

Pregnant substance-abusing women in involuntary treatment: Attachment experiences with the unborn child

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ABSTRACT

BACKGROUND – Use of coercion against pregnant women who misuse substances was legalised in Norway in 1996. The background for the law was that substance abuse during pregnancy represents a significant health problem for the child. **AIM** – The main aim of this study was to explore if an attachment between the mother and her unborn child was possible in a context of coercion as experienced from the woman's perspective. The women had many challenges, such as lack of social support and poor living conditions. **MATERIAL** – Data were collected in eight qualitative in-depth interviews. **FINDINGS** – The main findings show how involuntary detention enabled safety for and connection with the unborn child. Within this context, the pregnant substance-abusing women's own relational experiences and developmental histories represent the most significant barrier for their ability to bond with the expected child. **CONCLUSIONS** – The study underlines the importance of helping women with their own attachment experiences in order to break the generational transference of risk and pathology, and in this way, start the attachment process to the unborn child during the coerced treatment stay. Implications of the findings are discussed.

KEYWORDS – substance abuse, attachment theory, child protection, mothering, coercive context

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Introduction

Substance use during pregnancy has become a significant problem and has led to accelerated attempts to develop specific treatments. There is a growing literature showing the adverse effects of intrauterine substance exposure (Helmbrecht & Thiagarajah, 2008; Topley, Windsor & Williams, 2008; Vucinovic et al., 2008). Internationally it is estimated that there are between one and four children per two thousand live births who may have foetal alcohol spectrum disorders (FASD), while in Norway an estimated 600 children annually are born with FASD (Alvik, 2007). FASDs are presumed to have a prevalence 10

times higher than foetal alcohol syndrome (FAS) alone.

For children of mothers with drug abuse, we lack statistics for the number born each year with neonatal abstinence syndrome (NAS). The clinical picture of children born with NAS is hypersensitivity for stimuli, strong motoric unrest and strong persistent crying, with fever, vomit and tremor to various degrees (Elgen, Bruarøy, & Lægreid, 2007). The women in this study all had substance abuse problems, which makes it difficult to differentiate between effects of alcohol and drug abuse (Slinning, 2004). These effects of sub-

stance abuse on the unborn child during pregnancy were the background for the use of involuntary treatment on pregnant drug-dependent women, which was legalised in Norway in 1996. The core of the coercion paragraph 10.3 is that pregnant substance-dependent woman can be retained in inpatient treatment without consent if the abuse makes it reasonably likely that the foetus can be harmed and if voluntary health measures are insufficient. The unborn child in this context is favoured by lawmakers over the woman's right to liberty because of the risk of causing harm to the unborn child (Søvig, 2007). Norway is the only country in Europe with such a law for pregnant drug-dependent women (Leppo, 2009).

A second legal possibility for compulsory treatment is "voluntary coercion", defined in paragraph 10.4, which states that the patient may be retained in inpatient treatment by her own consent for three weeks. This agreement can be renewed up to three times. Despite the fact that §10.4 is presented as the general rule among the paragraphs that makes use of coercion possible, it is used to a limited extent. With pregnant substance abusers, part of the explanation can be that this often is a group of long-lasting and heavy substance abusers, and voluntary treatment has been used several times already (Søvig, 2004).

One Norwegian study found that even if coercion is used to a limited extent, its use has increased over time (Lundeberg & Mjåland, 2009). The authors point out that as treatment under coercion is practised in many ways, the experience of coercion is also described in many different ways. The study underscores that viewed in relation to the nature of the intervention, the

level of knowledge production has been surprisingly low, and that there is a great need for more understanding from the users' perspective.

In Norway, there is a lack of research about how one can reach female substance abusers early in the pregnancy and which intervention methods are most effective (Programme note for drug research 2007–2011).

In her case study of two women admitted under coercion in Norway, Söderström & Skolebekken (2012) looked at the ethical and clinical aspects of coerced admittance. She concludes that it is a challenge to protect the women's ethical rights and at the same time establish a therapeutic alliance, as coercion as a context is challenging in itself. However, according to this author, protection of the foetus and the therapeutic alliance must be seen as two sides of the same coin.

This illustrates some of the dilemmas the present study will explore. The existing research has been primarily concerned with patient rights, the right to autonomy and the consequences for women's motivation, as well as with issues of how use of coercion will influence the therapeutic alliance. The debate, both professionally and politically, has been directed towards the balance between individual autonomy and protection of the foetus, and where the consequences for the pregnant women's motivation and accessibility to receive treatment are challenged (Leppo, 2009; Søvig, 2011).

The treatment context is just one factor influencing the women's relation to their unborn children. Prenatal attachment theory is a new research area that originates in attachment theory and points to a number

of factors that are important in the assessment of attachment experiences. Attachment theory focuses on the relationship between parents and infants, governed by the parent's inner working models about what parenthood is. Such working models are created through the experiences expectant mothers have had with their own parents, and these patterns are to a great extent passed on to the expected and newborn baby (Broden, 2004; Bowlby, 1998; Fonagy, 2006; Stern, 2000). Attachment processes begin during pregnancy with all the fantasies and thoughts the woman has about her unborn child.

In addition, families afflicted by substance abuse have a double risk. Pajulo, Suchman, Kalland, & Mayes (2006) found that women from high-risk groups struggle to hold their focus on the expected child when their attention must compete against dependency on drugs. Siqveland, Smith, & Moe (2012), in a study of women's sensitivity and ability to be present for their baby, compared pregnant women with drug and psychiatric problems with a control group without such problems. They followed the women during pregnancy and until the child was three months old. The mothers with drug problems still had significant challenges in spite of the treatment during pregnancy and early in the baby's life.

Against this background, we hope to get a better understanding of the extent to which these are factors that affect women's understanding of the relation to their unborn children, regardless of the treatment context they are located in.

The main aim of the study was therefore to explore the attachment process between mother and the unborn child, and how coercion as viewed from the women's

perspectives influenced a possible attachment. The women were also given the opportunity to reflect upon how their own early attachment experiences influenced their ability to connect themselves to the expected child. The results are discussed in light of existing research on substance abuse and prenatal attachment theory.

Methods

The sample was composed of eight in-depth semi-structured interviews with women admitted on coercion under paragraph 10-3 in the Norwegian Law of Health and Care Services.

The women were pregnant substance abusers admitted to two closed units for pregnant substance-abusing women within the specialist health service. The women in the sample were at different stages in their pregnancy (12 to 35 weeks) at the time of the interviews.

Participants

The interviews took place between November 2011 and May 2013. All the women who were asked to participate in the study did so. The average age of the informants was 26 years (range: 17–44 years). Three of the women were interviewed twice, due to exhaustion during the interview. Six women had grown up in a home where both parents had substance abuse problems. One had parents without substance abuse, but she had been moved to a child protection institution at the age of 13 because of her own drug abuse. Only one of the women had no substance abuse experiences from childhood.

All interviewees were diagnosed with substance use disorder (SUD) according to the International Classification of Diseases

(ICD) 10, F10–F19: Mental and behavioral disorders due to any form of substance abuse, usually classified as a dependence syndrome (World Health Organization, 2010). Five of the women were first-time mothers, and one had a child for whom she had retained custody. Two women had children over whom they had lost custody because of their own drug abuse. One woman had the child's father admitted with her in the closed unit.

Seven of the women had intact relationships with the unborn child's father, but all relations were drug-related and six of the fathers had an active abuse. All relationships were of short duration. The remaining woman had recently left a relationship with the child's father.

Interview schedule

Central to the first part of the interview was an open description of the involuntary admission and how this affected the women's relations to the unborn child. In this part of the interview, the main aim was to bring out the women's own stories as openly and close to their experience as possible. The second part of the interview was about the women's descriptions of the conception and the prenatal attachment to the unborn baby, how they experienced pregnancy and whether they could describe an internal picture of their child. The Working Model of the Child Interview (WMC) (Zeanah, Keener, Stewart, & Anders, 1985) inspires the section in which the focus is the mother's representations of the unborn child and what sort of thoughts and feelings she has about the expected child. The questions in the first part of the interview guide are based on open questions.

The questions in the third part of the

interview guide are inspired by the Adult Attachment Interview (AAI) (George & Solomon, 1984; 1985; 1996), but used as open questions. The interview was originally developed to predict the child's attachment strategies from the parents' experiences. An array of studies have shown that the interview has high validity and reliability on care capacity in parents, predicting attachment security in children and as a method in psychiatric work (Benoit & Parker, 1994; Griffin & Bartholomew, 1994; Van Ijzendor, 1995; George & Solomon, 1996). Our study applied questions that emphasise the informant's childhood family and attachment strategies. This requires the interviewee to reflect on her own life story. By using elements from the AAI, our goal was also to investigate the women's own attachment histories, viewed in connection with their ability to develop prenatal attachment to the unborn child.

Interview procedure and ethics

The responsible treatment professionals in the closed units were contacted for clearance at the start of each interview. The first author contacted all the informants both orally and with written information about the study. All those asked provided signed consent. All the informants were told that they could withdraw from the study at any time if they doubted the consequences of further participation. The interviews were conducted at the individual clinic.

The interview period stretched over two years as it took time to locate respondents who met the inclusion criteria (pregnant substance abusers admitted under coercion). One of the inclusion criteria was also that the respondents should not be

admitted in the same period at the same clinic, as this could have meant that the women influenced one another in their descriptions. The interviews were audio recorded and transcribed in full by the first author.

The study was reported to the Regional Research Ethics Committee in 2011 and has followed the guidelines of the Helsinki Declaration. The first author, who performed the interviews, has lengthy clinical experience with this group of clients, which was a strength during the interview process. All the respondents were offered the opportunity for follow-up conversations with a resident therapist after the research interview was concluded. No informants made use of this offer.

Analysis

A phenomenological/hermeneutic method from the qualitative research tradition was used, with development of knowledge and meaning at the core (Dallos & Vetere, 2005). The most important intention in a phenomenological analysis is to understand phenomena from the perspectives of the informants and to open up for descriptions of the world as close to the informants' experiences as possible.

To search for the meaning of the process of admission to treatment from a phenomenological perspective means that the researcher intends to be open to what the informant conveys. A hermeneutic perspective supplements the pure phenomenological method. In a hermeneutic interpretation of phenomenology, prior understanding is not a problem but a resource in the encounter with the subjective experience to be explored. The researcher's concepts and theoretical resources were used

as tools to enable reflection on the experiences expressed in the interviews (Willig, 2009). These are important prerequisites both in the interview guide in which elements of AAI and WMC are applied and in the analyses.

The data is analysed by Giorgi's principles of phenomenological analysis of qualitative data. (Giorgi, 1985; Malterud, 2012). The analysis process is implemented in four steps (Table 1). The first step of the process was to provide an overview of the texts and select themes that were relevant for the research aims. The next step was to identify meaningful units in the selected text and sort them into different codes across the interviews. The third step was to condense the codes in terms of their significance and meaning.

The final process of analysis was to synthesise the significance of the condensates into new concepts and descriptions called categories. Each step of the analysis was thoroughly discussed by the first author and at least with one of the co-authors.

Three main categories emerged from the analysis of the qualitative data

1. Coercion as a context: enabling safety and connection with the unborn child.
2. Reflexive attachment to the unborn child.
3. Impact of adverse childhood histories and experiences during upbringing on the women's relationship with their unborn child.

Findings

The findings are presented in the light of three main themes. We shall first highlight the experiences of compulsory treatment and the implications coercion as a con-

Table 1. Analysis process

Themes	Codes	Categories
Experiences of being admitted under coercion	The law is just a law	Coercion as a context, enabling safety and the connection with their unborn child
Reactions to the pregnancy	Pregnancy as a surprise	Reflexive attachment to their unborn child
Reactions to the ultrasound examination	Pulled between addictions and the mother to be	
Drug problems and the description of the unborn child	Ultrasound examination as a turning point	
Childhood family and the relation to attachment figures	Lack of narratives and experiences of belonging	Impact of adverse childhood histories and experiences during upbringing on the woman's relationship with the unborn child
Description of the person's childhood family	Broken families and substance abuse in family constellations	
Understanding of contexts in upbringing history and own perspective	Lack of understanding in upbringing history and own perspective	

text had for the relations to the unborn child. This is contrasted to the women's original reactions to their pregnancies. Further, we focus on how the women's own attachment experiences and histories influence attachment to the unborn child. These three themes, together with five sub-themes, reflect the women's experiences of attachment to their unborn child and of being in involuntary treatment.

Coercion as a context: enabling safety and connection with the unborn child

A main, important finding was that all the women except one had asked to be admitted to coercive treatment when they discovered they were pregnant.

All respondents described that the involuntary admittance itself contributed to making everything simpler. They did not experience the involuntary admission as coercion. As one woman put it: the law is just a law.

I knew it was a coercion unit because I'd been hospitalised voluntarily earlier, and there I was, along with others who were admitted to the coercion unit when they were pregnant. I wasn't able to be voluntarily hospitalised now, I would've left, especially the first few months, then I wouldn't have had a chance, I want to have another life. (Linn)

The women talked about how their substance abuse came into conflict with being pregnant. Many talked about how difficult it was to stop using on their own. When they discovered their pregnancy, they all acknowledged that they needed help. Seven of eight respondents described in different ways how they asked to be involuntarily admitted when they understood that they could not stop their substance abuse on their own. They wished to protect the expected child against further substance abuse-related damage.

I don't care about the coercion but more what happens next. When I came here, I had an awakening. I don't care about the paragraphs. It's just a (legal) paragraph. (Ann)

The women described how coercion represented security and help to take care of themselves. They had come to understand that they would not be able to cope alone. The coercion decision in itself seemed to be a lesser concern than the experienced need to protect the child against the effects of substance abuse.

No, it's OK of course that I'm here on coercion, doesn't mean much. I want to get help and make plans. (Linn)

Only one of the eight respondents said that she had been "captured" by the social services and had been admitted coercively.

Reflexive attachment to the unborn child
Pregnancy as a surprise: Common to all the women was that the pregnancy was unplanned and thus a big surprise. The women spoke about lives with drug abuse and poor living conditions not suitable for children. Some spoke about misusing their bodies over many years to such an extent that they had lost their menstrual cycles. They believed that they could not become pregnant. It had taken a long time to interpret their symptoms as pregnancy, as these were perceived as consequences of a complicated lifestyle with SUDs and poor nutrition and health.

I didn't know it before I felt the baby, and then I was so surprised and

thought, "My God, I'm pregnant of course." (Sophie)

We didn't plan to get pregnant, but it happened. If we hadn't become pregnant, we would've died from the abuse. (Aurora)

All the informants describe in different ways how they wanted to get things right this time. They looked at the pregnancy as a new opportunity, describing the context represented by the involuntary treatment as supportive.

Pulled between addiction and mother to be
The respondents described that before the pregnancy, they had no thoughts about problematising their SUD behaviour. They felt they had been thrown into having to take a position on whether to keep the baby or not. Several considered abortion as a solution. However, after some time the pregnancy became a reason to stop getting high.

In the beginning, it was very difficult because I had strong cravings to get high. I just wanted to get rid of the baby so I could get high again. (Linn)

It gave me a better reason to stop, but the craving for drugs was still there even though I was pregnant, so it's not enough motivation to quit. It's hard to have an active substance abuse problem and to be a good mother, so I'm very happy that I've managed to stop. (Aurora)

Yes, I suppressed it in a way; I didn't have the motivation at all. (Leah)

Several describe the fear of having hurt their baby. They had abused drugs without knowing that they were pregnant. When they discovered the pregnancy, fear appeared as a barrier to daring to bond with the expected child.

I was afraid that the baby had been damaged by my abuse – I didn't dare to think about it. (Ann)

The ultrasound as a turning point: All the respondents described the ultrasound scan as a turning point. The ultrasound examination contributed to a change of perspective and to choosing to keep the baby. The most important function of the ultrasound was the confirmation that everything appeared normal and that the baby did not show signs of drug-related damage. The ultrasound contributed emotionally to an awakening and helped the women to understand that they were becoming mothers. The women describe the scan as a turning point, which fostered hope and faith.

When I knew that everything was OK and that there wasn't anything wrong, that my child hadn't been damaged by my drug abuse, I could bond with the baby, because I'd gotten high while I was pregnant and without knowing I was pregnant. (Aurora)

It's fantastic to see how everything lives in you, and see all the movements. It was then that I began to get a feeling – when they showed me the baby on the screen. (Ann)

I saw the difference in my tummy from when I went to the hospital and when I came back – my stomach was much bigger. That's because I'd decided not to have an abortion. I'd let my stomach out, let my child free. (Sara)

The ultrasound made it possible to keep the expected child, but only some of the women showed an emotional attachment to their unborn child.

Impact of adverse childhood histories and experiences during upbringing on the women's relationship with their unborn child

The women talked about an upbringing dominated by dysfunctional family interaction. They talked about painful and traumatic separations, stays in child protection institutions, and, for many, few or no secure caregivers.

In an upbringing characterised by uncertainty and, to varying degrees, negligence, the women had been left alone as children with their anxiety and restlessness. Two of the respondents, without SUD problems in their families of origin, described other forms of dysfunctional family interaction.

I remember that I felt quite insecure many times; I think I was quite close to mama when I was little. I did everything she said and I think probably that I was a little nervous that she would get sick again, I was afraid of being left alone and tried to please her, I can't remember exactly, but I think mama loved me. (Leah)

The only person I felt close to while growing up was my sister, and she mis-

used substances. I didn't have a good relationship with my mother because she gave me up in a way and pushed me away, it was painful. I started to get high at eleven. (Sophie)

I was two years old when I entered the foster home where I was from 2–15 years, and then I moved to the youth home, I didn't exactly get along with my foster mother. (Arlene)

The women said it was new for them to think about how a childhood history could form the person and the perspective one had today. Nevertheless, they were concerned about protecting their expected child against traumatic experiences like those they had been exposed to themselves.

No, I don't know really – it's completely new to think that way. (Nora)

I don't know exactly – because I've had so many traumatic experiences that have affected me. Yes, I feel that I've become a bit paranoid, scared and sceptical, and I don't trust anyone. (Leah)

It was painful and difficult to think about an upbringing dominated by drug-related interactions, a daily life filled with fear and unpredictability, and an upbringing in which close care persons had enough with coping with their own problems. Some of the women had thoughts about what they did not want to pass on to their own expected child.

It's painful what's come up now; no, I don't know really. That I haven't had family and others around me and it's so hard to think that I mustn't make the same mistakes. I want to be there for my own children. (Aurora)

It was new to think about oneself into a context that connected past and present. The narratives bore the marks of lack of language and signs. The most prominent features were wishes to be able to cope with being drug free and present themselves to their child in a secure and predictable way, something the women had not experienced in their own upbringing.

Discussion

Experiences of being admitted under coercion

The debate around coercive treatment for substance-abusing pregnant women in Norway has tackled possible challenges connected to deprivation of autonomy and thereby motivation to receive treatment. It is something of a surprise that all the women in this study, except one, had asked themselves to be admitted to compulsory treatment. They did not experience their admission as compulsory and negative. They had asked help to be admitted under coercion when they understood they were pregnant and would not be able to stop using substances on their own.

This complicates the understanding of involuntary admission. Seen as a combination of voluntary and involuntary treatment, it did not negatively influence the relationship to the unborn child; rather, it opened up for potential attachment. One way to understand this could be that the decision to ask for help to stop taking

drugs arises when the users' addict identity conflicts with and creates problems for others (Biernacki, 1986). For these women, the affected other is their unborn child. The key to the recovery process lies in the individual's coming to an understanding that his or her damaged sense of self has to be restored together with a reawakening of the individual old identity and/or the establishment of a new one (Biernacki, 1986). Hence, the attachment experiences influence the depth and complexity of processing one's own inner life and relational experiences, and this may be a starting point on a long and troubled road.

These women could have asked for voluntary admission. Instead, they wanted to be relieved of the responsibility of having to decide at every point whether they should continue treatment or not. The women described ambivalence in relation to the pregnancy, describing a conflict between pregnancy and continued substance abuse. After the involuntary admission, it was the child and the child's needs that were in focus. The women's statements show that the admission under coercion made possible a context from which the women themselves could take a position as pregnant, expectant mothers. The pregnancy becomes a relation to an unborn child.

A study by Stern & Bruschiweiler (2000) claims that the presence of the mother for the child in the womb and the emotional engagement is dependent on whether or not she is able to overcome ambivalent feelings toward the child and the pregnancy.

Stern & Bruschiweiler (2000) and Broden (2004) use the term "mothering process" for all the feelings and actions that con-

cern giving care for the expected child. This develops through biological processes in which the most important factor is the emotional availability the mother develops to the unborn child. The women in this study underscore that the compulsory treatment context was a prerequisite for this process to be initiated.

The ultrasound as a turning point

Several of the women in this study describe that they had thoughts about having an abortion, but when they saw "life" on the screen this contributed to wanting to keep the baby. The women described how ambivalence was connected to fear of having harmed the baby. The ultrasound confirmed that everything looked normal and that the baby did not show any visible signs of damage from drug intake. At the same time, the women had the possibility to emotionally attach themselves to the expected child. This is in line with Söderström's (2011) findings: voluntarily admitted pregnant drug-dependent women had extremely troubled life histories, and for many, it was a problem to relate to the fact of pregnancy. Söderström also found that the ultrasound examination was decisive in choosing to keep the baby.

Another perspective could be the importance of an identifiable "turning point" in the individuals' drug-using career; a point at which the decision to give up drugs is taken and/or consolidated (McIntosh & McKeganey, 2000). The authors point out that addictions researchers disagree on the number and nature of the stages through which an individual may pass in the course of recovery. Such turning points have been described as experiences of constituting a "rock bottom". To be a

pregnant substance abuser could be such an existential crisis and an essential step to recovery from addiction (McIntosh & McKeganey, 2000).

While the women in our study all had negative models of parenting, they showed to some degree that they had developed attachment to their unborn child. The emotions the women described after the ultrasound examination could be seen as a turning point in the process of attachment to the unborn child. In this way, they showed potential for change, development and new possibilities.

Lack of narratives and experiences of belonging

The women in this study were all bearers of adverse childhood experiences. Their wish was a drug-free existence for themselves and their expected child, a secure and predictable family life, which they had not experienced in their own upbringing. None had reflected on how their own experiences could affect their ability to achieve this for their own children, but most shared the hope of being able to achieve something new for the expected child.

Wiig, Haugland, Halså, and Myhra's (2014) study looks at mothers who have grown up with drug abuse problems in their families of origin. The study shows that the women felt alone, on the edge of society and that they required help to break the cycle of adverse childhood experiences. According to our findings, the women talk about being adult, expectant mothers, conscious of what they lack, but not able to understand fully how to achieve a change. Maternal substance abuse problems are often a marker of several mental and psy-

chosocial adversities coexisting with low education and income, single parenthood and poor social networks. Substance-abusing women often have a history of childhood trauma, parental substance abuse and abusive relationships as well as negative representations of their childhood and the parental care they received. They may therefore be negative models for parenting (Hans, 2001; Beeghly & Tronick, 1994). Parental substance abuse problems are also associated with unpredictability and family conflict. (Haugland, 2003). Attachment patterns in particular have been reproduced through generations (Barrett, 2006). If no other relational experiences and inner working models change this perspective, this will affect the relation the woman develops to her child (Pajulo, Suchman, Kalland, & Mayes, 2006).

Sarfi's study of interactions between mothers in substitution treatment and their small child demonstrates that after controlling for other factors, the only significant contribution to both child behaviour problems and health-related quality of life was concurrent maternal psychological distress (Sarfi, Sundet, & Waal, 2013).

George et al. (1984; 1985; 1996) found a robust relation between the parents' inner working models measured by Adult Attachment Interview and the child's attachment. They found this association also in mothers' attachment representations measured prior to the child's birth (Steele & Fonagy, 1996). Main (1995) and several others (Carlson & Sroufe, 1995; Van Ijzendoorn 1995) have over the years supported the assumption that a mother's capacity to regulate and organise her own thoughts and feelings towards her own caregivers is closely connected to the care she will

give her own child. In line with this, our findings indicate that the pregnant women will have to overcome considerable challenges in order to create the life they want for themselves and the expected child and in processing adverse experiences from their own childhood.

Limitations and strengths of the study

The number of respondents in this study is small. Thus, these findings can only present examples of understanding and descriptions, and cannot be generalised to all pregnant, substance-dependent and coercively admitted women. The in-depth interviews point, however, to important factors in further attempts to help these women to connect to the unborn child. Also, this is to our knowledge the first study to explore substance-abusing mothers' experiences of attaching to an unborn child when being in "compulsory treatment".

Another strength is that the first author was employed as a treatment manager in a family unit within the substance abuse treatment field of the specialist health service in Norway when she conducted the interviews. This contributed to the understanding of the informants' situation and helped in the organisation and completion of the interviews.

Clinical implications and conclusions

This is the first study to present pregnant women's own descriptions of their experiences of compulsory treatment. Their stories illustrate how "coercion as a context" influences attachment to the unborn child in a positive way. Being admitted under coercion affords an opportunity to focus on the relationship to the unborn child.

For the helping services, this also represents an opportunity to come into a position to break the cycle of intergenerational transmission of internal representations of care-giving experiences. The compulsory treatment was experienced as a support and as an opportunity to relate to and develop an alliance with the treatment staff in order to protect the unborn child. In addition, the child and the child's needs became a concrete topic in the mother's consciousness that in this context *did not* have to compete with drug cravings for the mother's attention.

Seven of the eight women had asked for compulsory treatment themselves, even though they could have been admitted on a voluntary basis under §10.4. This suggests we need to rethink the concept of compulsory treatment in this context. For the women in this study, it represented an opportunity to reduce the ambivalence that a substance use disorder creates. The women quickly entered a context that prevented further use of drugs and provided the opportunity to focus on the expected child. The principle of the law §10.3 is that the abuse is of such a nature that the child will most likely be born with injuries (Søvig, 2011). The women in this study had many experiences of being in voluntary treatment, and two of the women had lost custody of their child earlier because of substance abuse.

The women were also in a high-risk group in terms of negative childhood experiences, socioeconomic conditions, drug dependence and lack of network membership. The study confirms the recognition of the challenges our own attachment histories create, and shows that these are issues the helping services must meet

at the first opportunity. It is important to enable stable, quality attachment relations between the mother and the unborn child. This should be an important focus in all interventions in this approach.

Existing knowledge about attachment challenges has identified a key point: if prior experiences have not been processed and given a form that makes them a potential starting point for new experiences, the prior experiences hinder the development of attachment to one's own children. The women talked about a dawning attachment but were not yet reflexive about the limitations created by their own histories. A sufficient treatment option should therefore include exploration of the woman's challenges and risk factors. This would help her to enter a position where she could continue the attachment process to the unborn child.

These women require help to create stories about their own attachment experiences that would give them the opportunity to connect with their unborn child. They need help – with a point of departure in their own complicated experiential background – to become sensitive enough to prevent negative interpretations of the child, such that they achieve a good enough interaction when the child is born,

and further help to understand and regulate the child's expressions and needs. In this way, the generational transmission of risk and pathology can be prevented and broken. "Involuntary coercion" as a context for the women in this study represents a start from which this complex work can begin.

Declaration of interest None.

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