictable in terms of being loving or violent and they did not believe that they were loved by either of their parents. They felt that they were neither understood as individuals nor affirmed for the responsibility that they often took in the family.

Almost none of the violent incidents resulted in reports to the Social Work Authorities or visits to a health-care centre. Most of those interviewed described their parents' relationship as conflict-laden at best, often disastrous, resulting in divorce or separation. When the interviewees reflected over their upbringing, several of them stated that they had difficulties in trusting people as a result of their upbringing.

Inadequate support for the development of functional affect regulation

As children the subjects had experienced difficulties in understanding and dealing with their feelings, and they reported that their parents were incapable of helping them. Many told of own deficient anger control and externalized, aggressive outbursts. They had learned to dissociate from their difficult feelings during their childhood and continued to do so as adults. It was especially difficult to handle the fact that their parents fiercely denied the existence of their substance abuse and as a result the subjects were isolated with their own experiences, unable to talk with anyone about their home situation. This increased their feelings of fear and insecurity, and of being abandoned. Many had poor self-preservation strategies.

Most said that the dysfunctional family context made them feel very bad and that they suffered from all kind of mental health problems during their childhood. Several described how they put themselves into dangerous situations during their childhood.

Taking the role of a parent

Most subjects described that during their childhood their role was to look after, care for and forgive their parents. They described a kind of role reversal in the family.They were the ones who had to manage difficult situations, and when something bad happened to them, they had to be a parent to themselves. It was a childhood in which they took both a practical and an emotional responsibility for the family, and above all took care of their parents. The informants brought home drunken parents from the pub, took care of contacts with the police when fights broke out, took contact with the social services and tried to stop the doctor from prescribing medicines that their parents abused. They also had to protect younger siblings from being physically abused - for example by keeping themselves awake and staying on guard and when necessary ringing a neighbour or the police. This disturbed their sleep and their peace and quiet so that they could not do their schoolwork. Consequently, they did not get the necessary support to develop a sense of personal autonomy, or to acquire adequate affect regulation and necessary social skills.

School time

Problems in school were common with attention and learning problems, changing schools, bullying and truancy. For some school was a place where they could get positive affirmation, often from "nice" teachers, and for them school was seen as a refuge from the stressful home conditions.

The silence of the social network

One important, recurring theme for many was the silence of the adults in their network regarding their home situation. Almost all of the informants told that they had never spoken to anyone about their home situation and that they had absolutely no-one with whom they could talk about their parent's substance abuse. They said that they had no support from either their relatives or from the neighbours, and that not a single adult in their immediate circle acknowledged in any way that they were aware of their difficult situation. Most of the interview subjects told how difficult or even impossible it was to talk about their parents' substance abuse. It was something that was always present, but which could not be put into words. Even if there was no official or explicit ban in the family about talking about the substance abuse (as it could not be talked about) the informants experienced strongly that it was a forbidden subject.

Being drawn into abuse themselves

Several subjects interviewed described that they themselves had had a serious substance abuse, often beginning in their early teenage years. When they reflected over this, they had difficulties in understanding and explaining for themselves how they were drawn into the world of alcohol and/or/drugs despite the fact that they did not want to.

The psychosocial situation and psychological well-being of the interviewees at the time of the interview

All of the interview subjects had experienced a high degree of stress and inadequacy in their role as parents and identified these feelings as being the primary motive for seeking help from the Infant and Toddler Psychiatric Unit. The majority described that they experienced being a parent as very demanding. Many of them said that they lacked constructive models for how a parent could be, and that they only knew that they wanted to be *"100% different"* from their own parents. Many said that the emotional coldness, the silence and the lack of engagement that they had experienced from their misusing parents were qualities that they did not want to be a part of their own parenting as this would mean that they would then become a part of their own children's developmental experience. The majority stated that they did not want their own children to have contact with the misusing grandparent(s).

Challenges in being a parent oneself

High levels of parental stress

Most subjects experienced being a parent as very difficult. They described a high degree of parental stress and lived with strong feelings of anxiety. All of the informants reported that they had experienced threatening or traumatic events both as children and as young adults. Almost all of the traumatic events that were described involved threats of violence and actual violence directed against them personally, in which they were physically beaten or were the victim of sexual abuse or rape. For half of the interviewees such traumatic events were carried out by their substance abusing parents.

The interviewees described how the effects of traumatic events had been reinforced after they had become parents themselves and had responsibility for a defenceless child. The trauma that they had experienced meant that they were continually alert for possible danger, above all in relation to their child, which meant that they had difficulties in interpreting their child's signals in a sensitive, nuanced way. The feeling of anxiety could become dominant in relationship to the child, and influence both interaction and intimacy. It could also result in them acting in an over-

protective manner towards the child and thus limiting the child's world of possible experience.

Difficult and challenging feelings

Other expressions of parental stress were described in terms of having difficulties understanding and managing their own negative feelings towards their children. They had difficulties in being balanced and were either too demanding or too compliant. One woman described how she sometimes wanted her child to just disappear and another could not stop herself from shouting and screaming at her child when she showed signs of unhappiness. Some could not bear to see their child become frustrated and they wished that they could give their child everything that she wanted. Many interviewees described poor anger control, and that the child became the target for these feelings.

Anxiety and guilt in being separated from the child

Another difficult area concerned separation: even brief separations from their child were experienced as a threat to their relationship and even to their own identity.

Several of the parents described a conflict they had between wanting to be always available for their child, whilst at the same time needing to be able to take care of their own needs. Such contradictory experiences created conflicts within the parents, resulting in emotional outbursts that were difficult to control, followed by paralyzing feelings of guilt that were coupled to the fear that their child would not like them anymore and that they were not a good enough parent.

Lack of trust

Many of the interviewees described that because of their experiential history, it was difficult for them to trust the people around them. This applied to trusting a neighbour or a teacher who worked at the official child-care services. At the same time they were conscious of how important it was for their child's sake to be able to display trust and to show the child that the world is a good and safe place. The single most important desire amongst all of those interviewed was to have the ability to give to their own children that which they themselves had not been given in their own childhood – and a little more if possible.

Attachment style according to ASQ

A majority of the subjects had an insecure attachment style. The most common pattern involved an ambivalent attitude towards relationships: on the one hand they had difficulties in trusting others and being dependent upon them, whilst on the other hand emphasising the importance of close relationships.

General discussion

The motivation for this thesis was the desire to learn more about a group of patients that seemed particularly vulnerable - patients who had grown up with substance abusing parents. How did they experience their own childhood, and how did that experience influence them when they became parents themselves? The possible value of this information was that it could be of practical use in developing more effective treatment interventions for those who had difficulties in their parenting role and who themselves had experienced different forms of neglect and abuse. While many studies have explored the ways in which children to substance abusing parents are exposed to neglect and abuse and how this is connected to an increased incidence of mental disturbance (Balsa et al., 2009; Burnett et al., 2006; Cuijpers, 2005; Hill et al., 2008; Kelley et al., 2011; Velleman et al., 2008), there is less knowledge concerning how such childhood experience influences the development of the individual when she becomes a parent herself (Wiig et al., 2017).

This thesis is anchored in an earlier report carried out in an IMH unit which identified mothers who had grown up in a family where one or both parents were substance abusers (Tedgård, 2008). The data in this thesis were collected from analyses of self-report questionnaires and in-depth interviews carried out over a two-year period with men and women who had turned to the IMH unit seeking support for their parenting role.

It has been said that parenthood consists of three elements: the parent, the child and their relationship. David Winnicott's famous statement - "There is no such thing as an infant – there is only a child and a mother" – emphasizes the observation that an infant can only exist within the relation that is to be found between the primary caregiver and the child (Winnicott & Lundh, 1983). The relationship is formed by both actors – caregiver and child – and is molded by the continuous feedback loop of mutual influence. This study reflects data from one of the three elements: the parents themselves.

Comments on main findings in Study I (Paper I, II)

Growing up with substance abusing parents

In study I almost 30% of the mothers and the fathers reported an upbringing with substance abusing parent/s: this in comparison with the three percent of all children in Sweden who grow up in families with severe alcohol and/or drug abuse according to a large longitudinal patient register study. That same study reported that seventeen percent of children in Sweden live with parents with high-risk levels of alcohol consumption (Hjern et al., 2015). In other words, there is a strong over-representation of adults who were children to substance abusing parents in the group that sought help from IMH.

A comparison of women with and without substance abusing parents (Paper I)

The women who participated in the study and who had substance abusing parents experienced more difficulties than other women - for example, it was more frequent that they themselves had misused drugs. This fits with previous studies that report that girls with substance abusing parents may be more susceptible to mental disorders and substance abuse than boys (Chassin, Pitts, DeLucia et al., 1999; Morgan et al., 2010; Sørensen, Manzardo, Knop et al., 2011). Further, the women reported significantly higher levels of symptoms associated with ADHD when compared to the women without substance abuse in their family of origin. One meta-analysis which studied parents who had the diagnosis of ADHD noted that this disability could influence parenting skills negatively in that parents behaved in inconsequent ways – an observation that held true across different categories of ADHD (Park et al., 2017).

Symptoms of depression were more common with women who had grown up with substance abusing parents when compared to those who had not. Today, a great deal is known about how depression influences parenting in a negative way: for example, that it is more difficult for a depressed parent to respond to her child's signals, more difficult for her to help reduce her child's stress and to offer positive feedback (Barr, 2008; Feldman, 2007). Depression may affect the interaction between parent and child in such a manner that the child's development may be influenced in negative ways in a number of basic areas (Field, 2010; Luoma, Tamminen, Kaukonen et al., 2001; Murray et al., 2011; Murray, Fearon, & Cooper, 2015; Thompson & Fox, 2010).

The women who had grown up with substance abusing parents had experienced more traumatic events than those who also participated in treatment and who had been raised in families where there was no substance abuse. Earlier studies show that children from families where there are substance abusing parents are subjected to more serious traumatic events (Killén, 2009; Taplin, Saddichha, Li et al.,2014) and that this is yet another factor that may negatively influence their parenting abilities (Cohen et al., 2008; Thakar et al., 2013). Trauma, even when it occurred a long time ago, is a risk factor that may influence a parent's feelings about whether or not they are able to protect their own child. The interaction with the child may be imbued with the traumatized parent's stress and aggressive behaviour (Lang et al., 2010; Thakar et al., 2013).

Further, the offspring of substance abusing parents in this thesis had more often experienced that their parents separated. When parents separate children are affected on many levels. Factors such a parental conflict, place(s) of residence and economic standards may all have a deleterious effect on the child's school situation (Bramlett & Blumberg, 2007), behavioural development (Richards & Wadsworth, 2004) and even health (Weitoft, Hjern, Haglund et al., 2003). A Swedish study showed that a significantly higher number of children - especilally the girls, whose parents were divorced - sought help from CAP services compared to children living with both parents. (Ängarne-Lindberg & Wadsby, 2012).

A comparison of men with and without substance abusing parents (Paper II)

The men at IMH, those who had grown up in a family where one or both parents were substance abusers had a significantly lower level of education, more frequently experienced trauma and experienced parental divorce more often then the rest of the men. A Swedish register study that examined physical health and psychosocial factors amongst children who had grown up with substance abusing parents found that there was a four times higher risk for personal substance abuse, a threefold higher risk for an early death and a significantly lower chance of continuing their education after secondary shool (Hjern, Arat, & Vinnerljung, 2014).

Gender differences in the total sample of parents in treatment (Paper II)

In order to make a general comparison between mothers and fathers, data from all patients in the study were coded by gender. As a group, the mothers who participated in treatment at IMH had a higher incidence of mental health problems than the fathers, as well as higher rates of symptoms generally connected with depression

and anxiety. They also had higher degrees of parenting stress and had experienced more traumatic events than the fathers. All of these factors – individually or together - are likely to impair the development of parental competence.

It has been established that there is a gender difference in affective disorders: women in their reproductive years, for example, run twice the risk of suffering from major depression in comparison to men (Kessler, McGonagle, Swartz et al., 1993; Soares & Zitek, 2008; Sundström Poromaa, Comasco, Georgakis et al., 2017). The differences have been attributed variously to the effects of the burdens of pregnancy, childbirth, female sex steroids and parenting (Sundström Poromaa et al., 2017). Another factor is that women, even as children, are socialized into caregiving and parental roles and in most families the primary caregiving relationship still involves the mother rather than the father (Genesoni & Tallandini, 2009; McBride, Brown, Bost et al., 2005). This places an extra burden on the woman, one which may be experienced in both positive and negative ways. Guilt and shame are factors which have been suggested to be inherent elements of motherhood in our society (Sutherland, 2010). Further, an association has been found between feelings of shame and depression (Kim, Thibodeau, & Jorgensen, 2011).

As a group, men have a lower incidence of post-partum depression when compared to women (Cameron, Sedov, & Tomfohr-Madsen, 2016). However, there is an ongoing discussion about how depression in men is diagnosed. The incidence of depression in men may be underestimated as it seems that they express different kinds of symptoms and so there could be a diagnostic bias (Brownhill, Wilhelm, Barclay et al., 2005; Veskrna, 2010). In addition to decreased activity and sadness, which are confirmed symptoms of depression in both men and women, men often express their depression through irritability, anger, hyperactivity, and poor impulse control (Winkler, Pjrek, & Kasper, 2005). This may imply that more men in our study could suffer from depression than those actually identified, as current instruments do not include these different symptoms (Psouni, Agebjörn, & Linder, 2017). If this is correct, it is important to identify and include gender-differentiated symptoms in the diagnosis of depression and anxiety in order to be able to offer more adequate support to associated caregiving difficulties (Stein, Pearson, Goodman et al., 2014).

However, as an example of the increasing interest in and an increased knowledge of the importance of the father for children's development, a recent review reporting on both mothers and fathers notes the negative effects of the mothers' postnatal depressive moods on early child development, and the protective effect of nondepressed fathers (Hoffman, Dunn, & Njoroge, 2017).

Hypothetically, changing gender roles might help in reducing differences in levels of parenting stress and mental disorder, especially in those countries where fathers have the possibility to stay at home for several months and share parenting

responsibilities. However, while an emotional openness and a sensitive involvement in the child's development enriches the parenting role, it also opens the risk of increased vulnerability both for men and women. A recently published study that examined "happiness" in different countries indicates that family relationships are crucial when parents share responsibility for child-care. In those countries where gender equality is high, family relationships rather than work relationships have most significance for the experience of "happiness". In countries with more traditional gender roles, family relationships are not to be so important for men in relationship to the idea of "happiness" (Nordenmark, 2018).

Factors that predict parenting stress (Paper II)

In Paper II, depression predicts a higher rate of parenting stress for both mothers and fathers, which is in line with some earlier studies (Andersson & Hildingsson, 2016; Saisto et al., 2008). For mothers in paper II, anxiety was also a predictor, a connection confirmed by a recent Italian study (Crugnola, Ierardi, Ferro et al., 2016), and anxiety is thus a factor that should be considered in treatment planning.

Comments on main findings in Study II (Paper III, IV)

Descriptions and reflections over an upbringing with substance abusing parents (Paper II, IV)

Sweden has a clearly defined ambition to offer support to children who live in vulnerable families and a relatively new law assigns responsibility to staff in health and welfare services to be attentive to the needs of children with, for example, substance abusing parents (Johnsson & Sahlin, 2010). Despite the fact that support groups are being created in Swedish boroughs *(kommuner)* (Elgán & Leifman, 2011) difficulties are experienced both in identifying such children and in getting them to attend the help programs that are available (Cuijpers, 2005). At the same time those who participated in the present study clearly described difficulties in obtaining help during their childhood. The analysis of the interview material they provided reveals an "external perspective" that identifies conditions and factors in their childhood and adolescence which, if they had been observed, could have caused alarm-bells to ring. At the same time, the same material provides an "internal perspective" where the thoughts and conclusions presented by the participants describes the complexities to be found in their life-situation.

Adverse Childhood Experience and Trauma (Paper III, IV)

All of those interviewed described how they had been victims of traumatic events, often in the form of violence or sexual abuse. Several of them described how, in their family, they had been subjected to repeated trauma during their childhood in the form of aggression, threat and/or humiliation, without having access to any form of protection. The presence of emotional abuse was often reported and research suggests that emotional abuse has the most negative effect on a child's development (Allen, 2011; Glaser, 2011; Iwaniec, Larkin, & Higgins, 2006) and is that form of abuse most likely to influence one's own parenting in a number of negative ways (Banyard, Williams, & Siegel, 2003; Muzik, Bocknek, Broderick et al., 2013; Steele et al., 2016).

The culture and the conspiracy of silence (Paper IV)

In families where substance abuse is present, it is common that it becomes almost like a member of the family, rather in the manner of an elephant that is always in the room but which no-one is allowed to mention (Kroll, 2004). This "culture and conspiracy of silence" that the interview participants described risked to influence in negative ways both their internalized image of self and of the world. They revealed that they had not been able to talk with anyone about the difficulties they experienced in the family, that they received hardly any emotional support from anyone and little or no support from society. The culture of silence, together with the experience of many difficult experiences that were connected to the "elephant" of substance abuse, may have contributed to a distortion of the subjects' perception of the world, in that they had no help in trying to cope with what was happening to them, and just as little help in understanding it or being protected and comforted. Consequently, it was made more difficult for them to learn how to identify and protect themselves from danger and they often felt very uneasy in the face of what for others were ordinary everyday situations. Children who do not get adequate help to identify and prioritize their own needs run a risk of developing inadequate strategies to take emotional and physical care of themselves and victims of childhood emotional abuse run a higher risk generally of developing risk-filled behaviour (English, Thompson, White et al., 2015; Kendall-Tackett, 2002; Oshri, Sutton, Clay-Warner et al., 2015).

Social protection for children living in substance abusing families is often incomplete and inadequate and even the social network around the child usually does not seem to understand the signals from the child and therefore fails to react. For example, in a recently published report from Sweden, of teachers who worked with seven- to twelve-year-old children and said that they suspected that certain pupils lived with alcohol abusing parents, only two out of ten actually forwarded their suspicions to the relevant authorities (Systembolaget, 2017). In a parallel manner, 20 percent of physicians at Local Health Care Centres in Sweden admitted

that they did not report children whom they suspected to be the victims of severe neglect (Talsma, Boström, & Östberg, 2015).

Parentification: competence that has a high cost (Paper IV)

For a child, emotional parentification is an especially difficult situation because she may be encouraged to consider her parent's (and perhaps her siblings') emotional and physical wellbeing to be her responsibility (Haxhe, 2016). Such a commission is beyond the competence of the child but at the same time is one that she is unable to refuse, and it becomes a paradoxical situation that has its cost.

The interview material contains many detailed and nuanced descriptions of how such children act in an apparently very competent manner, assuming responsibility for adult tasks and responsibilities, whilst at the same time feeling completely abandoned. Their parents' needs were always reckoned to be more important than their own. Their apparent social and behavioural competence did not make it easy for people outside the family to have any idea of just how difficult their situation was. A number of studies have shown that parentified children run a risk of developing internalized problems both in preschool (Macfie, Houts, McElwain et al., 2005; Sroufe et al., 2005), and in their teenage years (Byng-Hall, 2008; Mayseless & Scharf, 2009; Shaffer & Egeland, 2011). When the parentified child becomes an adult and a parent herself some studies suggest that problems may emerge. For example, it may be difficult for her to show warmth for and acceptance of her child's emotional communication and she may even have difficulties in seeing her child as a unique individual with unique needs (Dearden & Aldridge, 2010; Nuttall, Valentino, & Borkowski, 2012).

The parentified child's role is very contradictory: in taking an adult responsibility for her parents and siblings her own childhood is stolen from her and much is lost and little is gained. This was expressed clearly in the interviews where the participants described how they felt abandoned, left with feelings of anxiety, emptiness and despair – which in some cases led to serious suicide attempts. And on top of this - they received no positive affirmation for their contribution to the family.

In summary it can be said that the many of the participants grew up feeling they were abandoned by their parents, their network and by society in general while suffering the consequences of emotional abuse, emotional isolation and the inability to put words to their experience in a context that seemed not to want to know.

Specific challenges to becoming a "good enough"parent (Paper III, IV)

When focusing on problems in the process of becoming a parent, a number of challenges can be identified: *negative role models, affect regulation, trust, separation* and *stress*.

Negative role models have significance in the development of competence. The individuals in the study emphasized that they viewed their own parents mostly as bad parents and that they did not want their own children to experience the trauma, stress, abuse, neglect and disqualification that they themselves had experienced. Many of them wanted to be "100%" different from their parents. They wanted their children to have a positive experience in their formative years and above all experience having a good mother and/or father.

The problems that many of the participants in the present study experienced in this area are of particular interest from a learning perspective. Individuals who have only learned from their experience what they do not want to be like – how are they to define and understand what they would like to be like? They have few or no reference experiences that can serve as a specific guide to how they shall behave and think. While much of conscious learning is the product of socially-supported, goal-oriented behaviour, much is unconscious, learned without knowing while participating in daily activities (Ormrod, 1990). Many relationship skills fall into the latter category, including many parenting skills. For many of the participants in this study such knowledge did not exist, leaving them confused and uncertain, knowing only what they did not want to do, but not having a guiding, concrete idea about what they actually wanted and how they could achive it.

Affect regulation is a central aspect of human interaction and human relationships (Schore, 2003). While in some contexts the free expression of emotions is appropriate and even necessary, in others it may be inappropriate and disturbing. Central to affect regulation are two abilities: firstly, to understand one's emotions – what stimulates them and what information they contain and secondly to be able to control their expression in a way that is appropriate to the context in which they emerge (Stern, 1985). The participants interviewed in the present study had gotten little or very little help from parents, who themselves had difficulties in regulating their own affects. This lack of understanding and control was experienced as particularly distressing in relation to the participants' own children. Being angry and frustrated and not being able to manage such feeling could be felt as a serious threat to their ongoing relationship with their child. In turn, this introduced the risk that their child might become alienated from them, just as they often felt in relation to their own parents. Such experiences, and reflections over such experiences could increase their uncertainty and self-criticism and in turn serve to undermine even more their judgement of themselves as parents.

Trust is a complex phenomenon. How to learn trust when it contains the seeds of possible disappointments? If in our personal history we have experienced the world and the people in it to be worthy of trust, and that the response to our trust has been positive for us, then we will probably in the future be prepared to feel confident and trusting. We learn from both good and bad relationships to make judgements as to whom seems worthy of our trust and to create strategies that help us to cope with betrayal of trust. Many of the participants interviewed in this study had difficulties in trusting others. Their parents had often proved themselves to be almost totally untrustworthy and their social network had betrayed them by ignoring their situation. For some the lesson was that to trust was to risk too much, and this was particularly acute in connection with their own children – the very idea of leaving their child in the care of someone else seemed a dangerous one.

Separation is a recurring theme in life, from the most common examples of going to school or work to more momentous issues such as divorce or death. Perhaps the theory that helps us most to understand the complexities of separation in relationship to a significant other is attachment theory (Bowlby, 1980). The theory tells us that separation is part of a larger cycle of relationship patterns. Learning to be apart is intimately connected with being together, and both contain life-skills of which many are first learned in the context of relationships between children and parents.

For some of the participants in the study, being separated from their children was perceived as a negative and threatening experience. It was expressed in affective and existential terms as being something unbearable. One common, recurring factor in the narratives of the participants was their own feelings of being abandoned, of being of no importance, of being ignored, of being unseen and without value. As children the strategies a majority of them developed to cope with such experiences were probably centered around the denial of these feelings and replacing them with behaviour that gave them alternative feelings of having a value, such as parentification. It could be a reasonable assumption that separation from their own child could reawaken such early childhood trauma.

Stress takes many forms and one that is often associated with trauma is a continual preparedness for threat. As children, the *conspiracy of silence* that surrounded their parent's substance abuse helped form a family environment full of threats. And with the lack of support most of them experienced, they lived in a dangerous milieu were traumatic events could happen anytime. To fail to develop an awareness of the continual potential arrival of danger would be a denial of experience, and a further source of danger in itself. As adults, many of the participants commented on this continual preparedness for danger, and as parents this was also connected to their children. Danger was everywhere, and one of their primary tasks was to scan the environment for its possible arrival. Such experience is connected with high levels of parenting stress.

In summary, it is an obvious risk that all these different circumstances can interact with each other in destructive ways. They may create difficult challenges to learning the new role of becoming a parent and making it difficult to develop a sensitive parenting style and to help their child to develop a secure attachment.

Strengths and Limitations (Study I, II)

One strength in the present studies has been the use of several research methods and that it has been carried out as a clinical study. By combining results from self-report questionnaires and in-depth interviews it has been possible to examine the research questions from several perspectives. Another strength is that the parents who were interviewed had participated in a family therapy intervention. This intervention had focused on parental functioning and they had been given the opportunity to reflect over their own parenting role which meant that they were able to respond in a nuanced way to the interview questions. Finally, it is considered a strength that the present thesis examines the transgenerational question of how being raised with substance abusing parents can influence such children's abilities in their attempt to become competent parents themselves – a question that affects many, but one that has been researched in only a limited way.

Study I (Paper I, II)

One limitation is that the study does not enable causal conclusions to be drawn. Another limitation is the size of the clinical sample in Study I (Paper I, II). Further, although they were compared to Swedish norm, we had no controls from the general population or from other clinical samples. All participants had pronounced difficulties with parental functioning, but the findings cannot be applied to all grown children of parents with substance abuse.

A further limit is the lack of balance in group size between the men and the women: of the participants, only 68 men and 129 women completed the self-report questionnaires. The difference for the most part was caused by the fact that less men than women participated in the treatment program. The lack of men is common in all studies of families and children, partly because of their absence in child care settings (Macfadyen, Swallow, Santacroce et al., 2011).

A severe limitation is the lack of a validated self-report questionnaire for identifying our index group. There is a well-validated instrument, the Children of Alcoholics Screening Test (CAST) (Hodgins & Shimp, 1995), which has been used in several large population studies (Hill et al., 2008), but it has not been validated for the Swedish population.

The HADS has been criticized in the past for not distinguishing sufficiently between anxiety and depression, and it has been suggested that the HADS items should be considered in terms of general distress rather than anxiety and depression specifically (Norton et al., 2013). However, the results have been inconsistent; some studies have lent support to the two-factor model used in this study (Helvik et al., 2011; Norton et al., 2013).

One important limitation concerns the reliance on self-report instruments - the sociodemographic and psychosocial data were based on the reports of the respondents and no clinical diagnoses were obtained.

The cross-sectional design of the study means that the assessment of post-partum symptoms in the parents is problematic as depression normally emerges at different times for mothers and fathers. For mothers, the highest rates of depression symptoms occur soon after childbirth, while fathers more often develop symptoms when the child is 3 to 6 months old (Paulson & Bazemore, 2010) and we report on parents with children aged from one month to four years.

Study II (Paper III, IV)

The in-depth interview study deals with and is based on retrospective memory and there is an ongoing discussion on how valid such data are (Hardt, Vellaisamy, & Schoon, 2010; Widom, Raphael, & DuMont, 2004). It is, of course, virtually impossible to control the "objectivity" or the "truth" of such memories under normal circumstances but at the same time it is this very information that the informants themselves use to make sense of both their present and their past situation. The data collected are accepted as the memories and experiences that these women and men have of their childhood.

A further limitation concerns the bias of the interviewer (ET), who has worked for almost twenty years as a psychologist and psychotherapist in the IMH intervention program from which the participants were selected. This means that, as a result of her experience, the interviewer had preconceptions concerning the nature and construction of the parenting role, something that may have affected the results of the thematic in-depth interviews by influencing the choice and nature of follow-up questions in a context where treatment and research perspectives may influence each other.

Directions for future research

A study that proposes only to explore the parenting of people who have themselves been raised by substance abusing parents should ideally focus only on the participant's own parenting and not investigate childhood experiences at the same time. A double focus creates the possibility that descriptions of their own childhood experience may influence descriptions of their own parenting. It would also be desirable to include not only parents who belong to a clinical population, but also parents who have not sought and received treatment in their role as parents.

In this project we planned to ask the parents to judge their own children's relational and communication abilities using The Vineland Adaptive Behavior Scales (Sparrow & Cicchetti, 1989). Unfortunately, the scales were not filled in correctly and were not used in the study. Further, parent-reported assessment of the child should be supplemented with clinical assesment. This is especially important in the case of aberrant child development with early symptoms of cognitive, motor, and social impairment, as some of these children could meet the criteria for one or more of the neurodevelopmental disorders, for example ADHD, before the age of 6 years (Fernell & Gillberg 2010).
It would also be relevant to include assessments of the parent/child interaction using video-tapes followed by blinded assessment procedures. Further, there is a need of studies with a longitudinal design in order to follow both the child's and the parent's development over time.

In most of the earlier studies the term "parent" refers almost exclusively to "mother" – but it is also important to include fathers and their relationship with the child.

Clinical implications

To grow up in a family in which one or both of the parents are substance abusers is a personal reality for many children in Sweden (Hjern & Mahnica, 2015). These children need to be identified and together with their parents offered targeted treatment and support from Primary Health Care Centers, the CAP clinics and the Social services. Sweden has passed legislation to ensure that families in which there is parental mental illness being treated by psychiatric services are provided with child-focused interventions. Unfortunately, only one in four adult patients received help for their underage children (Afzelius, Östman, Råstam et al., 2018), despite the fact that there is a growing body of knowledge concerning the transgenerational transference of neglect and abuse (Berlin et al., 2011; Dixon, Browne, & Hamilton-Giachritsis, 2005; Smith, Cross, Winkler et al., 2014). One important step would be to develop a relatively simple, legally secure and easily-administered system to

facilitate consultation and cooperation between the education system, the mental health system and the social welfare system so that it would be easier for those who work in these organizations to fulfil their legal responsibilities and report their suspicions about children whose development and health may be in danger. Also, patients who receive treatment in IMH units should routinely be screened for substance abuse – concerning both themselves and their parents.

A further implication, for the vulnerable group of parents who grew up with substance abuse in their family of origin, is that treatment requires a trustworthy alliance, and should include strategies to help with affect regulation, to reduce of feelings of shame and possibility to reflect over and grieve for their lost childhood.

General conclusions

- The parents and in particular the mothers from the IMH unit had experienced critical strains in many dimensions, e.g. trauma, symptoms of anxiety, depression and ADHD. This knowledge should be important to health professionals, with the implication of screening for anxiety, depression and ADHD before the start of therapy.
- When separated from the group of all women, it could be seen that those mothers who had experienced substance abuse in their family of origin were an even more vulnerable sub-group, with high reported prevalence of traumatic experiences and high levels of symptoms of depression, ADHD and own prior substance abuse.
- The challenges faced by men and women who had been brought up in a family with substance abuse were often characterized by difficult emotions that were hard to control, stress and clear difficulties in the regulation of closeness and distance. These difficulties constitute a risk that their child will not be able to develop a secure bond with her parents.
- Children raised by substance abusing parents run the risk of being severely affected by a family life usually characterized by the absence of love, by a culture and conspiracy of silence and by serious breaches of care including psychological and physical violence and other forms of trauma.
- In a family with substance abusing parents the children run a high risk of receiving little or no support from society and become invisible children. They may need support even if they do not offer any significant displays of externalizing/internalizing behaviour.
- To prevent the transgenerational transmission of substance abuse, it is important in a clinical setting to carry out a systematic investigation of substance abuse, violence and trauma in families of origin, in order to understand and accommodate the effects involved in growing up in families with substance abuse.
- It is important to develop easy-to-administer methods to facilitate consultation and cooperation between the education system, the health system and the social welfare system to help and encourage the relevant professionals to be able to fulfil their legal responsibilities to children whose development and health may be in danger.

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Struggling with parenthood after an upbringing with substance abusing parents

Picture "Double feelings" Erik Tedgård 2007

Eva Landegren Tedgård is a psychologist and a psychotherapist and has worked for many years at the Infant Mental Health unit Viktoriagården in Malmö.

After many years of practicing psychotherapy with parents who fought to cope with their infants and toddlers despite the burden of what they experienced was their own inadequate parenting skills, she felt a desire to understand more about the complex process of becoming a parent. What specific kind of treatment do newly-become mothers or fathers need in order to become competent parents if, for example, their own parents had been negative role-models, often absent because of a heavy substance abuse? The clinical implications learned from the study show the importance of detecting and supporting children from families with substance abusing parents. When these children become parents themselves and ask for help, they often need a treatment that emphasizes the importance of a trustworthy alliance, offers strategies to help with affect regulation, helps to reduce shame and provides the possibility to reflect over and grieve for their lost childhood.

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