

Troubled families and individualised solutions?

An ontological, discursive and interactionist analysis of families' involvement in alcohol and other drug treatment

by

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This thesis are dedicated to the memory of my father, for being a constant source of critical thinking, existential and intellectual curiosity, and emotional support.

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Summary

The main concern in this article-based thesis is the situation for families in the course of addictive processes and the conditions for support and involvement in treatment, where we ask: how can we understand practices towards families and affected family members (AFMs) in alcohol and other drug (AOD) treatment? Three articles are linked together in their common focus on family-oriented practices.

Firstly, on the theoretical level, analysing how two models of families in addiction; the Stress-strain-coping-support (SSCS) model and the social ecological (SE) model, aiming respectively towards AFMs in their own right and towards relationships between family members, relates to the phenomenon of addiction, and which options and actions they provide for families.

Secondly, on the institutional level, analysing how theories are applied in practice, and what the conditions are for receiving attention and support as AFMs within AOD-treatment.

Thirdly, on the family level, analysing processes of treatment and recovery from the interrelated perspectives of persons with a problematic use of substances and their AFMs, related to the possibilities and options encounters with treatment facilitates.

The empirical basis for these analyses was obtained from three different AOD-treatment institutions in Norway. Both clinicians ($n=15$), directors ($n=3$) and representatives from families ($n=16$ from 10 families) were interviewed to gain knowledge about families encounters with treatment, and the interactional context in which family-oriented practices are exercised. Concept retrieved from a critical realist, discursive and interactionist research tradition were used as tools underlying the different analysis. A common ground is a sensitivity towards discursive opportunities and possibilities at work in talk and interaction.

In Article 1 both the SSCS model and the SE model are highlighted as essential for dealing with the complexity of the phenomenon of addiction in families. The SSCS model by providing agency for a neglected group of AFMs and

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developing a method to address their needs, and the SE model by advocating the relative position of social solutions in the field of alcohol and drug (AOD) treatment and developing a framework for conducting joint sessions and family therapy. Both models and their respective practical guidelines for interventions could work complementary in a clinical setting, as useful tools in different types of case and at different stages of treatment—combining the level and emergence in the interaction between agency and structure—for the betterment of families and individuals.

In Article 2 it is revealed that family-oriented practices are gaining ground within the field of AOD-treatment, as a “going concern”. Still, the relative position of family-orientation in the services, is constrained and shaped by three other going concerns related to : (1) discourse on health and illness, emphasising upon addiction as an individual medical and psychological phenomenon, rather than a relational one; (2) discourse on rights and involvement, emphasising upon the rights and autonomy for the individual patient to define the format of their own treatment; and (3) discourse on management, emphasising upon the relationship between cost and benefit, where family-oriented practices are defined as not being cost-effective. All three discourses are networked together in underpin the “gravity” towards individualised practices. The findings point to a paradox: although family-oriented practices are supported by research, and are (or are in the process of) being implemented in policy guidelines, the conditions of possibilities for performing family-oriented practices in the services are limited.

In Article 3, three main “storylines” were analysed as facilitating different processes of treatment and recovery within families: (1) a “medical” storyline, (2) a storyline of autonomy (for AFMs), and (3) a storyline of connection (in families). These storylines positioned AFMs respectively as outsiders, as individuals (in need of help in their own right), and as part of a family system. The medical storyline is revealed as insufficient for dealing with the problems associated with addiction; it needs to be supplemented by storylines which facilitate processes of reintegration and repositioning within families. The storyline of autonomy and the storyline of connection facilitate processes of unilateral and bilateral repositioning respectively. Within a storyline of autonomy, AFM described the importance of being acknowledged in their life situation, to be “just me”, to get knowledge about the situation, to get support

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in take care of oneself, to set boundaries, and make the person using substances responsible for their own drinking or drug taking. Within a storyline of connection, participants described how important it was that AOD treatment provided a safe place for open communication and trust building. They appreciated the assistance in establishing a language to talk about their difficulties, hinder a situation where AFM and PAR is “out of step” with each other, and help in translating and synchronizing mutual processes of change.

Overall, the findings of this thesis involve three main contributions to the research literature:

1. Examples are provided of how the potential in focusing on family relations and social mechanisms is restricted in the way services are organized and function in the current situation.
2. Examples are provided of how family involvement in treatment and family-oriented practices make sense and give opportunities for families struggling with addiction.
3. Attention is drawn to the relevance of the ontological level of social relations in addiction theorizing and practice.

The thesis as a whole offers an analytical critique of the field by contextualizing the barriers in implementing family oriented services. By viewing addiction as a necessarily laminated system, with a layered ontology, all possible layers (e.g biological, psychological and social) of the phenomenon play a potential role, and need to be taken into consideration in the practices of AOD services. The case of AFMs, children and families represents a going concern, but still it is a struggle to incorporate these perspectives in everyday clinical life. The findings of the study suggest a re-articulation of the order-of-discourse and a strategic mobilisation of a social ontology in addiction theorising and in practice. The SE model with its focus on reintegration, encompassing a social ontology, is an interesting “gaze” and overarching framework in this respect that can play a part in such a strategic mobilization. So, that those interventions that are highly recommended therapeutically would also represent organisational and operational sustainability.

List of articles

Selbekk, A. S., Sagvaag, H. & Fauske, H. 2015. Addiction, families and treatment: A critical realist search for theories that can improve practice. *Addiction Research & Theory*, 23, 196-204

Selbekk, A. S., Sagvaag, H. 2016. Troubled families and individualised solutions: an institutional discourse analysis of family involvement in alcohol and other drug treatment. *Sociology of Health and Illness*, Volume 38, issue 7 (September).

Selbekk, A. S., Adams, P. J., Sagvaag, H. 2016. Positioning families in alcohol and other drug treatment: how storylines facilitate healing processes.

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1 Introduction

“Of particular sociological interest, however, are troubles that are inextricably interpersonal matters” (Emerson and Messinger 1977)

1.1 Families in trouble

Addiction and other drug (AOD) problems are not something that only involves particular individuals. A person’s intensifying relationship to an addictive substance (to use Peter Adams’ (2008) term), affects the person’s environment and especially the relationships to close family members in profound ways, across both vertical (intergenerational) or horizontal (intragenerational) family relationships.

It affects children, due to the impaired parental functioning of their substance using parents. It affects siblings, in that their substance using brother or sister requires extra attention at the expense of other relationships within the family. It affects spouses by affecting their relationship as a couple in an asymmetrical direction leading to stress and strain. It affects parents, constantly worrying about their substance using children. It further affects the wider social network and other important relationships in life. Addiction in families encompasses a wide spectrum of life situations, at different phases of life, involving different kinds of substances, both illicit and legal.

Research documents how addiction and substance use problems affect both the physical and psychological wellbeing of AFMs (and of the substance using person) (Orford et al. 2005, Barnard 2007, Casswell et al. 2011, Benishek et al. 2011, Moore et al. 2011, Lindgaard 2012, Ruud 2015). It has also been documented how it affects the quality of relationships within families (Hussaarts et al. 2012, Rodriguez et al. 2014, Haugland 2005, Ruud 2015). The literature also shows how negative effects of addiction and substance use problems can be seen over generations (Lieberman 2000). Our knowledge demonstrates the inextricably interpersonal character of problems with addiction (Rodriguez et al. 2014). Adams (2008) identify intimacy (close relations) as the primary site of addictive processes, and where the destructiveness of addictive relationships is most active (Adams 2008: 71).

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It is estimated that 50 000-150 000 children and 50 000-100 000 partners live with a person with high-risk alcohol consumption in Norway (Rossow et al. 2009). The issue of “harm to others” is now receiving increased interest in research and policy making, focusing on the adverse effects of addiction and substance use problems at a societal level (Room et al. 2010, Room 2000).

1.2 Research on family-oriented interventions

At the same time as addiction and substance use problems harm families, it occurs in families, and families can have a role in both perpetuating problems with addiction and preventing relapse and supporting recovery processes (Gruber and Taylor 2006). Family-oriented treatment interventions and approaches attempt in different ways to meet the challenges families face. Moreover, the institutions providing services are in a position where, to use Gubrium and Järvinen’s (2014) words, they turn people’s troubles into institutionally defined problems.

An increasing amount of research is being conducted to study the effectiveness of family-oriented treatment methods. These interventions have multiple objectives and favourable outcomes in many respects. They have been seen to be effective in recruiting patients to treatment, changing consumption patterns, improving family functioning, reducing relapse and helping AFMs in their own right (e.g Finney et al. 2007, Copello et al. 2006, Lindgaard 2012, O’Farrell and Clements 2012, Rowe 2012, Meis et al. 2013). Family involvement represents an active ingredient in the most effective interventions for people struggling with addiction (Lindgaard 2012). Lindgaard (2012) sums it up in the following way: “the question is no longer ‘why’ we should perform family-oriented services, but ‘how’” (Lindgaard 2012: 32).

One limitation in existing research is that it largely measure effect on the person using substances, and to a smaller degree measure effect on AFMs and on processes within families (Copello et al. 2005, Sexton 2004):

”Most research relied on quantitative methods with little use of qualitative methodology or attempts to measure treatment process. This, coupled with the lack of a clear conceptual and theoretical basis to some of the approaches, limit our understanding of how these interventions may help

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family units that include both family members and substance misusers.”
(Copello 2005:380)

By widening the scope of potential recovery processes to include not only substance-using individuals, but also AFMs, vital processes of change can be illuminated. More research is needed on how treatment approaches relate to processes within the family setting (O’Grady and Skinner 2012, Adams 2008), and the family recovery process (Spaniol and Zipple 1994). Orford (2008) sum up three directions for further research within the field of AOD, which this study relates to. First, by focusing less on the comparison of techniques and more on exploring common change processes, second, by studying processes of change in a broader context (including the family and community settings) and in a longer-term view, and third, by including a broader variety of research paradigms, including qualitative studies.

This study will follow this lead by examining the process of treatment and recovery from the interrelated life situation of persons using substances and their family members.

“Family-oriented practices” is a wide category and will be used in this thesis to represent all types of encounters between families, AFMs and treatment, varying in amount, length and aim. These kinds of practices have certain features that make them more than just a “method”, because they aim at more than one person.

1.3 Gap between theory and practice?

So how is knowledge about the situation for children and AFMs, and research on family-oriented interventions integrated in routine AOD-treatment practices? In spite of solid documentation of family-oriented interventions, the literature points out how services only to a minor degree are facilitating help for intimates, family members or relatives (Flynn 2010, Copello and Orford 2002, Steinglass 2009, Selbekk and Duckert 2009, Vetere and Henley 2001). Work with families and family members still has low priority in institutions (Orford et al. 2010d, Orford et al. 2010c). Copello and Orford stated in 2002 that one of the most significant barriers to family involvement in routine addiction treatment results from “the commonly held notion among service

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providers that family members are ‘adjuncts’ and are not central to addiction treatment services” (Copello and Orford 2002:1362). In 2013 the call for more attention to this matter was repeated (Orford et al. 2013).

Within a Norwegian context, we know that many regular AOD-treatment institutions offer some kind of family-oriented interventions or have some kind of encounters with AFMs (Bjørnstad 2007, Selbekk and Duckert 2009, Solbakken 2006). Still these interventions cover a wide range of practices, and are in varying degrees implemented in routine addiction treatment¹. A recent Norwegian study of patients receiving outpatient treatment (Osborg Ose and Pettersen 2013)² found that 53% of the patients lived with someone in their household (partners, children or parents). In this population, in 2013, co-operation with AFM was established in approximately 20% of the treatment cases and 8% received some kind of family consultation, which underlines the existence of a gap between the potential of family involvement and actual family involvement.

Research initiatives have been made to discover these barriers in more detail. In a study from Lee et al. (2012) barriers and enablers were found on the level of clinicians, on the level of problem drinker and family, and on the level of organisation (Lee et al. 2012)³. Barriers on the level of clinicians was related to a lack of role and self-efficacy, to role conflict and to insufficient resources, barriers on the level of the problem drinker and family was related to resistance, to difficulties in maintaining engagement and in problematic networks, barriers on the level of organisation was related to lack of infrastructure and support. Orford et al. (2010b) points to how an explicit commissioning and funding, management support, organizational procedures and practices that are family-relevant, training and continued support for practitioners was needed in

¹An exception is those AOD-treatment institutions that offer in-patient treatment for parents with substance use problems, and where their children are admitted together with them. Solbakken, B. H. L., G.; Lund, M. Ø. (2005). Barn innlagt sammen med foreldre som er i behandling for rusmiddelproblemer, SIRUS, Oslo.

² This reference provides information on the context of the families involved in this study (though with a fairly low response rate of 46%).

³ From a clinical perspective, within the Norwegian context, there is an interesting article reflecting on barriers in family involvement from the side of the clinicians and the affected family members. Mjeldheim, H. (2015). Å involvere pårørende i behandling - hindringer og muligheter. *Rusfag*, 5-13.

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overcoming these challenges. Copello et al. (2000) make similar point when highlighting the importance of knowledge, confidence, support from the service, legitimacy, motivation and self-belief as important factors in promoting family oriented approaches. Fals-Stewart et al. (2004) found that clients' barriers to bring along their partners were related to the fear of blaming, that clinicians' barriers were related to their ability to deliver an accepted "production", and that the organisation was handling the problems as something belonging to individuals. This study aims to elaborate on this issue by examining the discursive environment of AOD-treatment institutions.

1.4 Theorizing families in addiction

Selbekk and Duckert (2009), in assessing family-oriented practices within a health region in Norway, showed how the aims of family-oriented interventions, as they was described, varied from one treatment setting to another. In some treatment trajectories AFMs was primarily included to support the primary patient, in other treatment trajectories AFMs received help in their own right. In other family-involving treatment trajectories again, interventions was aiming at the way the family functioned, therefore not to the need of *individuals*, but to the needs of the family as a *system*, concerned with what happens in-between family members, in the relationships. In other treatment trajectories the aims was shifting along the way. Two answers given in the assessment were pinpointing a distinction between practices in particular. The first answer was: "We do not engage in family therapy, we give affected family members support", and the second: "We try to assist the whole family system with change" (Selbekk and Duckert 2009: 19). These answer were also related to different formats for interventions, in "separate" or "integrated" treatment trajectories (Selbekk and Duckert 2009).

The distinction and tension between focusing on individual needs within the family (of AFM and of the person using substances) and on how the family functions as a system, can be found in the literature as different ways of modelling families in addiction. One family-theoretical model that focus on the needs of AFMs in their own right is the stress-strain-coping-support (SSCS) model (Orford et al. 2010a). In this model, problems belongs to persons, and people close to persons with a problematic use of substances, respond to a

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stressful situation using different coping strategies. Orford and colleagues criticise alternative “systemic” and “pathological” ways of modelling families in addiction (Orford et al. 2005), along the lines that focusing on “system” pathologise family members and make them part of the problem. Researchers and clinicians advocating systemic or ecological models of families in addiction, will on the other hand argue that peoples problem must be interpreted according to systems of interaction, in which the problem can be understood and handled (Vetere and Dallos 2003, Adams 2008). These two approaches represent different discourses of problems and solutions regarding families in addiction.

An interesting example where the distinction between these two approaches was demonstrated, is taken from an assessment of help and support offered to AFMs by Norwegian AOD service providers (Bjørnstad 2007). The scope of the assessment was defined in the following way:

”Intervention to persons in a close relations to someone struggling with addiction, and who needs help to cope with psychological and somatic strain. To delimit the scope of assessment is necessary because many treatment institutions include affected family members in treatment and claim that they gain from this inclusion. Nonetheless, interventions like this, is not primarily targeting affected family members in their own right, and must be considered as a part of the primary patients treatment, where affected family members participate as a resource. This report will therefore not include these kind of interventions” (Bjørnstad 2007: 9)⁴.

Behind this way of delimit the assessment lies an individual-focused way of understanding problems and solutions for AFMs, it relates to “individuals-in-trouble”. It does not related to the level in-between, to relationships within families and “relations-in-trouble”. Daly (2007) emphasis the tension between

⁴This is my own translation. The original text is as follows: “Tilbud til personer som i kraft av sin nære relasjon til noen med rusproblemer trenger hjelp til mestring av psykiske eller somatiske belastninger og lidelser. Denne avgrensningen av tilbudet er nødvendig fordi mange behandlingsinstitusjoner trekker pårørende inn i behandling av rusmisbrukeren og hevder at de pårørende berikes av denne deltakelsen. Slike tilbud er likevel ikke primært rettet mot å hjelpe pårørende, men må betraktes som en del av det å behandle personer med rusmiddelproblemer, og hvor de pårørende inngår som en ressurs i behandling. Rapporten vil derfor ikke omfatte denne type tiltak».

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autonomy and connection, as one of the most central contradictions in relationships, and as a key ontological assumption about human nature. Families can be approached focusing on the situation and autonomy for particular family members, or can be approached by focusing on relationships and connection within families.

The literature quest for an increased awareness of the theoretical assumptions underpinning our practices (Copello et al. 2005). Lee (2014) suggest, the relation between ways of constructing or theorizing families and addiction and the way it forms our services and give opportunities for families, is an interesting and important area of research:

“Assessing the impact of various ways of framing addiction, with codependency⁵ being one example, and how they are internalized and appropriated by clients and professionals, and with what effects, would make intriguing futures studies (Lee 2014: 3f).

This study will take up on this lead, and elaborate further on some distinctive ways of theorising families in addiction, more specifically the theoretical underpinning of interventions aiming at individuals and interventions aiming at relationships within families, respectively the stress-strain-coping-support (SSCS) model and the social ecological (SE) model.

1.5 What is “family”?

An alternative to the term family member is “intimate”, meaning someone in a close relationship with a person, here a person in an addictive relationship (Adams 2008: 312). “Intimate” broadens the term family member as more than connection by blood or marriage. The term family can then be understood in

⁵ Different terms have over the year been used to frame and conceptualize addiction and interventions regarding families. Categories like “family system”, “attachment”, “ecology”, “co-dependency”, “stress and coping” have been used in describing several aspects of the matter, emphasizing different ways of understanding and acting on the problem, representing different opportunities for the people involved. E.g Lindgaard, H. (2006). Familieorienteret alkoholbehandling: et litteraturstudium af familiebehandlings effekter, Sundhedsstyrelsen, Viden- og dokumentationsenheden, København.

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the following way as “the layer of strongest interlocking intimacy around a person”:

“...the circle of intimates surrounding one person overlaps and interlocks with the circles of intimates around other people. The strength of these interlocking circles then form into layers of increasing closeness around each person, and on the closest layer, the layer where there is the strongest overlap, that is where people identify as family. Consequently, for the purposes of this discussion, the term *family* refers to the layer of strongest interlocking intimacy around a person. This understanding is intentionally broad and recognizes both the traditional meaning of family as a group of people connected by blood or marriage as well as the looser understanding of a group without blood or marital links connected purely by varying degrees of closeness, compassion, commitment, and accord.” (Adams 2008: 102)

Families in this thesis typically consist of a male substance-using father, where the substance is alcohol, the problem has a moderate character and the wife and children are included in treatment at some stage. However, the insights and the findings are not limited to this situation; they represent the variety to be found in contemporary outpatient AOD-treatment in Norway. Further, when we refer to particular family members in the course of this thesis the term “person in the addictive relationship” (PAR) (Adams 2008) will be used for the substance-using person, and “affected family members” (AFM) (Orford et al. 2010d) for the intimates around this person. The way we categorize families is an underlying point of interest in the course of this thesis, underpinning the broader research interest and the research questions.

1.6 *The field of policy*

The issue of families and addiction is closely related to the field of policy. In 2004, the field of AOD treatment services in Norway was transferred from social services to health services. Norway’s alcohol and drug treatment (which also includes gambling) is organized under the state-owned regional healthcare enterprises as a multidisciplinary specialized service for substance abusers (Nesvåg and Lie 2010), which represents the framework for service provision.

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In the social democratic welfare regime setting of Norway (Esping-Andersen 1990), the concern for families and AFMs, especially children, is highlighted in policy documents. In 2010, an important change was made regarding the rights of children of patients (Helsedirektoratet 2010), by making health professionals obliged by law, to assess and attend to the needs of these children. In addition, a person responsible for children should be admitted in each treatment department. This legal change has been subject to a multicentre study in Norway and preliminary results indicate that the new legislation is only to a limited extent being complied with (Ruud 2015).

Further, the next of kin of patients are entitled to information and involvement in treatment, as long as the patient permits it, according to §3.3 of the Patient and User Rights Act (Helse-og-omsorgsdepartementet 2001). Family and network involvement in treatment is now strongly recommended on a national level (Helsedirektoratet 2015a), due to research on treatment outcomes. AFMs are also entitled to individual treatment in AOD institutions (Helsedirektoratet 2015c). This has been recently debated in the media regarding a draft for priority guidelines for AOD treatment (Helsedirektoratet 2015b), where “affected family members” (pårørende) were removed as a target group (tilstandsgruppe) (Cordt-Hansen 08.07.2015, Syversen 28.05.2015, Selbekk 06.07.2015, Selbekk 11.07.2015, Kjellevold 10.07.2015, Prestvik 24.06.2015). The reason for doing so was argued along the lines that “affected family members is not a diagnosis”. The draft went through, at the same time as the health authorities claimed that “nothing will change” (Helsedirektoratet, Facebook 13.10.2015). This debate has illuminated central dilemmas and challenges in the field regarding family involvement in treatment. Family approaches are necessary and sensible, but do not always make sense within the ways in which we organize our services.

2 Aims and research questions

2.1 Broader research focus

This study aim to contribute to the research literature by examine the theoretical and conceptual basis for treatment approaches, by addressing barriers in implementing family-oriented practices in the services and by focusing on processes within families and the position of AFMs in the course of treatment and recovery.

The curiosity behind this thesis can be summed up in three types of answers provided in assessing family-oriented services in 28 AOD treatment units in Norway prior to this PhD study in 2008 (Selbekk and Duckert 2009) (see also Section 1.4). Representatives from the AOD treatment units were asked how they would define family treatment.

One of the answers was as follows: 1. “The question is not relevant to us; we have primarily an individual approach” (Selbekk and Duckert 2009: 19). This answer captures my curiosity regarding the conditions for performing family-oriented services at all and the relative position of families in the services.

The two other answers, as already mentioned in 1.4, were given along the following lines: 2. “We do not engage in family therapy, we give affected family members support” and 3. “We try to assist the whole family system with change” (Selbekk and Duckert 2009: 19). These two answers capture my curiosity regarding the distinction between approaches aiming at respectively AFMs individually in “separate” treatment trajectories, and approaches aiming at relationships between family members and the family system in “integrated” treatment trajectories, and how these distinctions have been modelled accordingly in the SSCS model and the SE model.

These three answers represent the process that have formed the framework and structure of this thesis, pondering: How is it that some treatment units do not consider families at all? How do different ways of understanding families in addiction lead to different opportunities for families? What are the rationalities behind different ways of thinking? How do the families themselves experience these constructions and when and how are they useful? When is it best to be

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met by the treatment system as a particular family member, and when is it best to be met as a family system? This curiosity represents two broad research foci in this thesis: A. The relative position of families in AOD treatment and B. Comparison of “individual-focused” and “relationship-focused” approaches to troubled families. From these broader research foci, one main research question and three sub-questions have been developed, related to three different articles.

2.2 Research questions

The main research question in the research underlying this thesis is:

How can we understand practices towards families and affected family members in AOD treatment?

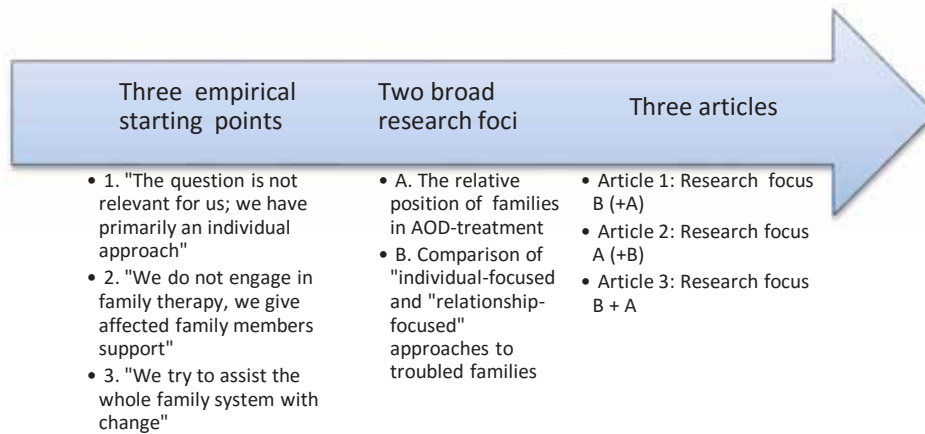
The following sub-questions elaborate on the main research question in three articles:

1. In the light of theories of addiction: How do models of families in treatment relate to theories of addiction, and what are the consequences for practice?
2. In the light of the discursive environment of AOD institutions and conditions of possibilities: What are the conditions for receiving attention and support as affected family members in AOD treatment?
3. In the light of storylines facilitating healing processes within families: How are families positioned in encounters with treatment, and how do storylines facilitate processes of reintegration and repositioning within families?

Table 1 presents an overview over the relationship between the empirical starting points, the broad research foci and the associated articles.

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Table 1 Three empirical starting points and broad research foci



The three articles are linked together in their mutual focus on family-oriented practices. Firstly, from a theoretical angle, they analyse how two different models of families in addiction, the SSCS model and the SE model, relate to the phenomenon of addiction, and which options and actions they provide for families. Secondly, from the institutional angle, they analyse how theories are applied in practice, and what the conditions are for receiving attention and support as AFMs. Thirdly, from the angle of families, they analyse how encounters with treatment are described by the people involved, both PARs and AFMs.

We will now turn to the theoretical framework in which these research questions were further developed and shaped.

3 Theoretical framework

This thesis is concerned with how families and AFMs are acted upon in the field of AOD-treatment. A common ground is a sensitivity towards discursive opportunities and possibilities at work in talk and interaction (Holstein and Gubrium 2011: 345). We are further interested in both the *whats* and the *hows* of family involvement in treatment, meaning both which discursive formation creates the possibility structure for families in this arena, and how the interaction with treatment and within families plays out (Holstein and Gubrium 2011: 349). Here the theoretical framework draws on sources related to a critical realist and a constructivist research tradition. In Article 1 we focus on models as representing mechanism at different layers of reality (this entails the *whats*, but not the *hows*), while in Article 2 both aspects are included, but with a stronger emphasis on the *whats* than on the *hows*. In Article 3 they are also combined, but here greater emphasis is placed on the *hows* of reality constructions within families.

A theoretical starting point is the critical realist notion of the “necessarily laminated system”. It serves as an analytical tool in Article 1, as well as a framework in contextualizing the results from the thesis as a whole. It will be elaborated on and discussed in 3.1.

In analysing the discursive field of AOD treatment and the relative position of family-oriented practices, the concepts of “going concern”, “conditions of possibility”, “institutional identity” and “order of discourse” are used as the main analytical tools and will be elaborated on and discussed in 3.2.

In analysing encounters with treatment from families’ point of view, and processes of change in families encountering AOD treatment, positioning theory is used as an analytical tool, and will be elaborated on and discussed in 3.3.

3.1 *The necessarily laminated system*

A central concept of analysis in this thesis is the “necessarily laminated system” (Bhaskar and Danermark 2006, Collier 1989), crafted within a critical realist

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research tradition. In this section we will introduce the concept of the necessarily laminated system and critical realism (in somewhat more detail than was possible in Article 1). We will further present the analysis made in Article 1 of two models of families in addiction within the larger field of addiction theorizing, and further accentuate the necessary laminated system as a potential framework for contextualizing the results of the thesis as a whole.

Critical realism is a meta-theory concerning the inclusiveness of different layers of reality from the natural to the social world; hence the term necessarily laminated system, and how it is used here in understanding addiction as a phenomenon. The different layers of reality emerge together in explaining events in the world. Critical realism, generally associated with the work of Roy Bhaskar (Bhaskar 2008), emphasizes the distinction between the transitive (what is real - ontology) and the intransitive (what we have knowledge about - epistemology). According to Bhaskar, the external world exists independently of our representation of it. It is considered possible to gain knowledge about the world, but knowledge is always fallible, more or less true and more or less applicable. According to critical realism, there are three overlapping domains of reality: experiences on the empirical domain, events on the actual domain, and mechanisms on the real domain (Bhaskar 2008: 252). The real domain consists of generative mechanisms and processes, which causes things to happen in the world, both physical and social. Research is ultimately about searching for those mechanisms, and encompasses retrodiction as a research strategy (Blaikie 2007).

Addiction and AOD problem is a multidisciplinary field of research. By adopting an inclusive ontological framework, where reality is multi-layered, stratified and necessarily laminated, research related to biological processes within the brain, psychological processes within the head, social processes in close relations and networks and processes on the cultural and societal level can be considered as part of the same phenomenon. An inclusive ontological framework also contributes to encourage reflection on the interrelationship or emergence between different areas of research. A critical realist framework gives concepts to the essential complexity and necessary lamination that includes all potential causally relevant levels of reality and their co-determination (Bhaskar and Danermark 2006: 280).

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This position can be related to the “ontological turn” in social science in general, and in medical sociology and anthropology. One example is Mol (2002) who describes how social perspectives on disease should be considered not just as perspectives on reality, but as part of the reality and enactment of disease “itself” (Mol 2002: 12). According to Mol (1999), there are different versions, different performances and different realities that co-exist in the present. Ontology can be defined as what belongs to the real (Mol 1999). An ontological turn represents a shift from focusing on how we can gain knowledge (epistemology) to what there is to know (ontology). This growing interest in ontology is represented within different theoretical traditions, one of which is critical realism (Law 2005).

Social strata includes both the levels of agency and structure. Social strata have emergent properties and powers, including the intentionality of human beings, reflexivity, language, and skill to change, which implies that social studies are conducted in open systems (Danermark 2003). Agency and structure have their respective properties and powers at the same time as they are closely interrelated. Structure enables and constrains social actors, at the same time as actors reproduce and transform structure (Danermark 2003). Social mechanisms do not have the same stability as natural mechanisms; yet they are not merely mental constructions in people’s heads. They change over time, although their connections to the material world represent some stability and duration. The world is socially produced and “real” at the same time (Danermark 2003: 69). Here there is an overlap between critical realism and constructivist research traditions (Bhaskar and Danermark 2006: 283, Andersen 2007). The intersection between a critical realist and constructionist research tradition will be further discussed in Section 3.3. The way to find social mechanisms is through structural analysis and conceptual abstraction. To judge the validity of a theory in relation to other theories is by using historical, emancipatory, critical and instrumental criteria (Danermark 2003: 344).

Critical realism reinvented the term “causality”, as something different from prediction as in empiricism, and not as an opposition to meaning, which make the mechanistic metaphor not necessary (Sayer 2000: 182). Sayer states how causality is contingent to whether our powers and susceptibility are activated, which again depends on the causal powers and susceptibility of other objects, and how people push and pull, and are pushed and pulled, within the field of

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forces according to their position, and the relative strength of their powers and vulnerabilities (Sayer 2000: 182). In this way, the dualism of causality and meaning is no longer central. Elder-Vass (2012) describes it in the following way

“A realist social constructionism, in other words, would see language, discourse and culture as products of interacting causal powers and also, potentially, as causal forces themselves. This opens up the prospect of seeing social construction as a real causal process, or a family of such processes. By developing a social ontology of language, discourse, and culture we can then develop an understanding of the entities, powers, and mechanisms at work.” (Elder-Vass 2012: 12).

As Fiaz (2014) points out, critical realism moves beyond the material-ideational question by insisting that a variety of structures and underlying processes are ontologically “real” and have causal effects. So it is of little consequence whether the process or structure is “material” or “discursive”, but rather whether it has the potential to enable or constrain social reality. In this respect, the social is a necessarily relevant ontological condition (Fiaz 2014: 497).

In all levels of reality and in the emergence between them, there are potential reasons why addiction occurs. Taking this argument the other way around, in all these levels of reality there are potential tools for accommodating, alleviating or remedying the situation. This brings us to the analysis in Article 1. Here the SSCS model and the SE model, were analysed according to their answer to the ontological question: what is addiction? The critical realist notion of the necessarily laminated system highlights what the models presuppose, in our case presumptions about addiction, and what it is about the models that enables them to do certain things, in our case, what kinds of AOD practices they are enabling. Analysing the basic assumptions of theories or models of addiction in families makes it possible to discuss implications for practice. By applying the framework of critical realism to the models, they are not analysed as mere discourses (if there is such a thing), but as models relating to mechanisms that are “real”.

Models are here understood as pictures or images that are intended to represent explanatory mechanisms; they indicate what a mechanism might look like, and

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thus help researchers in the search for them (Blaikie 2007: 84). There is another point to be made, namely that the relative importance of the models or theories and the mechanisms involved varies from case to case, and we should never give the same form of treatment and social response to each case of addiction (Bhaskar and Danermark 2006: 292). The articulated lamination is in relation to the experience and perception of the experience of addiction (Bhaskar and Danermark 2006: 293).

The analysis in Article 1 was restricted to models of families in addiction, emphasizing the layers of psychological and social mechanism, of agency and structure. The relation and interaction between these models and mechanisms on other layers of reality were not examined, e.g. how neurobiological processes of addiction affect parental reflective capacities (Söderström and Skårderud 2009). This is a demarcation of this study. Bhaskar and Danermark offer some comforting remarks: “Of course, this does not mean that each of these dimensions has to be consciously referred to in every social explanatory act. That is a matter for the pragmatics of explanation, given the focus of the particular explanatory inquiry” (Bhaskar and Danermark 2006: 289).

Moving from the world of models to the world of social practice. The concept of the necessarily laminated system serves in this thesis also as a critical tool for analysing practices in the field. The critical realist research tradition are concerned about underlying mechanisms that are intrinsically connected to the emergence of phenomena. That includes questions like the ones Joseph (2007: 354) asks: Why do phenomena get constructed in the way they do? Why are some constructions more powerful than others? What are the conditions of possibility for specific social constructions? It is interesting that when Joseph uses the term conditions of possibility here (which we will come back to in the next section), it is used to describe the search for such mechanisms. Research on family-oriented treatment intervention supports in general the validity of including AFMs and affected families in theorizing addiction as a phenomenon. Yet how does this work in practice? What is the relative influence of different enactments of the world? By using the concept of the necessarily laminated system, practices can be evaluated according to their emphasis on the different levels of reality, and also the emergence between levels.

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This brings us to the next section, where we will elaborate on the concepts used to analyse the discursive field of AOD treatment and the relative position of family-oriented practices in more detail, which represent the main focus of Article 2. In Article 2 the concepts shift from “mechanism” to “discourse”, “going concern” and “institutional identities” and from “necessary lamination” to “conditions of possibilities” and “order of discourse”. Although these concepts have been crafted within different research traditions, they are potentially not far apart.

3.2 *Discursive and interactionist approaches*

Operating within the social realm, we have drawn heavily in this thesis on discursive and interactionist research traditions. In this section we will introduce the concepts “conditions of possibility”, “going concern”, “institutional identity”, and “order of discourse”, which we used as a framework in analysing the discursive environment of AOD treatment in Article 2. The concepts are used in the analysis of “institutional talk” (McHoul and Rapley 2001), based on interviews with clinicians and directors at three different AOD treatment institutions in Norway. The concepts “conditions of possibility”, “going concern”, “institutional identity” and “order of discourse” and their theoretical background will be elaborated on and discussed.

The focal point in Article 2 is not to describe and analyse concrete family-oriented practices performed by institutions, but, following Miller (1997), to study the interactional context in which these practices are exercised. The term “conditions of possibility” is used to describe how salient discourses and their interrelatedness and discontinuity constitute the conditions in a given setting, within which some social relationships and realities are more likely to emerge than others (Foucault 1981, Miller 2001).

So what do we mean by discourse in this setting? The term discourse is here applied in the sense of particular ways of understanding the world, as an integral part of social practice (Fairclough 2003, 1992, Holstein and Gubrium 2000). In this way of approaching discourses, they are never “mere” discourses in an abstract sense, but entities closely connected to discursive and social practice and to power.

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Holstein and Gubrium (2000) conceptualize the interplay between “discourse-in-practice” (available discourses – the *whats*) and “discursive practices” (the *hows*) as two interrelated ways of approaching social practice. The project is, according to Miller (1994), who operates within the same research tradition, to:

“...synthesize Foucault’s concern for specifying the conditions that shape what may be said and who can speak within socially organized settings with ethnomethodologists’ and conversation analysts’ interest in analysing the conditions associated with and the procedures through which reality claims are actually made.” (Miller 1994: 286)

By doing this and combining the discursive and interactionist elements, both the *whats* and the *hows* of reality construction are addressed (Holstein and Gubrium 2000:93). An alternative term, encompassing discourse in an interactionist sense, is Hughes’ (1984) notion of “going concern”.

In our study we found it useful, in line with the interactionist and discursive framework, to adopt the term “going concern” introduced by Hughes (1984) to analyse “discourses at work”. Going concerns assemble an understanding of discourse that incorporates the intersection between discursive formation and social practice and events. Using the term going concern allows us to focus on the interplay between discourses-in-practice (conditions of possibility) and discursive (and social) practices (Holstein & Gubrium 2000: 96-99).

Hughes argues that the term institution “in general suffers from an overdose of respectability” (Hughes 1984: 52). He states that the constitutive elements of an institution are a concept and a structure, and that the structure may be as unpretentious as perhaps “only a number of functionaries set to cooperate in prescribed ways at a certain conjuncture” (Hughes 1984: 53). Hughes emphasise upon the value of examining the processes, in which social values and collective arrangement are made and unmade and how things arise and how they change. In giving attention to the “not yet”, the “didn’t quite make it”, the “not quite respectable”, the “unremarked”, and the openly “anti” going on in our society (Hughes 1984: 53), the interactive and negotiating character of social life can be illuminated. Going concern can relate to a traditional institution as a whole, or to collective action within a larger enterprise (Wästerfors 2011). In our case it relates to the latter. Discursive and social

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practices related to the situation for families and AFMs can be seen as such a going concern.

Interactionist researchers like Gubrium and Holstein adopt the term going concern (Gubrium and Holstein 2000, Gubrium and Holstein 2001, Holstein and Gubrium 2000). They emphasize the lack of focus that traditionally has been given to conditions and possibilities by symbolic interactionists for fear of reifying social structure (Gubrium and Holstein 2000: 103). They recognize the power aspect connected to going concerns and people's unequal access to the same field of possibilities (Gubrium and Holstein 2000: 108). Each going concern represents an ongoing commitment to a particular moral order and patterns of concerted activity (Gubrium and Holstein 2000: 102). In Article 2 the going concern of families and AFMs are analysed in relation to other interpreted practices within the larger discursive environment of AOD treatment.

Gubrium and Holstein also conceptualize the relations between conditions of possibilities, going concern and identities within institutional settings (Gubrium and Holstein 2001, Gubrium and Holstein 2000). Certain settings, and their going concerns, make some opportunities for interventions more available than others, and hence offer certain institutional identities. This is what Hacking calls "making up people" (1986) or "making up kinds (of people)" (1999). Hacking focuses on how classifications and categorizations - "making up kinds" - are directed at new or changing classifications of people and exert influence as a social process within an institutional matrix (Hacking 2004). Applied on this study, it is relevant to ask; to what extent and in which ways are AFMs and families "made up" within the discursive setting of AOD treatment? Different ways of making up clienthoods or institutional identities represent different locations for both problems and solutions.

Alasuutari (2014), studying parental involvement in psychiatric treatment of children, explore the term "client" as both "a client of professional co-operation" and "a client of service provision for the designated problem". To be a client is not homonymous with being treated for a designated problem. One may be a client of professional co-operation in problem intervention, but not a client of service provision for the designated problem (Alasuutari 2014: 43). Clienthood is here broadly investigated as part of the target of professional

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work (Alasuutari 2014). This is of relevance for this study; family-oriented practices profoundly challenge the way “clienthood” is understood and made up within the services. Clienthood in family-oriented practices is shifting from aiming at PAR to focusing on the AFMs and to family systems or relationships. Family-oriented treatment involves more people constructing “clienthood” in different manners, with reference to Alasuutari (2014). Goals and solutions in the course of treatment do not only target change in drinking or drug taking, but also change in family relations and systems of interactions, involving “relationship-as-client” (Kurri and Wahlstrom 2003). So, what are the conditions within the discursive environment of AOD treatment for making up clients in this way? The point of interest here is how family involvement is included in the way institutions define and conduct their services, and which institutional identities are offered. What are the conditions of possibility for receiving attention and support as AFMs and as families within this institutional environment?

Conditions of possibilities are related to a certain “order of discourse”. Fairclough’s (e.g 1992) drawing on Foucault in developing critical discourse analysis (CDA) elaborated on this concept, which is useful in exploring the relationship between different going concerns in more detail. In analysing relations between different discourses, we can analyse the relationship between different social practices (Chouliaraki and Fairclough 1999: 45).

The term “order of discourse” refers to the specifically discursive organizational logic of a field (Chouliaraki and Fairclough 1999: 114), including the variety of discursive (and hence social) practices that are present in a certain setting, in our case AOD treatment, and how they are networked together. Fairclough (2010) emphasizes that a discourse analysis is not an analysis of a discourse in itself, but its relation to other objects, elements and moments, as well as internal relations and order of discourses (Fairclough 2010: 15).

CDA, in line with Foucault’s work, represents a critical entrance. Foucault highlights the analysis of exclusion, limitation and appropriation that is involved in social events (Foucault 1981: 70). Fairclough’s CDA sees critique as closely related to making the interconnectedness of things visible:

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“The paper suggests a view of critique as embedded within oppositional practice. Opposition and struggle are built into the view of “order of discourse” of social institutions as “pluralistic”, each involving a configuration of potentially antagonistic “ideological-discursive formations” (IDFs), which are ordered in dominance. The dominance of one IDF over others within the order of discourse results in the naturalization of its (ideological) meanings and practices.” (Fairclough 2010:43)

Fairclough’s CDA has an explanatory goal, aiming to elucidate how discourses cumulatively contribute to the reproduction of macro structure (Fairclough 2010: 66). In Article 2, the term order-of-discourse applicable in analysing the empirical derived term “gravity”, which is used in the material to describe the power in individual solutions. Guiding the analysis in the direction of domination and power to define services in the field of AOD.

3.2.1 Comparison of the two traditions

The concepts adopted here in the previous section, derive from two different research traditions, both heavily inspired by the work of Foucault. The first line of research is rooted in an interactionist/ethnomethodological framework, represented by Gubrium, Holstein, Hughes and Miller. Ethnomethodology has traditionally close links to conversation analysis (CA) as a framework for analysis. The second line of research is within the framework of CDA, as both a theoretical framework and a framework for analysis, represented by Fairclough and Chouliaraki. These two lines are only vaguely connected in the literature. However, they have a common interest in discourse and in social interaction.

Holstein and Gubrium have one reference to CDA in their literature on method (Holstein and Gubrium 2011: 352) as a potential tool for analysing discourses and interaction. CDA analysis is also presented as one of several methods of analysis in a book on interactionist research (Järvinen 2006). The comprehensive assembly of the two traditions is found in McHoul and Rapley’s (2001) book on analysis of talk in institutional settings, which covers both CDA related to Fairclough and Chouliaraki’s work, and CA closely related to ethnomethodology and often mentioned in Gubrium and Holstein’s work.

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There are both important differences and similarities between applied CA and CDA. One of the main controversies is the inversion of the starting points: CA begins with actual talk and builds its findings from there. CDA analyses text and interaction but starts with social issues and problems (McHoul and Rapley 2001: xiii). Holstein and Gubrium question whether the way CDA critically addresses the substantive *whats* of social constructions and “large discourses”, can shortchange the artful human conduct and agency involved in discursive practice (Holstein and Gubrium 2011: 352). Here they pinpoint some major differences between the two traditions, but also the potential in combining them, as exemplified by Article 2. In CDA there is no “party line”, and as McHoul and Rapley (2001) state, there is no reason not to include CA in the openness of CDA to any discipline that is concerned with linguistic and semiotic analysis. The two approaches are also similar with regard to topics (McHoul and Rapley 2001: xiii).

The work of Foucault have deeply inspired both research traditions, yet they have developed over the years towards, respectively, a constructivist/interactionist and a critical realist research paradigm (Chouliaraki and Fairclough 1999). The main controversies in this intersection are the understanding of structure, as we will return to in the next section. Constructivists would argue that critical realists reify structures, by ascribing them existence and powers, while constructivists themselves understand and study structures as conditions in concrete episodes of interaction. On the other hand, it is possible to argue that critical realists theoretically separate structure, at the same time as they see it emerging in, and inseparable from, the interplay with human actors. Adopting a methodological relationalism. This puzzle concerning structure is an ongoing issue in scientific discussions within the social sciences.

The discursive and the interactionist approaches to the institutional environment of AOD treatment applied in this article complement each other. The larger field of discursive practices or order of discourse conditions the going concern of families and AFMs, enacted in every day clinical life. Different concerns relate to each other in particular ways, including relationships of domination, complementarity and contradiction. This affects the treatment options for the people involved and the potential “institutional identities” in which they can receive help and support. For the purpose of

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Article 2, the theories applied, enable a critical analysis of the relative positions of concerns and discourses, and the possible interventions, help and support for the people involved. In Article 3, we will shift our focus from institutional conditions to how encounters with treatment unfold for the families involved.

3.3 Storylines and repositioning

From focusing on conditions of possibilities and the discursive environment of AOD institutions, we will now turn to families' accounts of those encounters where institutional identities (Gubrium and Holstein 2001) are rejected, accepted or negotiated, facilitating processes of treatment and recovery where realities are enacted. For this purpose, we have adopted the framework of positioning theory, as developed in Article 3 (Harré and Langenhove 1999, Harré and Moghaddam 2003, Harré et al. 2009). First a brief introduction to positioning theory will be given. Then this analytical approach and the concepts from positioning theory will be discussed in relation to the other theoretical concepts and research traditions that this thesis draws on.

Operating in the field of discursive psychology and inspired by symbolic interactionism, Rom Harré developed with colleagues an interactionist theory of discursive “positioning”. Positioning theory is described as “the study of local moral orders as ever-shifting patterns of mutual and contestable rights and obligations of speaking and acting” (Harré and Langenhove 1999: 1). Harré challenges the traditional epistemological form of conducting psychological research. Positioning theory represents a psychology where there is room for active persons and analysis of ordinary language outside the laboratory (Harré and Langenhove 1999: 3), focusing on how psychological phenomena are produced in discourse (Harré and Langenhove 1999: 4).

Positioning theory combines three central elements of social episodes into a mutually dependent triangle: (1) *position*, which means the moral positioning of the participants and the rights and duties that they have to say certain things; (2) *storyline*, which is the conversational history and the sequence of things that have already been said; and (3) *speech act*, which is the act of talking with its power to shape certain aspects of the social world, and comprises illocution (the meaning of a speech act) and perlocution (the effect of a speech act) (Harré and Langenhove 1999: 6). In using these analytical terms, positioning theory

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illuminates the normative frames within which “we live our lives, thinking, feeling, acting, and perceiving against standards of correctness” (Harré et al. 2009: 9). Opposed to the more static concept of “role”, he introduces the concept of “position” as a more flexible and open way of understanding people’s whereabouts in the world. In positioning theory, social acts are the basic substance of the social world and the object under scrutiny, comprising conversations, institutional practices and societal rhetorics at different levels of society (in contrast to studying people, institutions and societies) (Harré and Langenhove 1999: 14). In Article 3, positioning theory is used in two different ways: in analysing encounters with treatment, where possible storylines represent the institutional constraints of families’ involvement, and in analysing family interaction in the process of treatment and recovery. As Article 3 presents a more thorough introduction to positioning theory, this section will focus primarily on the intersection between this theory and other theoretical concepts used in this thesis.

In the framework of this thesis, we have used theoretical contributions from both Bhaskar and Harré. Blaikie (2007) describe the considerable overlap there has been in their theorizing, and how this has now diverged to a point where they reject important elements of each other’s position (Blaikie 2007: 146).

Retroduction as a research strategy was introduced by Harré, then developed by Bhaskar, first for natural science, and then further developed for the social sciences. Theories within such a research strategy provide answers to the question: Why is it that the patterns of phenomena are the way they are? (Blaikie 2007: 84). The theories provide an account of the constitution and behaviour of those things which in their interaction with each other produce the manifested pattern. Models are pictures or images that are intended to represent an explanatory mechanism (Blaikie 2007: 84). Retroduction refers to the process of building hypothetical models of structures and mechanisms that are assumed to produce empirical phenomena. Both Harré and Bhaskar suggest retroduction as an alternative to deduction and induction. But where Bhaskar focuses on explanations in social structures that are external to social actors, Harré focuses on cognitive mechanisms and socially constructed rules of behaviour and hence adopts a structuralist and a social constructivist version of retroduction (Blaikie 2007: 9-10).

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So while they both represent an ontological turn in overtly addressing what is “real”, they disagree about the ontology of social life, particularly on the nature, status and origins of social structure (Blaikie 2007: 150). For Bhaskar, structure has a causal role to play, and exists independently of social actors and their activities. For Harré, structure is intimately related to social actors, generated from networks of relationships of people, and has no causal efficacy, as it would be wrong to give rules and conventions causal efficacy. Harré is not rejecting social structure as such, but reject it as a causal transcendental force or mechanism. He emphasizes human actors, and the rules they follow or do not follow (Harré 2002b). The furthest he will go in describing something like structure is: “the patterns that might emerge in the flow of discursive acts as constraints on the action of individuals” (Harré 2002a: 147). Harré names his current position “conversational realism” according to Varela (1996). For Bhaskar, social structures do not emerge only out of human activity in the here-and-now; their origins are in the past. Human agency acts on pre-existing structures: it does not create them from scratch (Blaikie 2007: 150). However, as we have commented on earlier, critical realists are concerned with the world as simultaneously socially produced and reproduced.

It is interesting though, that when Harré and Langenhove (1999) write about further opportunities for research and development within the framework of positioning theory, they highlight the fine structure of the internal relations of the components of a position cluster and psychological, physical, characterological, autobiographical and personal characteristics, and further how duties are generic and derive from powers and capacities (Harré and Langenhove 1999: 198). This can be aligned with a critical realist understanding of how different layers in a necessarily laminated system represent powers and emerge into the social world. It is also interesting to see that when Archer, within a critical realist tradition, theorizes the interplay or “point of contact” between agency and structure introduces the term “position” (places, functions, rules, duties and rights) occupied (filled, assumed, enacted) by individuals and the practices (activities) in which they engage as a mediating system (Archer 1998: 371).

Conditions of possibility and going concerns are concepts that can be aligned with Harré’s term “storyline”. Positioning theory is both attentive to positioning according to a certain moral order (what is allowed), and also opens up

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conceptually for the possibility of reposition. Harré and Langenhove (1999) also described how institutional positioning occurs when an institution wants to classify persons who are expected to function within that institution, and is analogous to research on institutional identities and categorization (Gubrium and Holstein 2001, Hacking 1986). Positioning theory captures ongoing processes of change. It emphasizes the potential for change in situations, but the available storyline still plays a role in representing conditions of possibility.

Harré tends to emphasize the discursive here-and-now, and how it is only people that through their action generate structure and the necessary foundation on which the possibilities of social structure depend (Harré 2002b: 114). Thus, Harré puts more weight on the possibility of repositioning than on the restrictions in “possible storylines” and “dominating storylines”. According to Harré, they are “just storylines” (Harré 2002b: 117). In this thesis, Harré’s tools and thinking are used, but where the aspect of power and the constraint and conditions represented in dominating storylines is emphasized. In this way the whole thesis has a critical point of departure. For both Harré and Bhaskar practices and materiality (in a broad sense) are closely tied to discourses (language). Using positioning theory bring discourses very close to people’s daily lives and concrete everyday episodes, giving us an understanding of the concrete impact of certain discourses on AFMs and on families, and the potential in repositioning.

3.4 The “whats” and the “hows”

There may seem to be overly many concepts and theories presented in this chapter. However, as noted initially in this chapter, the concepts have grown in the research process. The different theoretical approaches used in this thesis are tied together in their focus and emphasize family-oriented practices related to social mechanisms regarding the phenomenon of addiction. The concept of the necessarily laminated system highlights and contextualizes the relevance of social mechanisms. The terms “conditions of possibility” and “order of discourse” enable an analytical critique of the relative position of these mechanisms and how they enfold in clinical life in AOD treatment institutions. Positioning theory is used to describe how these conditions are enacted in encounters with treatment and how families describe and highlight the

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importance of mechanism at different levels of reality in facilitating their processes of treatment and recovery. In this way the concepts collected from different theoretical sources are bound together in conceptualizing both the *whats* and the *hows* of reality construction. The various theoretical perspectives and the different concepts inform one another, from a theoretical level to the level of institutional practice and to the level of families' practices.

These three analytical entrances contribute in different ways to the *whats* and the *hows* and deepen our approaches. Concepts like the necessarily laminated system, "conditions of possibility" and "order of discourse" serve as tools in analysing the *whats*, but in relation to the concepts of "going concern", "speech act" and "position" that focus on the social practice within which these conditions are enacted, reproduced and transformed. Table 2 gives an overview over the main analytical concepts in the thesis, and how they relate to each other.

Table 2 The *hows* and the *whats*

	Critical realist analysis	Interactionist and discursive analysis	Positioning analysis
<i>Hows</i>		Going concern, institutional identities	Speech act, positioning and repositioning
<i>Whats</i>	Mechanism The necessarily laminated system	Conditions of possibilities Order of discourse	Storylines

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The theoretical concepts presented above borrow from different sources and have emerged in the process of analysis and research. Shifting theoretical concepts have been important tools in the research process, shaping and transforming research questions and illuminating the content of data. In this way, data and theory have mutually inspired the process of research. The three articles of this study each have their own logic, while at the same time being related to each other in a common focus on family-oriented treatment practice from different angles.

4.1 Five difficult questions

To clarify the methodology of this thesis, Mason's (2002) five "difficult questions" are used to provide a basic structure. She presents a theoretically engaged, grounded approach to qualitative researching and emphasizes how a scientific work can be formulated around an "intellectual puzzle" (Mason 2002: 7).

These five "difficult questions" cover the following areas:

1. The social reality: Your ontological perspective. What is the nature of the phenomena, or entities, or social reality, that I wish to investigate? (e.g. discourses, positions, interaction, people, emotions, institutions, underlying mechanisms)
2. Knowledge and evidence: Your epistemological position. What might represent knowledge or evidence of the entities or social reality that I wish to investigate?
3. Your broad research area. What topic, or broad research area, is the research concerned with?
4. Your intellectual puzzle and your research questions. What is the intellectual puzzle? What do I wish to explain or explore? What type of puzzle is it?

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5. Your aims and purpose. What is the purpose of my research? What am I doing it for?

This resonates with how this research has been crafted and developed. These five dimensions are closely related to each other, as the answer to one difficult question directly affects the answer to another, and they have been developed in a constant loop in the course of the research process. This cycle involves the dimensions in this thesis that have already been presented in the

. Each of the questions draws on, actualizes or changes the approach to another “difficult question”. In Table 3, the three articles in this thesis is presented according to how the answer the five difficult questions.

Mason’s (2002) question about ontological reality or the ontological component of the analysis draws attention to the underlying assumptions of the analysis, and the reality produced by the results. Addressing ontological components of research is not always done overtly in the course of research (See Article 1).

The ontological components central to this thesis as a whole can again be related to the *whats* and the *hows* of reality construction. The interest is in what mechanisms and conditions underlie episodes in the world (the ontological components of Articles 1 and 2), and how episodes are reproduced or re-articulated in social practice (the ontological component of Article 3).

Harré and Langenhove (1999: 114) articulate a switch from a traditional focus in social ontology on people, institutions and societies towards a focus on speech acts, institutional practices and societal rhetorics as “substances of the world”. In this respect this whole study, in contrast to “traditional” social ontology, focuses on underlying mechanisms (Article 1), going concerns and discourses (Article 2) and storylines and positions (Article 3). In this way the general interest is in “not men and their moments, but moments and their men” (Gobo 2008: 208).

As addressed in the theoretical framework, there is also a potential tension in the theoretical basis regarding the *whats* and the *hows* of reality construction. This goes along some of the central lines in the intersection between a critical

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Table 3 Three articles and five difficult questions

	Article 1: Addiction, families and treatment	Article 2: Troubled families and individualised solutions	Article 3: Positioning families in AOD-treatment
1. Ontological components	Multi-layered reality, underlying mechanism, models	Going concerns, discourses	Positions, social relations
2. Epistemological component	Literature analysis	Interviews with clinicians and directors	Joint and individual interviews with AFMs and PARs
3. Broad research foci	B. Comparison of "individual-focused" and "relationship-focused" approaches to troubled families	A. The relative position of a families in AOD treatment	B + A
4. Research questions	How do different models of families in treatment relate to theories of addiction, and what are the consequences for practice?	What are the conditions for receiving attention and support as affected family members in AOD treatment?	How are families positioned in encounters with treatment, and how do storylines facilitate processes of reintegration and repositioning within families?
5. Aims and purposes	To develop an awareness of different ways of conceptualizing families in addiction and their consequences To search for methods that can serve to underpin family-oriented work in AOD treatment institutions	To understand the conditions of family involvement in treatment, and potential barriers in implementing family-oriented services To discover unmet needs, and how they can be met	To understand the process of treatment and recovery from families' accounts related to available storylines To gain knowledge about when it is wise to interact in certain ways regarding families in the course of treatment

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realist and a constructionist research paradigm, involving e.g. the fear of reifying structures on the one hand, and of undermining the conditions of reality construction on the other. Yet both traditions emphasize the close relations between the discursive act and the broader network of discourses in which the discursive act is played out, or how structure and agency are inseparable from each other in simultaneously producing conditions and being conditions. All the articles are also based on the analysis of language. Both Holstein and Gubrium (2011) and Bhaskar and Danermark (2006) call for openness in combining different analytics. Holstein and Gubrium (2011: 345) describe it in the following way: “In our view, we need an openness to new, perhaps hybridized, analytics of reality construction at the crossroads of institutions, culture and social interaction” (Holstein and Gubrium 2011: 345). Critical realism presents itself as a methodologically inclusive theory (Bhaskar and Danermark 2006).

4.2 *Methods and material*

We now turn to the epistemological position: What might represent knowledge or evidence of the entities or social reality that I wish to investigate? To answer the three research questions underlying the three articles, different sources of data have been used. The first research question is a theoretical one, and the source of data is academic literature regarding different ways of approaching families in addiction. The second research question about conditions of possibilities is addressed by analysing interviews with directors and clinicians at three different AOD treatment institutions, thus approaching the institutional level. The third research question regarding how families are positioned in encounters with treatment, and which storylines these encounters facilitate, is addressed by analysing joint and individual interviews with families involved in treatment.

In line with the discursive and interactive framework of this study, all interviews were performed and analysed as interactive, producing and reproducing different lines of argument in the interview context. This is in line with Rapley (2004) description of interview situations as specific interactional moments that reflexively document contemporary ways of understanding, experiencing and talking about a certain subject, and how the interviewees’ talk

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is intimately tied to the context of the production - the local interactional contexts (Rapley 2004: 28). Speakers in an interview actively and collaboratively produce, sustain and negotiate contemporary knowledge (Rapley 2004: 28).

4.2.1 Approaching the theoretical level

The theoretical level was approached by examining existing literature on the the stress-strain-coping-support (SSCS) model and the social ecological (SE) model. These models represent respectively the distinction between focusing on individual needs within the family (of AFM in particular) and on how the family functions as a system, as presented in 1.4. In this way they represent a strategic sample of different family theoretical models. The primary sources of this analysis were texts from Adams and Orford et al. (Adams 2008, Orford et al. 2005, Orford 2001, Orford et al. 2010a).

4.2.2 Approaching the institutional level

On the institutional level, interviews with both directors and clinicians were performed. These interviews can be related to what McHoul and Rapley (2001) call “institutional talk”. Holstein and Gubrium refer to Drew and Heritage’s summary of the fundamental character of institutional talk: 1. Institutional interaction involves an orientation by at least one of the participants to some core goal, task, or identity conventionally associated with the institutional setting, e.g. an orientation towards the execution of institutional tasks and functions (going concern). 2. Institutional interaction often involves special constraints, such as what kind of talk is permitted. 3. Institutional talk is associated with the inferential framework and procedures of a specific institutional context (Holstein and Gubrium 2000:155). In this way the interviews represent knowledge about the discursive environment of AOD-treatment. Clinicians and directors were interviewed partly individually and partly in groups of two and three. The format was chosen according to the practical possibilities of data collection. The group interview has the advantage of encouraging lines of arguments where different ways of producing and reproducing the world are challenged more directly.

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Interview guides (see Appendixes) were provided and included the following topics: definitions of problems with addiction and substance use in general and in families, family-oriented practices in their institution, their role towards families, barriers and dilemmas related to family-oriented practices and experiences with concrete treatment processes involving family members. The interview guide functioned as a framework to aid the flow of the conversation. An essential part of the interviews was to follow up on leads provided by the participants within the broader thematic frame of the project. The interviews lasted from one to two hours.

4.2.3 Approaching the family level

According to the broad research focus B. “Comparison of "individual-focused and "relationship-focused" approaches to troubled families”, we adopted a design that included both joint and individual interviews with families and family members. The underlying curiosity of the study regarding “being me” and “being us” was in this way closely embedded in the research design. Each family was invited to a joint interview involving both AFM and PAR, and consecutive individual interviews with both parties. According to Reczek (2014: 331), this methodological approach provides a “gold standard” for gaining a full view of family dynamics, and allows for previous interviews of either type to be used as an informative tool for subsequent interviews. Studies with similar designs have been used to describe the roles of couples in parenting (McNeill et al. 2014).

The order of interviews was chosen on the basis of both ethical considerations and according to our interest in framing the study within a social realm. The ethical considerations will be handled in more detail in Section 4.4. Within such a design, an opportunity was given to examine the relation between individual processes of change (how was this for you in particular) and relational processes of change (how was this for you as family).

An interview guide was provided for the joint and the individual interviews respectively (see Appendix), focusing on how that process of treatment and recovery was for them *as a family* or for them *as individuals*. The interview guide was built around the following themes: definitions of addiction and substance abuse problems and family, the process that led to involvement with

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treatment, experiences with treatment and feedback to service providers (see the Appendix). The interviews in general had an open-ended character, sensitive to the way families would describe their encounters with treatment, independently of the broader research focus.

The characteristics of the interviews depended on where in the process the families were. In the joint interviews story present could come around as coherent and attuned – as a consolidation of an accomplished situation, or as different stories negotiated as we interacted. This was also interesting in relation to the individual follow-up interview; either the interview resembled the joint interview, or it represented a continuing process of negotiation or re-articulation of what took place in the joint interview. In some cases the individual follow-up interview represented “a break”, that is to say, a divergent story from what was told initially.

The relation between the research questions, research design and method will be further discussed in 4.5.

4.2.4 Sampling

All the participants were recruited from three AOD treatment institutions in Norway. The three institutions represent a strategic sample (Mason 2002) of institutions with somewhat different practices towards families, related to the distinction between “individual-focused” and “relationship-focused” approaches and separate and integrated treatment trajectories (Selbekk and Duckert 2009), which is both empirically and theoretically based, and central to our research focus. Originally, only two institutions were sampled, but in the course of the research and problems in recruiting enough families, a third institution was included in the study. The three institutions represent a variety of traditions in family-oriented practices - from a traditionally strong focus on family therapy to one in which families as units are seldom brought into consultations, but where AFMs are offered individual or group sessions. Although the institutions have different profiles in their family-oriented practice, they also represent a variety of practices internally. The primary focus of this study was the practices conducted in outpatient departments. All three institutions were located in a city centre and offered inpatient, outpatient and

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detoxication treatment. Data was collected in the period from 2011 until summer 2013.

4.2.4.1 Participants on the institutional level

Eighteen participants were recruited, representing the different institutions: the director from each institution and 15 clinicians who apply family-oriented interventions in outpatient departments. The clinicians were sampled strategically to provide comprehensive insight and reflection on family-oriented practices. The interviews were conducted by the first author either individually (8 interviews) or in small groups of two (2 interviews) or three people (2 interviews). The participants had different professional backgrounds: the directors were all psychologists ($n=3$), and the clinicians were either family therapists ($n=8$), psychologists ($n=5$), or specialists in nursing or social work ($n=2$). The number of interviewees was divided evenly between the three institutions. Table 4 present an overview over the interviews conducted.

Table 4 Interviews with directors and clinicians

	Number of participants	Individual interviews	Group interviews	Number of recruited families
Institution A	6	1	2	6
Institution B	5	2	1	2
Institution C	7	5	1	2
Total	18	8	4	10

4.2.4.2 Participants on the family level

From the three institutions, 16 representatives from 10 families were recruited who were receiving some kind of family-oriented intervention. Initially the criteria for recruiting families were that there were children under 18 living in the household, that alcohol was the primary problematic substance, and that the interventions represented both separate and integrated treatment trajectories.

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It was hard to recruit families, and the criteria were debated; a “typical family” was not so typical in this setting. A variety of “families” and relationships were included in treatment. It was decided to put the set criteria aside, to see what kind of family relationships it was possible to include. After some time we decided to include a third institution. This led to both an increase to more comprehensible data on the institutional level, and a better opportunity to recruit families.

It was also difficult to obtain clear-cut family cases representing separate and integrated treatment trajectories. In those cases where AFM was approached separately, it was difficult to get hold of PAR, who was either not receiving treatment at all at the time or refused to be included. Analytically (4.3.3) our approach was turning from searching for “individual-focused” and “relationship-focused” approaches in clear-cut family cases to different experiences within each family case, since it turned out that they were subjected to different treatment approaches in the course of their processes of dealing with addiction in the family. In this way the general interest was in “not men and their moments, but moments and their men” (Gobo 2008: 208). Thus the broad research focus B: “Comparison of “individual-focused and “relationship-focused” approaches to troubled families”, and its implication for sampling, was also tested and reformulated (Mason 2002: 196).

Table 5 provides an overview over the families included in the study. They were all provided with pseudonyms in alphabetical order according to their chronological entrance into the project. Joint interviews were conducted in 6 out of 10 family cases, both joint and individual interviews were conducted in 5 out of 10 family cases. These limitations would be further discussed in 4.5.2.

The sample contains both horizontal husband-wife (partner/partner) and vertical parent-child (or child-parent) relationships. Still the former type of relationships represent a majority. In the latter cases both parent and child are grown-ups. However, in these families other relations are also involved in the interview texts and storytelling, although indirectly through the accounts of the interviewees.

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Table 5 Interviews with families

	Relations	Substance	Age	Inter- view PAR AFM	Inter- view PAR	Inter- view AFM
Case 1	Andreas PAR= Husband Astrid AFM= Wife	Alcohol	30s (three children under 18)	X	X	X
Case 2	Birk PAR/AFM= Husband Bente PAR/AFM= Wife	Cocaine	30s (two children under 18)	X	X	X
Case 3	Christian PAR= Husband Caroline AFM= Wife	Alcohol	60s (three grown-up children)	X	X	X
Case 4	Dag PAR= Husband Dina AFM=Wife	Alcohol	50s (grown-up children)	X		
Case 5	Erik PAR= Husband Emma AFM= Wife	Alcohol	40s (one child under 18)			X
Case 6	Frank PAR= Husband Frida AFM= Wife	Alcohol	20s (no children)	X	X	X
Case 7	Gustav PAR= Son Grete AFM= Mother	Illegal drugs	50s (AFM)			X
Case 8	Heidi PAR= Mother Hanne AFM= Daughter	Alcohol/ Benzo	30s (three grandchildren)			X
Case 9	Isak PAR= Husband (Son) Isabell AFM= Wife (Mother)	Alcohol	60s (AFM)			X
Case 10	Jon PAR= Male partner Janne AFM= Female partner	Illegal drugs	20s (two children under 18)	X	X	X
				6	5	9

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Most of the families included, lived in situations where many social identities were still intact: they were all either employed or retired, and they had relationships with their family and friends, although these were compromised and endangered in different ways. The age of the participants ranged from 25 to 65 years. Alcohol was the only substance that caused problems in 7 out of 10 families, while in the other cases there were also illicit drugs involved. 7 out of 10 families had experienced both integrated interventions (in AOD treatment), separate interventions for PARs (inpatient or outpatient treatment) and separate intervention/support for AFMs (either in an outpatient treatment or in low-threshold support outside treatment) during the treatment trajectory. One of the families had only received integrated interventions, and in two families only the AFMs had received AOD treatment interventions.

This means that involvement with treatment in most cases was part of a longer trajectory with different kinds of interventions and encounters at different points in time. All encounters with treatment and support were considered relevant to the aim of this study, not only encounters with the AOD institution from which the subjects were recruited. In four of the families, children under 18 were part of the household, while in three families there were grown-up children. Their situations were not fully substantiated in this study, and more research is needed to understand the dynamics of their situations to ascertain how their experiences differ (Itäpuisto 2014).

If we compare our sample with the general population receiving interventions in outpatient AOD treatment, there are some interesting differences. A recent assessment of patients receiving outpatient AOD treatment in Norway (Osborg Ose and Pettersen 2013) found that 53% lived together with someone in their household, 28% were married or had a registered partner, 15% were divorced, 17% were living with children, and 11% were living in a household with a partner and children. Our participants represent to a larger degree the groups of patients that live together with someone. Seven of 10 PARs in the present study were living with a partner, and 4 of 10 PARs were living with children.

4.3 Analysis

The three articles involve analysis of texts: academic literature (Article 1) and interview transcripts (Article 2 and Article 3).

4.3.1 Article 1

The intellectual puzzle connected to Article 1 was the differences and similarities between a stress-strain-coping-support (SSCS) model and a social ecological (SE) model, conceptualizing the situation for families in addiction in two different ways. In this way the article approaches broad research focus B: “Comparison of "individual-focused and "relationship-focused" approaches to troubled families” and research question 1: “How do models of families in treatment relate to theories of addiction, and what are the consequences for practice?”

In these texts the two models were explained and discussed in various ways, in relation to other models/approaches, and also directly or indirectly in relation to each other. Multiple readings of the texts were performed stepwise by asking the following questions about the models:

1. What are their main assumptions?
2. What are the main problems that they try to solve?
3. How are they positioning themselves in relation to other models and to each other?
4. What are their answers to the ontological question: What is addiction?
5. What are the implications for practice?

The different steps involved the production of a new text: steps 1 and 2 introduce the models to the reader and steps 3, 4 and 5 describe the similarities and differences between the models and their implication for practice. Then the two models were evaluated, in terms of the wider field of addiction theorizing, with a theoretical and scientific basis in a critical realist tradition and the concept of the “necessarily laminated system” (Bhaskar and Danermark 2006).

4.3.2 Article 2

All interviews with clinicians and directors from the three institutions, conducted in Norwegian, were audio-recorded, and transcribed verbatim. These interviews were used as the empirical source in answering research question 2: “What are the conditions for receiving attention and support as affected family members in AOD treatment?” This was related mainly to broad research focus

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A: “The relative position of families in AOD treatment” and to the theoretical framework already outlined in in chapter 1, 2 and 3.

The interview texts were initially approached through multiple readings and coding in NVivo 9/10⁶. In the technical language of NVivo, the term “node” represents tags that serve to organize the content of the material. As pointed out in the theoretical framework, an interesting distinction between CDA and other interaction/discursive analyses like CA (conversation analysis) is that CDA starts with a problem (Fairclough 2001: 28f). In accounting for my own analytical process, my initial interest in “construction of problems and solutions” in AOD treatment informed the entrance to the field without a defined “problem”. The gap between theory and practice in the field, as elaborated on in 1.3, was an assumption primarily induced from the literature, and was initially more in the background. I was mainly occupied with *different* constructions of problems and solutions, and not relation of power, dominance and contradiction. In this way, my research aim was originally more descriptive and less “critical”, in an open search for interesting entrances, in this process the amount of nodes grew considerable in many different directions.

Still in the process of making nodes, the “problem” related to the relative position of families in AOD treatment grew larger. A metaphor used in one of the interviews, “gravity”, became a key analytical category, and guided the analysis in searching out what this gravity signified. In the following readings, *conditions* that shaped this gravity were searched for in more detail, manifested as discourses drawn upon in the interviews, in the “institutional talk”, and new nodes were developed. At this point the analysis was adapted towards a CDA. The problem was “gravity”, and the aim was to capture the conditions for this gravity in more detail by examining the semiotics. For this, the interviews was analysed by (1) identifying which going concerns and related discourses were drawn upon when discussing family-oriented practices, and (2) how they were networked together in a certain “order of discourse” (complementarity, dominance, contradiction) (Fairclough 2001: 28f). The following passage from Fairclough largely summarizes the analysis made:

⁶NVIVO 10 for Windows.

<http://download.qsrinternational.com/Document/NVivo10/NVivo10-Getting-Started-Guide.pdf>

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“A principled basis for sampling requires minimally: A) a sociological account of the institution under study, its relationships to other institutions in the social formation and relationship between forces within it. B) an account of the “order of discourse” of the institution, of its IDFs (ideological discursive formations) and the dominance relationships among them, with links between a) and b). C) an ethnographic account of each IDF. Given this information, one could identify for collection and analysis interactions which are representative of the range of IDFs and speech events, interactional “cruxes” which are particularly significant in terms of tensions between IDFs or between subjects, and so forth. In this way a systematic understanding of the functioning of discourse in institutions and institutional change could become a feasible target.” (Fairclough 2010: 74)

Another point of interest in the analysis was how different going concerns enabled certain institutional identities for the people involved. The analysis ended by suggesting a re-articulation of the field, in a way that gave the going concern of family involvement a more prominent position in defining services within the setting of AOD treatment. This is in line with Fairclough’s ways of finding the unrealized possibilities of change, focusing on the gaps and the contradictions in the way we see things, thus constituting a potential for resistance and change. (Fairclough 2001: 27-30). This represents an analytical critique of practices within the discursive setting of AOD treatments. In this analysis, the point was not primarily to understand why different institutions vary in their practice, but how different discourses and paradoxes in the field are made visible in the material as a whole. A concluding reading was performed to “validate the story”, looking for potential paradoxes challenging the results and the “story” of the article.

4.3.3 Article 3

All interviews with families and family members from the three institutions were conducted in Norwegian, audio-recorded, and transcribed verbatim. These interviews were used as the empirical source in answering research question 3: “How are families positioned in encounters with treatment, and how do

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storylines facilitate processes of reintegration and repositioning within families?" The main entrance in Article 3 was how the different families accounted for encounters with treatment.

After some initially open readings, the analytical process of Article 3, started by organizing the interview texts according to three main nodes "addiction in relationships", "encounters with treatment", and "experiences with treatment". Excerpts that were relevant for the three nodes were marked and organized together. Gradually two levels of interest, and their interrelatedness, emerged: (1) between families and service providers representing constraints and possibilities for service intervention, and (2) between family members in the process of reintegration.

Positioning theory was adopted as a framework for the analysis, and served as a tool to analyse both levels, and their interdependency. Positioning theory allowed an analysis that included both the social process of negotiation and the discursive environment in which these processes take place. Positioning theory is not concerned with "what you can do" or "what you do", but with "what you are permitted or forbidden to do" within a certain setting or episode (Harré 2015). Harré and Moghaddam (2003) state that all vertices of the positioning triangle ("position", "speech act" and "storyline") can be used as an empirical entrance to an analysis. They also emphasize how entering at "storylines" has certain advantages, which was the approach used in this analysis.

First the node "encounters with treatment" was examined, searching for storylines that unfolded in the accounts of these encounters as patterns of language use. The "storyline of autonomy" and "storyline of connection" served as two main entrances to the analysis, which related to the initial strategic sample of the whole study and the broader research focus B ("Comparison of "individual-focused and "relationship-focused" approaches to troubled families"), referring to interventions aimed either at AFMs as individuals, or at relations within the families. A comparison embedded in both the research design and the analysis. Furthermore, a third medical storyline, related to broad research focus A ("The relative position of families in AOD treatment"), was identified in the material and included in the analysis. Episodes not persons or families where the basic unit of analysis. What is interesting in this analysis is hence not the actual findings of these storylines in

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the interviews, but how they are interpreted and negotiated by the families, and how the positions offered were taken up, refused or re-articulated.

The next step in the analysis was to focus on what kind of processes these storylines were facilitating for the families in the course of treatment and recovery. For this purpose, the content of the nodes “addiction in relationships” (node 1) and “experiences with treatment” (node 3) were examined in more detail. Processes of unilateral positioning, related to the storyline of autonomy, and bilateral positioning, related to the storyline of connection, were identified and elaborated on.

4.4 Ethical considerations

4.4.1 Role as researcher

My role as researcher in encounters with the institutions and the families was both as an “insider” and “outsider”. I am inside the system because I work in a research and development department in an AOD treatment institution, and have cooperated closely with clinicians in several projects documenting clinical practice. However, I am not a trained clinician, and in that way more “naïve” in my approach to the field. In such a role as a researcher close to the field, I have the advantage of some “inside” knowledge of the system and current debates, and I am at the same time in the position of approaching the field by asking questions from an alternative scientific tradition, the sociological. This provides opportunities and alternative angles to the field of interest. This position is also interesting in relation to one of the major tensions in this thesis, that between a particle and a social paradigm (Adams 2008). Of sociological interest is very much “people-in-relationships”. This might give this thesis a certain bias in highlighting the relevance of the social realm in the context of AOD treatment. However, this research does not aim to make a comparison of different approaches to people’s problems, as they are all of value and part of the complexity, but rather investigates more closely precisely the social realm of the matter. Conducting interviews in a setting closely related to therapy, and in a situation very much similar to a therapy session, made it relevant for me to emphasize my role as a sociologist as different from that of a therapist. Still, in some situation it is hard, not to be solutions focused, only curious and reflective.

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In one interview the interviewees asked for professional advice regarding how they should handle a certain situation. We discussed the matter, but eventually I asked them to direct the question to their former clinicians. Still as researcher and interviewer, you are involved and in the course of the event, the interview, and resonance from your different experiences both personal and professional is part of the way the interaction unfolds. Several interviewees express a strong urge to share their experiences so that others can benefit from them.

4.4.2 The interview situation

The informants shared personal and challenging experiences in the interviews. As a researcher I was concerned with their opportunity to decide how much they wanted to share. If I asked any questions they did not want to answer, they were told to say so. If anything came up during the interviews that needed to be followed up afterwards, I had an agreement with their present (or former) clinician. The interviews took place wherever the participants felt comfortable about giving them (in their home, in treatment facilities or in public places like cafés) to enable them be conducted in the most favourable and practical way.

4.4.3 Consent and approvals

The project was sent to the regional ethical committee for review, and was approved on 07.10.2011 (see Appendix 2011/1234/REK vest). Relevant institutions were approached by telephone and e-mail, and information about the project was provided, either in formal meetings or to people representing leadership at the institutions. When they agreed to give the study access, relevant clinicians and directors were invited to participate in interviews. Clinicians working with AFMs and families were doorkeepers in recruiting families for the study. Selected clinicians were asked to provide information about the project and the invitation to participate (see Appendix). If the patients accepted the invitation and signed the declaration of consent, I was given their contact information and made a formal call planning the time and place for the interview. In cases where only one person from the family was receiving treatment at the time, the participants passed on the information to family members. In some cases this was not possible and the study was carried out with only one representative from the particular family. The interviewees both

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on the institutional level and the family level was allowed quote check on request.

4.4.4 Anonymity

All the information contained in the interviews was handled confidentially and anonymously, and the participants was assured that the information should be handled in this way. Participants' rights to withdraw from the study at any stage were emphasized. During interview sessions, no direct personally identifiable questions were asked. Sometimes information was passed on that could potentially identify people indirectly, and in those cases the information was anonymized in the transcript. Participants were allocated pseudonyms. All contact information identifying the participants was locked in a cupboard in a locked room during the recruitment period.

According to the design, the ideal was to conduct three interviews with each family, the first a joint interview, followed by two consecutive individual interviews. Steps were made to secure anonymity also within families. Divergent answers between the joint interviews and the individual interview were handled in the article text in ways that ensured anonymity within the family.

4.5 Limitations

In this section I will address the limitations regarding both the methods used and the sample made.

4.5.1 Research design

The method used to collect empirical data in this study was interviews. The interview is one of the most commonly used methods in qualitative research (Rødne 2009, Lambert 2011). Interview as a source of data is questioned for potentially representing a methodological individualism where knowledge about interaction and context is given little attention (Room 2000, Rødne 2009). In the thesis, interviews are used within a interactionist and discursive framework, focusing on the content of the interviews, not only as an expression of individual experience, but as an expression of discourses manifested in talk

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and interaction (Järvinen 2005). For this purpose, different forms of interviews are included: interviews on the institutional level, i.e. institutional talk, and interviews on the family level, i.e. joint interviews with families and individual interviews with family members. The different interview formats provide data that complement each other in illuminating the research questions. However, one can argue that the study would have gained by including fieldwork as part of the design. This could have provided even more comprehensive data about the discursive environment of AOD treatment and allowed for a closer understanding of the processes taking place in treatment. On the other hand, a research design using interviews allowed a greater number of institutions to be included in the study.

4.5.2 Sample

There are certain limitations regarding the sample used for this study. To recruit institutions and clinicians went according to plan, but it was difficult to recruit families. The initial inclusion criteria were widened. In this way our families represented a broader range of family situations than was originally planned. But in the material there is still a predominance of cases of partners/husbands/wives informing the analysis. Thus the conclusions drawn may be more representative of couples than of other family relationships.

Further, in searching for family dynamics, the study was designed to involve both joint and individual interviews. One limitation of the data is that both joint and individual interviews were conducted only in 5 of the 10 cases; in the other cases, there was only a joint interview (1 case) or only an individual interview (4 cases). Where there were only individual interviews, they were all with AFMs; the PARs either did not wish to participate or it was impossible for them to do so. This means that the material has a certain weighting, with the voice of the AFMs in defining family dynamics being more strongly represented than that of the PARs. Nonetheless, both voices are represented, thereby balancing to some degree the interpretations of the ongoing processes in the family setting in the course of addiction and recovery. The whole process of recruiting families was in some ways typical of the fragmented relations families experienced when living with addiction.

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One important group to consider when talking about families and addiction is children. When addressing the institutional level of AOD practices, their situation is naturally included in the discussion. However, in addressing the family level, their situation is not substantiated within the frame of this thesis. The stories told in the frame of this thesis is the story of the adults. Only two persons (adults) from each family were included in this study. Initially we wanted to recruit families with children in the household, and thereby address their situation indirectly. But this subject has not been elaborated on within the frame of this thesis. The situation for children during a treatment trajectory, in terms of how they can best be accommodated, is a field where more research is needed.

So does our sample provide enough data, with the right focus, to enable us to address our research question? (Mason 2002: 134). With this question, Mason pinpoints the important issues to be aware of in considering the data. It is a fundamental question regarding the validity of the analysis regarding the family level in particular. The study did not focus on experiences with a specific family-oriented programme, where participants were pre-defined as part of a fixed course of treatment. The services was approached in a “here-and-now”, “treatment-as-usual” way. Family-oriented interventions occurred, but maybe not to the extent that the clinicians and directors themselves wanted.

It turned out, however, that the participants in the 10 family cases had had experience of different kinds of approaches during their trajectories, both integrated and separate. In that sense, we were able to compare experiences or events in the families’ lives, and not the families themselves (Mason 2002: 134). The number of families (10) was sufficient to perform such an analysis, with the chosen ontological components. One might say that the elements of the research are encounters - whether with treatment or within the family. However, these encounters took place within a context of a longer treatment trajectory, involving different substances and different degrees of danger and fragmentation.

4.6 Generalization

How are the findings of this study relevant, valid and applicable to settings outside those researched? The question of generalization in qualitative studies

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is a much debated topic (Nadim 2015, Mason 2002). One division made is that between empirical and theoretical generalization. The latter is more commonly referred to by qualitative researchers.

The three institutions included in this study were sampled strategically (Mason 2002: 123), according to differences in approaches to families and to AFMs. They were thus not recruited to represent AOD treatment in Norway as a whole. However, there is no indication that our sample of institutions taken together is very unlike other AOD treatment institutions in Norway on average. They are also subjected to the same general conditions of service provision as other AOD treatment institutions within the national context.

The analyses in the different articles go along different lines, and hence represent different potential applicability to other settings. Article 1, with its theoretical base, would typically be relevant for any settings involving the models in question.

The second analysis highlights the similarities and not the differences in the institutional discourses at work in the institution. It is therefore relevant to think that the analysis could also give resonance and recognizability in other equivalent institutions. Mason refers to this as a “no reason to suspect atypicality” argument (Mason 2002: 195), which might be closer to an empirical than a theoretical generalization. Further, it can be argued that our findings are relevant as they relate to a wider body of theory, knowledge and existence (Mason 2002: 196) also internationally.

In Article 3, the analysis involves a comparison of different ways of approaching families in addiction, conceptualized as different storylines, derived from different contexts. The storylines represent key dimensions of the intellectual puzzle. This strategic comparison (Mason 2002: 196) can be relevant outside this research setting, since it is related to processes occurring in other places and other settings, inside and outside the Norwegian borders, and outside AOD treatment, where a theoretical generalization may be involved.

4.6.1 Analytical critique

All in all, the analysis in this thesis represents an analytical critique of the field of welfare production in AOD treatment services. As Mik-Meyer and Vildasen point out, analysis of welfare institutions and their service production may very well lead to a “normative critique” of practice within the field, with institutions being considered as inadequate for the ideal. My position will rather be an attempt to offer an “analytical critique”, as in Mik-Meyer and Vildasen’s approach, offering empirical data and analysis, showing the obstacles and possible points of support that participants must take into account when working for changes in a particular field (Mik-Meyer and Villadsen 2013: 125).

The different parts of this thesis thus examine the theoretical basis for services (models), the way in which our ideas and theoretical base actually penetrate the ways services are performed, and how they are received and experienced by the people involved. Here there is transferability to the field of practice, as a design for examining these issues in the local interactional setting of treatment entities and as a way towards critical examination of how theories and concepts actually affect our practice.

5 Summary of articles

5.1 *Addiction, families and treatment*

Selbekk, A. S., Sagvaag, H. & Fauske, H. 2015. Addiction, families and treatment: A critical realist search for theories that can improve practice. *Addiction Research & Theory*, 23, 196-204

The aim of Article 1 is to analysing the stress-strain-coping-support (SSCS) model (Orford et. al 2005, Orford et. al 2010) and the social-ecological (SE) model (Adams 2008, Adams 2015) in a search for theories that can serve as a foundation for improving the assistance and support provided to families affected by addiction and alcohol and drug problems. The basis for the analyses was a critical realist one, viewing addiction as a multilayered and necessarily laminated phenomenon.

The SSCS model and the SE model share a common concern for families and AFMs and represent important contributions in challenge current theorising the field of addiction and substance use problems. Still, the two models differ from each other in some interesting ways. Their theoretical background origin from respectively coping support model from health psychology, and social theory/system and ecological theories from family therapy. Their imperative is weighted differently, the SSCS is highlighting the situation of the group of AFMs living under stress and their individual needs and focus on their agency and empowerment. The SE model highlights addiction as a social event, where a person's relationship to a substance/process becomes the dominant relationship, at the expense of other relationships (e.g. that with intimates), and focus on reintegration, and the social opportunity for change in intimate relationship. Hence the models represent different directions for practice, emphasise hence support for AFMs in their own rights, and interventions in families and social network. The SSCS model represent a critique of the general lack of attention given families in the field, in addition they also position themselves as an alternative and in opposition to pathological approaches to AFMs (e.g co-dependency and family system models). The SE model represent a critique of the dominant "particle" way of understanding addictive processes, and also a critique of "individualistic" methods in approaching AFMs.

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The two models represent two different answers to the question: what is addiction? The implicit and explicit relates to the phenomenon as a social and a psychological phenomenon. In this, the two models approach two different layers of reality: the SSCS model highlights the importance of dealing with mechanisms at the psychological level for AFMs, while the SE model emphasizes the importance of intervening in relationships and systems at the social level of reality. When viewing addiction as a phenomenon that is a necessarily laminated system, the mechanisms underlying the different layers of reality must be taken into account in order to develop the best solutions.

Table 6 Summary of results - Article 1

	The SSCS model (e.g Orford et.al 2010)	The SE model (Adams 2008)
Theoretical roots	Coping support model from health psychology	Social theory, system and ecological theories from family therapy
Imperative	The situation of the group of affected family members living under stress, and their individual needs	The social opportunity for change in intimate relationship
Method	5-Step: 1. Listen, reassure and explore concerns, 2. Provide information, 3. Explore coping responses, 4. Discuss social support, 5. Discuss and explore further needs	Maximizing the first contact Social assessment Reintegration plans Facilitation of meetings including family members
Positioning in the field	Critique of the general lack of attention given families in the field Critique of pathological approaches to affected family members (e.g co-dependency and family system models)	Critique of the dominant "particle" way of understanding addictive processes Critique of primarily "individualistic" methods in approaching affected family members
What is addiction?	A psychological phenomenon	A social phenomenon

Both models are considered as essential in dealing with the complexity of the phenomenon of addiction. The SSCS model by providing agency for a neglected group of AFMs and developing a method to address their needs, and the SE model by advocating the relative position of social solutions in the field

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of AOD-treatment and developing a framework for conducting joint sessions and family therapy.

Both models and their respective practical guidelines for interventions could work in a complementary way in a clinical setting, as useful tools in different types of case and at different stages of treatment—combining the level and emergence in the interaction between agency and structure—for the betterment of families and individuals.

5.2 Troubled families and individualised solutions

Selbekk, A. S., Sagvaag, H. 2016. Troubled families and individualised solutions: an institutional discourse analysis of family involvement in alcohol and other drug treatment. *Sociology of Health and Illness*, Volume 38, Issue 7 (September).

Article 2 examines the conditions for involvement, and for receiving attention and support as AFM, within the AOD treatment setting. We ask what these conditions are, and what shapes them, examine how directors and clinicians perceive their actions towards the families, and how, in their discussions, they overtly and covertly relate to, and handle institutional discourses, thereby providing the basis for current practice within the field of AOD treatment in Norway.

To address this question, we draw on interviews with directors ($n=3$) and clinicians ($n=15$) from three different AOD treatment institutions in Norway. The interview text are analysed as “institutional talk”, in the sense that they were connected to core goals and tasks associated with the institutional setting, and its specific framework and constraints. The analysis process was inspired by elements in Fairclough’s critical discourse analysis (Fairclough 2001: 28-9) in: (1) identify which discourses (going concerns) were drawn upon, and how they related to each other, and (2) analyse how they were networked together, and their relative impact on treatment practices and conditions of possibility (order of discourse).

The study revealed that family-oriented practices are gaining ground, as a “going concern”, in the sense of “discourses at work”. Still, the relative position of family-orientation in the services, is constrained and shaped by three other going concerns related to : (1) discourse on health and illness, emphasising

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upon addiction as an individual medical and psychological phenomenon, rather than a relational one; (2) discourse on rights and involvement, emphasising upon the rights and autonomy for the individual patient to define the format of their own treatment; and (3) discourse on management, emphasising upon the relationship between cost and benefit, where family-oriented practices are defined as not being cost-effective. All three discourses are networked together in underpin the “gravity” towards individualised practices.

The going concern of AFM and family-oriented practices, in day-to-day clinical life, can be interpreted as a going concern that “didn’t quite make it”, or, as a “not yet”. The going concern is present within the setting, but its potentials are not utilised so far. The data indicate that “gravity” also *shape* the way in which children and AFM are attended to, where the easiest option within the discursive environment is to attend to them individually. A more integrated way of working with families, by facilitating consultations involving both patient and AFM, is more demanding, and according to a particle paradigm, not the best way to utilize resources.

The findings of the present study underscore a core dilemma: although family-oriented treatment practices are therapeutically effective and ontologically significant, these interventions are paradoxically interpreted as being less effective, from an organisational and operational perspective, within the current order of discourse. In order to increase the amount of family-oriented practices, the order of discourse has to be challenged.

What can be done to fulfil the potential of family-oriented practices and make the impact of the relational and social perspectives more applicable? Adams provided some suggestions as to how this can be accomplished within the institutional setting of AOD treatment, for example, by focusing on the team culture, maximising the first contact, performing social assessments, developing reintegration plans involving families and social networks, and facilitating meetings that would include families and social networks (Adams 2008: 247-63).

Another line of action is to take a closer look at the systems of referral and cooperation with GPs, discussing the potential of referring families, or more systematically including family and social issues in the referrals. Furthermore,

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this study has identified, not only as the potential tension, but also the common collaborative potential in the intersection between the discourse on rights and involvement, and the discourse on families and AFM, which still needs to be adequately addressed. Finally, our data call for a revision of the ways in which services are quantified, and, more specifically, a re-evaluation of family-oriented interventions. In this way, the order of discourse can be re-articulated, in line with the insights from a social paradigm. So, those interventions that are highly recommended therapeutically would also represent organisational and operational sustainability.

5.3 Positioning families in alcohol and other drug treatment

Selbekk, A. S., Adams, P. J., Sagvaag, H. 2016. Positioning families in alcohol and other drug treatment: how storylines facilitate healing processes.

In Article 3 the processes of treatment and recovery is analysed from the interrelated perspectives of persons with addiction and their AFMs. Based on interviews with 10 families recruited from three AOD-treatment institutions in Norway, positioning theory is used as an analytical tool to address the dynamics between service providers and families regarding treatment possibilities, and between family members in the course of treatment and recovery. We ask; how are families positioned in encounters with treatment and how do storylines facilitate or obstruct the processes of reintegration and repositioning within families?

Three main storylines were analysed as they occurred in the interviews about encounters with treatment: (1) a “medical” storyline, (2) a storyline of “autonomy” (for AFMs), and (3) a storyline of “connection” (in families); these storylines positioned AFMs respectively as outsiders, as individuals (in need of help in their own right), and as part of a family system. They facilitated different possibilities and normative frames of positioning and repositioning within families, representing steps of varying degrees of usefulness towards recovery and reintegration.

This study has shown how a medical storyline - which is prominent in many encounters - can serve to exclude family members, rendering them invisible

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and thereby reducing their options in handling problems with addiction. Considering addiction from the viewpoint of relational recovery and reintegration makes clear the limitations of the medical storyline. We have seen how a medical storyline represents a casting where family members at best are extras, and where the “real thing” is happening in the relationship between patient and therapist/doctor. The analysis of the data in the present study has revealed how real changes also occur in mending broken relationships and introducing alternative storylines that facilitate reintegration and relational recovery in families.

The two storylines of autonomy and connection represent a central contradiction in relationships, and highlight different approaches to families: individually as AFMs or relationally as families. Selbekk et al. (2015) analyzed these storylines as addressing two layers of reality that both need to be recognized in order to deal with the complexity of addiction processes. They further suggested that the two storylines are useful in different stages of treatment. The present study found that the way services position family members is not always in tune with how these members position themselves. This calls for a sensitive approach towards the needs of both PARs and AFMs in their current situation, and the need to keep a variety of “storylines” or approaches at hand to enable interventions to be tailored accordingly. When there is a will for reintegration within families, a storyline of autonomy must be supplemented by the storyline of connection to enable direct work on relationships. As pointed out by Lee (2014), working with partners of addicted individuals separately from the couple’s relationship could overlook the opportunity for concurrent growth and healing for both partners and the relationship.

The storyline of autonomy and the storyline of connection facilitate processes of unilateral and bilateral repositioning respectively. Unilateral repositioning was described as moving from being abnormal to normal, from being sick to getting better, from being a victim to a fighter, from “being in the waiting room” to “knowing what you are waiting for” and from being alone to identifying with a group of people in a similar situation. AFM described the importance of being acknowledged in their lifesituation, to be “just me”, to get knowledge about the situation, to get support in take care of oneself, to set boundaries, and make PARs responsible for their own drinking or drug taking. The storyline of

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connection, on the other hand, enables bilateral repositioning processes: from an unwanted positioning of caregiver/care receiver, mother/child, or perpetrator/victim, to entering into a symmetrical relationship, catching up with each other, and becoming a new couple. The participants described how important it was that AOD treatment provided a safe place for open communication and trustbuilding, assistance in establishing a language to talk about their difficulties, hinder a situation where AFM and PAR is “out of step” with each other, and help in translating and synchronising mutual processes of change from PARs to AFMs and vice versa. The results reported here underline how vital focusing on reintegration in families is in dealing with addiction problems.

AOD treatment strategies need to recognize at an early stage problems with addiction as relational as well as individual. The importance of reintegration as a perspective needs to be enhanced when defining the content and aim of services in the field. Relational problems and recovery processes in families must be taken into account in the provision of a variety of treatment options that include the needs of families at different stages.

6 Conclusion

The main concern in this dissertation is the situation for families in the course of addictive processes and the conditions for support and involvement in treatment, where we ask: how can we understand practices towards families and AFMs in AOD treatment? In this chapter, I will summarize the findings and discuss the theoretical and practical implications, and elaborate on how they contribute to existing literature in the field. Two broad research foci have directed the analysis: the relative position of families in treatment and the distinction between approaches aiming at *individuals* within the family and approaches aiming at *family relations*.

Overall, the findings of this thesis involve three main contributions to the research literature:

1. Examples are provided of how the potential in focusing on family relations and social mechanisms is restricted in the way services are organized and function in the current situation.
2. Examples are provided of how family involvement in treatment and family-oriented practices make sense and give opportunities for families struggling with addiction.
3. Attention is drawn to the relevance of the ontological level of social relations in addiction theorizing and practice.

6.1 Gravity and order of discourse

The findings of this study point to a paradox: although family-oriented practices are supported by research, and are (or are in the process of) being implemented in policy guidelines and are gaining ground as a going concern, especially the situation for children, the conditions of possibilities for performing family-oriented practices in the services are limited. These findings underpin similar findings from other studies in the field (Lee et al. 2012, Orford et al. 2013).

One participant summed it up in the following way: “Gravity is pulling towards the individual perspective, in practice on the intervention side”. Empirically

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three main discourses representing this gravity have been identified. Firstly, is the discourse on health and illness, emphasising upon addiction as an individual medical and psychological phenomenon, rather than a relational one. Adams (2008) elaborate upon the distinction between a particle paradigm, and a social paradigm, to capture some of the underlying discursive tension in the field of addiction. The particle paradigm, based on a dominant bifocal psychological and medical tradition, represent assumptions that identify human beings as distinct objects with their own boundaries, attributes and potentials, and as the focal point of interest (people-as-particles) in understanding addictive processes. Within a particle paradigm, change is primarily something that can be accomplished within the body and mind of the individual person. Whereas, the social paradigm understand identity as fundamentally social, and has human beings in relationship as their primary focus, including the relationship to an addictive substance or process (people-in-relationship). Thus, were the opportunity to change has been located in the intimate cycle and cross the various layers of connectedness to people both inside and outside the addictive system.

The findings of this study illuminate how the particle paradigm has considerably more impact on defining practices than the social paradigm. Practices in AOD institutions are primarily determined by a particle discourse of health and illness based on individual referral, medical assessment and diagnosis. Family involvement must be negotiated after referral and adapted to the system of diagnosis to fit in. This can be seen in relation to the Norwegian Substance Treatment Reform which took effect in 2004, developing a responsibility towards drug users and therapeutic institutions, from the field of social care legislation to the ordinary health service under health legislation (Willersrud and Olsen 2006: 87, Nesvåg and Lie 2010). “Clients” became “patients” and AOD treatment in Norway was re-articulated within the medical order of discourse. The principles guiding somatic practices were adapted to the field of addiction and substance use problems. There were good arguments for making this switch, mainly increased recognition of problems with addiction, still, in a discursive environment where individual health represents the “core mission”, family involvement became more of an “underground” practice (Mattingly and Fleming 1994), according to how tasks were defined and measured. This findings are in line with other research on barriers in

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implementing family oriented practices, focusing on how organisation was handling the problems as something belonging to individuals (Fals-Stewart et al. 2004), and treating AFM as “adjuncts” and not central to AOD-treatment practices (Copello and Orford 2002).

Secondly, a discourse of rights and involvement of patients were identified as interrelatedly contributing to a “gravity” towards individualised solutions. The notion of patient rights was an important argument for introducing the Substance Treatment Reform in Norway. Part of these rights is to make decisions regarding one’s own treatment, including the choice to exclude one’s family members if including them would be too uncomfortable. Some clinicians emphasized that patients alone decided whether they wanted to involve their relatives, and underlined the value of individual consent. The going concern of families and AFMs challenge the institutional identity of the AOD patient, and the complementary positions and loyalties between patient and clinician. It involved recasting the patient as a part of a larger system providing more people with both rights and involvement, where these are both determined by, and determine, how troubles develop or decrease. In the intersection between a discourse of families and AFMs and a discourse on rights and involvement of patients, there lie potential dilemmas that clinicians have to deal with in their everyday work. A strengthened role of patients in defining their own treatment can imply that family members are put aside. Similar competing agendas between consumers and careers would be identified in mental health services (Goodwin and Happell 2006), and would be an interesting area of further research. There is also some common ground and complementarity between discourses on families and AFMs and patient-centred discourses. Both challenge clinician-centred care, by placing more emphasis on general collaborative practices in treatment, involving both patients and AFMs (Madsen 2007).

Thirdly, the discourse of management underpins a particle paradigm in making individual consultation the most cost-effective way of performing services. What we find is that the way institutions construct their problems and manage the consequences is influenced by an individualised logic combined with neoliberal governing strategies involving state control and use of resources. These findings are in line with research on contrasting trends in encounters between welfare institutions and citizens: on the one hand facilitating, and on

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the other authoritarian (Mik-Meyer and Villadsen 2013: 5). Mik-Meyer and Villadsen (2013) argue how liberal ideals of freedom requiring a reduction of state control and expenditure are combined with governing techniques devised by central authorities for optimal utilization of resources through detailed management. This study reveals a general focus on cost-effectiveness in itself, and more specifically how cost-effectiveness is built around the autonomous individual. Within the current system, the extra time it takes to organize and prepare a family session and the need for a co-therapist in family sessions are not properly accounted for. Within this logic, family interventions are less cost-effective, even though this does not make sense in terms of potential treatment outcome. This is also in line with other research on how a focus on “production” is a barrier in implementing family oriented practices (Fals-Stewart et al. 2004), and how explicit commissioning and funding is needed (Orford et al. 2010b, Lee et al. 2012).

Family therapists and other professionals working with families are employed in this discursive setting, but find that they are working within a different logic than the dominant discursive formation. They are wanted as part of the system, but have limited possibilities to perform their profession. One of the participants stated: “Based on a strict understanding of disease with a diagnosis for the individual patient, the relatives or children are not there”. Within this discursive environment, the going concern of families and AFMs has a limited role in defining services. This also highlights how organisational support is of vital importance in keeping a focus on AFM and children (Lee et al. 2012, Orford et al. 2010b, Copello et al. 2000)

Family members’ accounts of encounters with treatment document the same gravity. Being subject to a “medical storyline”, they are “adjuncts”, “outsiders”, “not there”, “outside the core mission”, and one AFM “forced her way into treatment”. The families also give examples of how they actively reposition themselves in encounters with treatment, as involved, as in need of help, and requesting co-ordinated services: “When are these things (PAR’s and AFM’s problems) going to meet?“, “A problem like this isn’t like you’re a sole trader”.

Another finding is the way in which the discursive environment of AOD-treatment makes it easier to perform interventions aimed at AFMs individually than those aimed at relations within families. A focus on autonomy for AFMs

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is an easier option than a focus on connection in the affected family. Approaching AFMs separately, as individuals with needs in their own right, fits in better with the current discursive order. In this way, AFMs are given some individual, but fewer relational, options in handling their difficulties. The institutional identity offered is “patient” or “in need of help in their own right”, and to a smaller degree “relationship-as-client”.

This can be seen in connection with broader cultural trends. In theory about the “second modernity”, the term “institutionalized individualization” is used to categorize a twofold tendency. On the one hand, traditional social ties and belief systems are losing their significance, and on the other hand, people are more tied to modern institutions which produce their own rules addressed to the individual and not to the family as a whole (Beck & Bernstein-Beck 2004: 502). Approaches that include families and networks can be somewhat countercultural (Brottveit 2012).

However, based on the evidence from the literature and the findings from this study, there is an urgent need of providing *both* relational and individual opportunities to troubled families in relation to treatment. This is in line with Lee (2014), who maintains that couple therapy (as one of several family-oriented interventions) is an under-utilized and under-examined modality in addiction conceptualization and treatment, and could well be a critical missing component in the addiction service provider’s toolkit. An interesting question is whether this field needs a radical restructuring of the order of discourse (Fairclough 2001: 30). In this context, a key question to ask is: How is it possible to make it economically and organisational sustainable to execute the best practice (which includes family involvement) within the field of AOD?

6.2 Discourses of autonomy and connection

The theoretical analysis in Article 1 starts from focusing on two models of addiction in families, their relation to addiction as a phenomenon and their implications for practice. The SSCS and the SE models, respectively aiming at supporting AFMs in their own right and aiming at addressing fragmented relations in the course of addictive processes, represent two different ways of constructing families in addiction. Focusing respectively on psychological and social mechanism, they are both highlighted as important in addressing the

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essential complexity of addiction as a phenomenon. Both models contribute by widening the scope of addiction theorizing, following the concerns expressed by Copello and Orford (2002: 1362): “Models of alcohol and drug problems need to place the role of the social environment as central and as important as that played by individual factors”. This represents a challenge to the field of addiction theorizing in general by the lack of integrating social ontology (Granfield 2004).

However, in the field of family theoretical models, the premises for different models have seldom been compared in more detail, with some exceptions (Velleman et al. 1998, Orford et al. 2010a). In our case, the comparison is made within a more overarching framework (the necessarily laminated system), allowing an analysis of both contradiction and complementarity. In this way, the analysis represents a contribution in the underpinning of planning and developing future practices that cut across boundaries between models, considering relevant ontological levels.

The two models represent the distinction between a storyline of autonomy for AFM and a storyline of connection in families, is further analysed according to how they are accounted for by families involved in treatment. The storylines analysed here is example of discourses present in the field, but is in no way exhaustive for what happens in encounters between families and treatment. They represent a strategic sample and a focus for research.

The first point to be made is that AOD-treatment institutions represents conditions of possibility for families by introducing certain storylines and excluding others, and by this offering certain positions and institutional identities. The study show how the storyline of autonomy and the storyline of connection facilitate processes of unilateral and bilateral repositioning respectively. Unilateral repositioning was described as moving from being abnormal to normal, from being sick to getting better, from being a victim to a fighter, from “being in the waiting room” to “knowing what you are waiting for” and from being alone to identifying with a group of people in a similar situation. The participants also emphasized the importance of being acknowledged in their life situation, being “just me”, gaining knowledge about the situation, getting support in take care of themselves, setting boundaries, and making PARs responsible for their own drinking or drug taking. Many AFM

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are in a deadlocked situation, where joint interventions is neither wanted nor possible at the current stage.

The storyline of connection, on the other hand, enables bilateral repositioning processes: from an unwanted positioning of caregiver/care receiver, mother/child, or perpetrator/victim, to entering into a symmetrical relationship, catching up with each other, and becoming a new couple. This underlines the need of focusing on treatment not only as a process between a clinician and a patient, but on joint processes in the family. Naylor and Lee (2011) study underpins this point. In studying woman partners, they show how the PAR's recovery process does not necessarily entail the partner's concomitant recovery, nor is the sustainability of the couple relationship ensured. Lee and Rovers (2008) also point to how early conjoint couple therapy has the potential to allow couples to grow and recover in synchrony with each other, or to "keep both partners' recovery in tandem that would ease the strains of an arduous journey when taken alone" (Naylor and Lee 2011: 642). This is in line with the findings in this study. Participants emphasize the importance of a safe place for open communication and trust-building between family members, assistance in establishing a language to talk about their difficulties, prevention of a situation where AFM and PAR are "out of step" with each other, and help in translating mutual processes of change from PAR to AFM and vice versa. Adams (2008) term reintegration captures the essence of this concern, and represents a basic feature of a social paradigm:

"Practitioners should seek stronger social inclusion so as to prevent further social fragmentation of intimate relationships in the addictive system. Also, by working alongside other intimates, the practitioner validates the process of reintegration." (Adams 2008: 247)

A storyline of connection might be considered as a first choice. A quote from one AFM in this study underpin this point: "When the boat hasn't left the shore, the wife and family should be involved from the start of treatment". Lee (2014) points to how individual work with partners of addicted individuals apart from the couple relationship can be a potentially lost opportunity for concurrent growth and healing for both partners and the couple relationship. Still, as a supplement, and in situations where it is not possible to focus on connection

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within the family, a storyline of autonomy might be introduced, combined with a focus on establishing connections elsewhere.

One suggestion is that the two models can be useful in different stages of treatment and in different cases, where a focus on autonomy and connection can mutually support one another (Lee 2014). Adams identified four different strands of connectedness in intimacy: closeness, compassion, commitment, and accord. These strands become progressively asymmetrical during the course of an addictive relationship, with family members encountering increasing levels of spasmodic closeness, unreciprocated compassion, one-sided commitment, and unilateral accord (Adams 2008: 73 - 101). In a similar way to Steinglass (1987), Adams tracked these disruptions by dividing the longer term development of an addictive system into early, middle, and late phases, and then analysed how the strengths of different strands of intimacy change during these phases (Adams 2008: 104). The storyline of connection and the storyline of autonomy have their relevance in different phases of such a process. In Article 3, the stories of families involved in a treatment trajectory support such an approximation. These discourses give meaning at different times and in different cases. The results also call for a strong awareness and assessment of the current situation of families encountering treatment. A focus on different ontologies and necessarily laminated systems opens up for new interesting research combining insights and data from different “layers” of reality and their interrelatedness, and hence possibilities for practice. Vetere and Henley (2001) give an example of how this can be done within an AOD treatment trajectory, combining support for the PAR and the AFM individually with couples and family therapy. Processes focusing on autonomy and on connection can both be of great value and strengthen each other.

Research on effects of family-oriented treatment interventions has mostly examined the situation of the PAR (Copello et al. 2005). The findings of this study underpin the importance of challenge this way of framing such research. Our cases show how both PAR and AFM are in a process of change and play interrelated parts in the process of recovery. This is in line with how Adams (2008) and O’Grady and Skinner (2012) and others reframe the field as reintegration processes or recovery processes within families. The accounts of family members show how services can be a part of or facilitate such a process, either during a joint process, or by attending the needs of both PAR and AFM

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individually. These parallel and joint processes require increased awareness and flexible services. This also broadens the scope of potential problems and solutions, and promotes further collaboration between specialist care and community care.

Positioning theory represent a framework that conceptualise interrelated processes of change within families in the course of treatment and recovery, including the potential in interactional repositioning. The concept of repositioning is also closely related to the concept of reintegration, as reintegration involves a process of repositioning. For clinicians, positioning theory could be a used a potential framework for an increased awareness of addictive processes and recovery processes as interactional, and as a potential therapeutic tools in working with families on the road from unwanted binding relationships towards mutual reciprocity relationships.

Viewing the phenomenon of addiction within a social ontology involves taking more people and more relations into consideration, not only the needs of the PAR, in service provision. The aim must be to organize services in a way that encompasses the individual needs of both PAR and AFM, and their interrelatedness.

6.3 Analytical critique

By viewing addiction as a necessarily laminated system, with a layered ontology, all possible layers (e.g biological, psychological and social) of the phenomenon play a potential role, and need to be taken into consideration in the practices of AOD services. Mol (1999) uses the term “ontological politics” in framing the way in which “the real” is implicated in politics and the other way around. Certain ontologies might have privilege over others. As Law (2005) asks: Which realities, in our case, does the current system of AOD treatment help to enact or erode?

What we find in this study is that all relevant layers of reality is not necessarily included in the way services are organized and performed. The nature of the phenomenon with its essential complexity is not guiding practices - other concerns are, potentially in a reductionist way. There is a gap between the multi-layered character of the phenomenon of addiction, and the way troubles

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are turned into institutionally defined problems. Both the institutional practices and the user experiences documented in this study underline this gap between theory and practice. The findings build on existing literature that discusses the same gap.

According to our findings, practices in the field do not reflect this necessary lamination to a large enough degree; the field is not sufficiently “multidisciplinary”, meaning that all disciplines, when called for, do not have the necessary power to offer the services needed. The entire thesis thus represents an analytical critique of the current order of discourse and conditions of possibilities for families in AOD treatment. Important critical questions to ask are: What kind of reality is the basis for developing our services? Are different ontological levels taken into account?

Our findings suggest that the system is developing in a way that does not match the ontology of the phenomenon of addiction. One example of this is the management discourse that twists our practices in a way that does not fit the complexity of the phenomenon. Making family oriented intervention less cost-effective, discourages the ambition to provide the best possible service.

The case of AFMs, children and families represents a going concern, especially with regard to how new policy guidelines are shaped. Health authorities are concerned with this issue, as are institutions and clinicians, but still there is a struggle to incorporate these perspectives in everyday clinical life. The discourses that represent “gravity” are powerful. There is a core mission, and this core mission reduces family involvement to something outside this core, something of lesser importance. The problem is not individual approaches to persons as such, they are of vital importance; the problem is when they become reductionist in dominating the field. In viewing the world as multi-layered, there is no “core”: there are mechanisms at different layers of reality which all need to be considered. Not every mechanism is equally relevant in all cases, but they should be given equal consideration in the search for problems and solutions.

6.4 The field of policy

The issues discussed here are closely linked to the field of policy and recent developments. There are two interesting parallel processes regarding guidelines for AOD service provision: one is the national guideline for treatment and rehabilitation of AOD problems and addiction (Helsedirektoratet 2015a), and the other is priority guidelines for AOD-treatment (Helsedirektoratet 2015b). In the first one, inclusion of family and network in a treatment trajectory is highly recommended, while in the second one, AFMs are removed as a target group. There is something contradictory in these two texts; family and network involvement should be implemented, at the same time as AFMs are no longer prioritized as a target group. These two points are clearly related, and these two guidelines appear to be pulling the field in opposite directions, because family involvement in treatment trajectories also involve individual sessions for AFMs.

The priority guidelines have been subject to debate in the media. The reason to remove AFMs as a target group was essentially because “affected family members are not a diagnosis”. A central consideration, particularly when involving children, is whether AFM are best helped in AOD treatment, or could perhaps get even better support outside of it. What does it imply that AFM are included in AOD-treatment services, are the field given them “problematic” identities? Everybody agreed with that to be AFM is not a diagnosis, but many people still fought to keep them as a group of featured patients.

Different arguments were introduced. Pointing to how AFMs strain represent such a heavy burden that many need help in their own right (and mental health care is already burdened), and that keeping AFM within the setting of AOD treatment allows for coordinated treatment trajectories. Further, AOD clinicians have the skills and experience to provide services to AFM and families, and that by starting a treatment process with AFM, in many cases to help to recruit the PAR to attend treatment. Important financially aspect is also related to the subject; this study shows how AFMs who receive their own right to treatment in AOD represent the core mission because they bring about “production” and economical sustainability, and in this way secure some kind of family oriented possibilities. In the dispute, AOD treatment institutions were assured by the health authorities that “nothing would change”, but this remains to be seen.

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One of the dilemmas is that AFMs are categorized along two lines; either they are “patients” in need of help in their own right, or they are a resource for the patient. Family involvement is mainly constructed as these two positions in official guidelines. What is lacking is a clearer positioning of AFMs (and PARs) as “relationships in trouble” and as “relationship-as-client”. The current system struggles to include this position, and thus the social paradigm, in its policy and treatment approaches.

The argument that “AFM is not a diagnosis” can be counterproductive to providing the best solutions within a system based on diagnosis and where it is the individual that counts. In relation to the findings of this study, leaving AFMs outside the scope of treatment, regarding their individual rights to treatment there, can mean further fragmentation and uncoordinated services based on a particle and individualised understanding of problems and solutions. By searching for the best solutions, we have to overcome or play along with the over-arching order-of-discourse. It remains to be seen whether the national guideline for treatment and rehabilitation of AOD problems and addiction (Helsedirektoratet 2015a) containing the recommendation of including of family and network in treatment trajectories, comes with an economical underpinning.

The situation for children in connection with treatment is an issue that has gained growing attention in recent years in AOD treatment in Norway. The most concrete example of this is the change in legislation from 2010 that gives health workers the duty to assess the needs of children and ensure that support is provided in their situation. Although the situation for children is not fully substantiated in this study, it still provides some input regarding this change in the law. While their situation is broadly acknowledged with increased importance, treatment practices applied to children vary between institutions and between clinicians. One issue that was raised concerned the potential individualisation of the way in which services approaches children. It was noted that the change in law, gave children of patients more attention, but does not necessarily make the clinician see the family or the relations within it more clearly. In this way the children of patients—and not families—have emerged as a kind. One of the participants put it this way: “You can register that it is a child, and can say that someone else has to talk to the child. But you can continue to focus on Dad”. This is an interesting issue to follow in the year to

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come. How can the children of patient get the support they need, and who shall do it, in which formats? Recent research has also indicated that in general many treatment institutions do not follow-up their responsibilities towards children of patients (Ruud 2015).

6.5 Strategic mobilization of a social ontology

What can be done to fulfil the potential of family-oriented practices and make the impact of the relational and social perspectives more applicable? Hardy et al. (2000) emphasized the way discourses can be mobilized as a strategic resource. The present findings call for such a strategic mobilization, advocating the insights from the social paradigm, and balancing the dominant position of the particle paradigm along with a wider bio-political significance of the individualizing impulse of biomedicine (Clarke et al. 2003).

The concept of “reintegration” generally illuminates some “holes” in our storytelling. This concept and the SE model (based on a social paradigm) emphasize recovery as a social process, and can potentially serve a role in such a strategic mobilization, promoting a social ontology of addiction for the services. The SE model is based on the assumption that “relation to a an addictive substance” intensifies at the expense of other relationships in life, where intimate relations are the ones most affected, but where primary opportunities for change, reconnection and reintegration also lie within these intimate relations, and in the various levels of connectedness outside them.

It can also serve as a framework that comprises other family-oriented approaches and models like the SSCS model. According to Adams, the term “reintegration” moves beyond reconnection in families; when this is not possible or wanted a process of reintegration is still necessary, making new sustainable connections to the world. This applies to both AFMs and PARs. In this way the SE model encompass both processes of connection, and autonomy.

Adams provided some suggestions as to how a focus on “reintegration” can be accomplished within the institutional setting of AOD treatment. He suggest focusing on team culture, maximizing the first contact with treatment by inviting significant others to a first session, performing social assessments, developing reintegration plans involving families and social networks, and

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facilitating meetings that would include families and social networks (Adams 2008: 247-63).

AOD treatment strategies need to recognize at an early stage that problems with addiction are relational as well as individual. The importance of reintegration as a perspective needs to be enhanced when defining the content and aim of services in the field. Relational problems and recovery processes in families must be taken into account in the provision of a variety of treatment options that include the needs of families at different stages.

Other steps that underpin such strategic mobilization are to take a closer look at the systems of referral and cooperation with GPs, to discuss the potential of referring families, or to include more systematically family and social issues in referrals. It is also important to consider more closely not only the potential tension but also the common collaborative potential in the intersection between the discourse on rights and involvement and the discourse on families and AFM, which still needs to be adequately addressed. Our findings also call for a revision of the ways in which services are quantified, and, more specifically, a re-evaluation of family-oriented interventions. In this way, the order of discourse can be re-articulated, in line with the insights from a social paradigm. So that those interventions that are highly recommended therapeutically would thus also represent organizational and operational sustainability.

6.6 Further research

This field is in a process of change, where various trends are taking place at the same time. There is an ongoing process of defining the role of AOD services towards families, where the social consequences of addiction may have a stronger impact on the ways services are performed. On the national level there are several interesting aspects to examine in the years to come, especially in the aftermath of the priority guidelines (Helsedirektoratet 2015b) and in the follow-up on the national guideline for treatment and rehabilitation of AOD problems and addiction (Helsedirektoratet 2015a), and their impact according to conditions of possibility. It is also interesting to see the guideline in relation to how the rights of children of patients are followed up. According to Lindgaard (2012), the main task is now not to investigate “if” family-oriented treatment works, but “how” it can be implemented.

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Regarding further research, it will be of vital interest to follow these processes in more detail. The potential for further research goes along many lines. One important and interesting field of research development in the Norwegian context is how the new guidelines promoting family involvement in treatment can be implemented in the services in the years to come.

Such studies would benefit from including institutional studies closely related to day-to-day clinical life; initiatives to promote a focus on reintegration (SE model) could for example be evaluated in this way, in researching how processes of change and strategic use of discourses work out within different contexts. It would also be interesting to investigate in more detail how a family-oriented approach can be implemented in the intersection between specialist health care and community health care, as the guidelines for treatment and rehabilitation also have community services within their scope, by designing studies that involved close follow-ups and fieldwork.

Another interesting option is to develop theoretical and empirical research in the intersection between a focus on families and on user involvement and recovery, which both represent potential counterforces to the dominance of a particle paradigm.

In this context, it is important to gain more knowledge about the processes of treatment and recovery from the accounts of both PARs and AFMs, including the voice of children, regarding how different approaches work at different times in different phases and which barriers are involved. Such research would gain from studying processes in families over time to enhance knowledge of interdependency within families in the course of addiction.

This thesis has been concerned with how different constructions of families in addiction make sense and provide families with opportunities, with the main focus on the distinction between approaches aiming at the individual AFM and those aiming at relationships within families. There are several other constructs in the field that would also be interesting to examine in more detail; e.g. “harm to others” and “co-dependency”. To mention some of the ways in which the field is trying to frame problems and create solutions regarding a complex and multi-layered phenomenon.

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Articles in full text and appendixes

Articles in full text and appendixes

Article 1:

Addiction, families and treatment. A critical realist search for theories that can improve practice

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Abstract:

The stress-strain-coping-support (SSCS) model and the social-ecological (SE) model were analysed in a search for theories that can serve as a foundation for improving the assistance and support provided to families affected by addiction and alcohol and drug problems. The basis for the analyses was a critical realist one, viewing addiction as a multilayered and necessarily laminated phenomenon. The two models approach two different layers of reality: the SSCS model highlights the importance of dealing with mechanisms at the psychological level for affected family members, while the SE model emphasizes the importance of intervening in relationships and systems at the social level of reality. Both models are highlighted as essential for dealing with the complexity of the phenomenon of addiction in families: the SSCS model by providing agency for a neglected group of affected family members and developing a method to address their needs, and the SE model by advocating the relative position of social solutions in the field of alcohol and drug (AOD) treatment and developing a framework for conducting joint sessions and family therapy. Both models and their respective practical guidelines for interventions could work in a complementary in a clinical setting, as useful tools in different types of case and at different stages of treatment—combining the level and emergence in the interaction between agency and structure—for the betterment of families and individuals.

INTRODUCTION

There is a growing public concern regarding the adverse consequences of addiction, not only for individuals, but for the well-being and life situation of families and family members (Barnard, 2007; Casswell et al., 2011; Copello et al., 2006; Copello et al., 2005; Ferris et al., 2011; Lindgaard, 2002; Orford, Copello, et al., 2010; Orford et al., 2005; Rodriguez et al., 2014). Research into “harm to others” in this context has become a growing focus in the field of social epidemiology (Room, 2000; Room et al., 2010).

The question in this article is how the case of families and family members can be approached, acted upon and “implemented” in the field of alcohol and drug (AOD)

treatment. Treatment methods that include family members are in general shown to be effective, but represent a variety of objectives; from initiating treatment, reducing the intake of substances, improving family-functions and by supporting family members' specific needs (Copello et al., 2006; Copello et al., 2005; Finney et al., 2007; Lindgaard, 2006, 2012; O'farrell & Fals-Stewart, 2003, 2006). Behind these treatment objectives lie different ways of modelling or approaching the case of addiction and close relationships. One major distinction is between focusing on family relations, in family therapy or joint consultations, or on individual family members in separate consultations. These differences may be viewed as different answers to the question of what addiction is. Analysing the basic assumptions of theories or models of addiction in families makes it possible to also discuss implications for practice.

Two models are examined and discussed in particular depth herein: (i) the stress-strain-coping-support (SSCS) model, which focuses on the stress and strain of affected family members and their coping strategies (Orford, Copello, et al., 2010), and (ii) the social-ecological (SE) model, which focuses on how addiction unfolds in a social world, and the process of fragmentation and reintegration of close relationships (Adams, 2008). These two models were chosen because they represent two central traditions in the field, and are particularly relevant to the practice that was assessed with respect to AOD treatment in Norwegian families (Selbekk & Duckert, 2009). They are not "new" models, but are based on respectively coping-support models in health psychology and system and ecological theories from the field of family therapy. They represent the distinction between separate tracks of interventions, where family members are provided with support in separate consultations, and integrated tracks, where families participate in meetings together (Selbekk & Duckert, 2009), and focus respectively on relationships and interaction systems, and the individual needs of

family members. The SSCS and SE models differ from each other in some interesting ways, highlighting central dilemmas in the field regarding the position and needs of families and affected family members, and what they should be offered in terms of professional support.

ANALYTICAL FRAMEWORK

Ontological questions and a necessarily laminated system

The two models under scrutiny in this article are analysed in terms of critical realism, which is a meta-theoretical position, with an ontology involving powers and mechanisms in different layers of reality. This approach views a phenomenon, in this case addiction, as a necessarily layered or laminated system, involving mechanisms at a biological, psychological, social and cultural level, where powers at the more basic level of reality (physical, biological, psychological) are emerging into more complex strata of reality (social, cultural). It is thus viewed from an ontologically and methodologically inclusive perspective; it is inclusive in that it can accommodate the insights of other meta-theoretical positions such as empiricism, realism and social constructionism (Bhaskar & Danermark, 2006, p. 280). Such a synthesizing approach enables a discussion of the ontological assumptions underpinning the two models. Ontological questions are seldom discussed, but the point made by critical realists is that research implies ontology although it is not always explicated.

Critical realists argue that a realist ontology is presupposed by the social activity of science (Bhaskar, 2008, p. 9). Empirical regularities are defined as tendencies that interact with other tendencies in such a way that observable events may or may not occur. The real world is complex and stratified, and different mechanisms are involved in a particular phenomenon (in this case addiction). To understand and explain a phenomenon such as addiction, social, cultural and biological mechanisms must all be taken into account. A quotation from

disability research explains some of this, and the premise can be easily transferred to the field of addiction:

“For here we are dealing not only with mere ontological pluralism, but with essential complexity - and in particular that kind of essential complexity that we have characterized as a necessarily laminated system. If this is so, then it follows that reductionism is not just a mistake, but a categorical mistake. Thus the medical model was always (at least in part) a cultural phenomenon, the social model presupposed a manifold of bodily impairments, and the cultural model itself had definite economic causes, etc.” (Bhaskar & Danermark, 2006, p. 295)

Critical realists retain an ontological realism while accepting a form of epistemological constructivism and relativism. There is no single, “correct” understanding that is independent of any particular viewpoint. The heuristic value of critical realism in this article is to illuminate the complexity of addiction as a phenomenon, and thus analyse the characteristics of the two models.

Critical realists also conceptualize the classical dichotomy of agency and structure in social theory. Within the framework of critical realism, Margaret S. Archer focuses on how agency and structure represent separate strata of reality, with their own powers, attributes and mechanisms (Archer, 1995, p. 14; Danermark, 2003). Agency and structure are interrelated and should be studied according to how the interplay between their respective properties and powers can explain the outcome for either and both (Archer, 2003, p. 44). In this model, known as “analytic dualism”, the concepts of agency and structure are combined with the time dimension, structures restrict and enable the action of agents, and agents again reproduce and transform structures (Danermark, 2003, p. 136).

In the present article, the basic analytical question is how the different models answer the ontological question: “What is addiction?” Their answer would then be analyzed in terms of the necessary laminated system, and to see how they open up for different mechanisms involved. Another aspect under discussion is how the different models reveal (or give) directions regarding practice in the field of addiction and treatment. The two models represent different ways of highlighting various dimensions regarding families and addiction, replying to different trends and developments within the field, addressing different issues. The aim of this study was to clarify their origins, their imperatives and their implications for practice.

THE SSCS MODEL: THE QUEST FOR EMPOWERMENT AND AGENCY

The SSCS model was developed within the field of addiction and substance use problems and was inspired by stress-coping models from health psychology (Copello & Orford, 2002; Orford, Copello, et al., 2010; Orford et al., 2005; Orford et al., 2013). The SSCS model was introduced as a model of family health, with affected family members as the primary concern. The imperative in the model is to highlight and recognize the situation of the group of affected family members. Their situation of living with alcohol and substance use problems in their close relationships is considered highly stressful, and if not coped with satisfactorily, the risk of strain and departure from a state of good health and well-being would become evident (Orford et al., 2005, p. 2). Added to the model is the aspect of social support, which potentially buffers the effects of stress and strain (Orford et al., 2005, p. 2). The central idea is that people facing such conditions have the capacity to cope and the potential to be active in the face of adversity, and are capable of effective problem-solving, being agents in their own destiny and not being powerless (Orford et al., 2005, p. 2). The model is seen as a tool for potentially empowering affected family members (Orford, Copello, et al., 2010, p. 37).

The SSCS model has resulted in the development of the 5-Step Method¹ to give family

members help in their own right (Copello, Ibanga, et al., 2010b, p. 6). The different components of the model (e.g. stresses and strains, coping, and social support) were incorporated into the 5-Step Method in a stepwise manner for use when supporting family members (Copello, Templeton, Orford, et al., 2010, p. 87). This model has a primary focus on affected family members:

“We believe the 5-Step Method is almost unique in having as its primary focus the needs of affected family members in their own right” (Copello, Ibanga, et al., 2010a, p. 205)

Positioning in the field

A basic concern that precedes and underpins the SSCS model is the general lack of attention given families and affected family members in the field of addiction and substance use problems, which is an imperative the SSCS and the SE model share. Despite accumulating evidence for the important role of families, Copello and Orford emphasized how the service delivery remains focused on the individual drinker or drug user, with their families and other members of their network playing only a peripheral role (Copello & Orford, 2002, p. 1361). They further point to how the predominantly individualistic approach leads to a situation in which the associated costs to families and society of their sufferings, the stress the family experience, and the care they provide to the substance user receive little attention (Copello, Templeton, & Powell, 2010, p. 70). They highlight the lack of a sound model of addiction problems and the family as one of the reasons why affected family members have been so neglected in health and social care policy and provision (Orford, Copello, et al., 2010, p. 37).

Existing models in the field are criticized for operating from a pathological view of the family, as exemplified by the use of terms such as codependency, family illness and family

system theories (Orford et al., 2005, p. 4-8). According to Orford et al., these models point to family or family-member pathology, dysfunction or deficiency, or take an ambiguous or unclear stand on this issue (Orford, Copello, et al., 2010, p. 38). Models comprising these concepts, including family system thinking, are criticized for speaking of family members in non-sympathetic ways, suggesting that affected family members are part of the problem of addiction. The SSCS model rejects the “systemic” idea that excessive drinking is likely to be a symptom of a more fundamental problem elsewhere in the family system, and that the excessive drinking may be serving to maintain the status quo within the family or to divert attention from the more-basic problem (Orford, 1998, p. 130f). It is further argued that by suggesting this, there is the risk of obscuring the real problem (the drinking), and to blame close family members by suggesting that they are part of the problem (Orford, 1998, p. 131). There is no room in the SSCS model and the 5-Step Method “to think of family members as part of the ‘disease of addiction’ or having responsibility for causing the addiction problem.” (Copello, Templeton, Orford, et al., 2010, p. 88). This critique can also be applied in part to the SE model, as discussed below, in that family members are not conceptualized in their own right, but rather as part of an addictive system.

This critique can further be analysed in light of the concepts of agency and structure, as different layers of reality. The SSCS model inherently criticizes the structural perspective pertaining to addiction in families, seeing families as systems. According to the model, a focus on structure or system as generative mechanisms involves a potential ignorance of the needs of affected family members in their own right, and does not pay enough attention to the condition of powerlessness under which affected family members are living (Orford, 2013). The SSCS model responds to this issue by focusing on the agency of affected family members. Affected family members are the focal point of interest in the model, and their

agency is the main focus and resource empowering them.

The SSCS model conceptualizes affected family members as people with normal reactions under the given circumstances. Orford and his colleagues focused first on how their needs have been neglected, rendering them invisible, and second on how these people have been misinterpreted as being part of the problem (pathologized family members). In recent published works, the entire framework has been integrated into a broader societal understanding using the concept of power, whereby affected family members are in a situation of powerlessness by living with addiction (Orford et al., 2013). Orford suggested the concept of “subordinated class” to describe the situation of affected family members, a class lacking a collective voice, being isolated due to them not being aware of the enormous number of people sharing their predicament (Orford, 2013, p. 94). This approach strengthens and underlines the importance of raising the awareness of and focus on affected family members as a group of people whose interests are compromised by the power of addiction. Orford et al. advocate the need for a clear focus on the affected family members as a natural and necessary reaction to the former situation in the field of addiction:

“From our perspective, the few existing psychosocial interventions which involve affected family members (AFMs) suffer from a number of limitations. For a start the majority lack a clear focus on AFMs.” (Orford et al., 2013, p. 75)

The SSCS model can be viewed as a way of restoring the balance of power in the relationship between “the person in the addictive relationship” and “the person in the addictive system”, so that affected family members no longer should be seen as “adjuncts” and not central to addiction treatment services (Copello & Orford, 2002, p. 1362). In focusing on family systems there is always a chance that one part will be more “visible” than the others, or that

the power relationship will influence the contact and meetings in a negative way.

This clear focus is strongly embedded in the SSCS model, representing a theory that deals with the situation of powerlessness when living with addiction and the possibilities of obtaining support within the health system.

A psychological ontology

A strong concern for the social side of the phenomenon of addiction underlies the SSCS model. However, when it comes to answering the question “what is addiction?”, Orford and his colleagues make the distinction between the phenomenon of addiction per se and the impact of addiction:

“We refer, not to addiction per se, but to the impact of addiction (defined socially and broadly to include dependence/pathological use or misuse/problem use of sufficient severity to cause significant difficulties for both the using relative and family members; including non-substance addictions such as gambling) on the lives of wives, mothers, husbands, fathers, children and other close family members of those who themselves are experiencing alcohol, drug or some other form of addiction.”(Orford et al., 2013, p. 70)

The SSCS model focuses on the stress and coping associated with the phenomenon of addiction, and addiction as such is described as “appetite for a substance that has become excessive”, referring to Orford’s psychological model of addiction (Orford, 2001; Orford, Copello, et al., 2010, p. 39f). According to the SSCS model, addiction is defined as a psychological phenomenon with social consequences; which, as described below, represents a difference in the basic assumptions underlying the SSCS and SE models. This psychological ontology also goes for the way affected family members are approached within the SSCS

model; on the individual psychological level of reality, focusing on the stress and strain they are experiencing and trying to cope with. The SSCS model advocates for affected family members to be recognized, and for their situation to be taken seriously by service providers.

This type of modelling considers addiction to be not a social phenomenon, but rather a psychological phenomenon with social consequences. Orford and his colleagues themselves address some of the limitations of the SSCS model, indicating that it does not address the coping of family members in a broader social and cultural context (Orford et al., 2005, p. 19), but concluded that “a perspective that views family members as people faced with tasks of trying to cope with stressful circumstances offers the clearest alternative to pathology models” (Orford et al., 2005, p. 19).

THE SE MODEL: A SOCIAL THEORY OF ADDICTION

The SE model, which was specifically developed for the field of addiction, is based on traditions of philosophy (knowledge as situational), social theory (the situatedness of everyday life), public health (well-being) and family system theory, with intimacy as the primary concern (Adams, 2008, p. 28ff). The main focus of the SE model is “people in relationships”, and how a person’s relationship to a substance/process becomes the dominant relationship, at the expense of other relationships (e.g. that with intimates).

Adams highlighted addiction in terms of relationships, family systems and interactions within wider social networks: “Rather than a solitary experience, addictions are seen as forming, intensifying, and dissolving in a social world” (Adams, 2008, p. vi). Identity is fundamentally social in Adams’ model, with people relying on their connections as a source of their own identity (Adams, 2008, p. 48). When it comes to the relationship with the substance/process, Adams describes the cycle of deteriorating connections, disconnections, intensifications and replacement (Adams, 2008, p. 47). When it comes to the situation for intimates, he

describes how the process of fragmentation affects intimacy in terms of closeness, compassion, commitment and accord, and how the relationship becomes asymmetrical (Adams, 2008, p. 73ff). He is further describing twin cycles of intimacy response phases: the joint phases of fragmentation, crises and reappraisal, and the subsequent phase of reversion and intensification (for the person in the addictive relationship) and reconnection and collective action (for the intimates) (Adams, 2008, p. 153ff). The outcome of the cycle can be either reintegration or separation (Adams, 2008, p. 153).

Adams introduces a new vocabulary that can be applied to a social way of understanding addiction. He talks about “the person in the addictive relationship” and “people in the addictive system”. Instead of “recovery” he uses the term “reintegration”, where treatment implies rebuilding of the patients’ world through reintegration (Adams, 2008, p. 65).

Reintegration is described as a social process, focusing on multiple people across several social layers; looking at how the social connections interact as a whole within the addictive system (Adams, 2008, p. 174). Another expression Adams uses is “restoring intimacy”, which implies either restoring previous connections or creating new ones (Adams, 2008, p. 67).

During this reintegration, it is not only up to the person in the addictive relationship to initiate and pursue change, but also on others to enable and participate in this reconnecting process (Adams, 2008, p. 66). Adams focuses on the social opportunity of change in the intimate circle:

“The social opportunity of change has been located on the intimate cycle, and responsibility for change has been located across the various layers of connectedness to people both inside and outside the addictive system” (Adams, 2008, p. 160)

Adams adopts a strong stand regarding the social dimensions of addictions, considering them to be genuinely important when investigating ways to reduce the suffering associated with

addictions—“the suffering experienced by both the person with the addiction and by their immediate loved ones” (Adams, 2008, p. 8). When it comes to interventions, the key challenge is to integrate what happens in session with what happens in the person’s social world (Adams, 2008, p. 245). Adams considers that the practitioner should seek stronger social inclusion so as to prevent further social fragmentation of the person’s intimate relationships in the addictive system. This involves maximization of the first contact by establishing an expectation of social inclusion, to provide social assessment and reintegration plans with participation of intimates and to facilitate meeting with various constellation of members from the addictive system (Adams, 2008, pp. 247-263)².

Positioning in the field

The starting point for Adams’ exposition of the SE model is a profound critique of the ontological position that dominates the understanding of addiction in the field. He focuses on a distinction between the “particle” and “social” paradigms. The particle paradigm has been central to both the medical and psychological traditions and emphasizes the complex organism of the human being, and the behaving and thinking individual (Adams, 2008, p. 26), including biomedical and psychological theories of addiction. The particle paradigm is described more precisely as follows:

“A cluster of assumptions that revolve around the idea that the self is primarily an individual object and that this object—or particle—is the appropriate focal point for understanding addictive processes. Other selves, too, are viewed as individual objects and together they move about within an environment connecting, disconnecting and influencing each other, but always moving as discrete objects—objects with their own boundaries, attributes, and potentials” (Adams, 2008, p. 23f).

Conversely, the social paradigm focuses not on the individual human being, but on human beings in relationships. Adams interprets this perspective as a significant shift in the way personal identity is understood. It represents a change from seeing people in terms of qualities, attributes and potentialities, to seeing them in terms of the nature of their relationships with other people and other objects, from seeing people as particles to seeing people in relationships. Addiction involves a very intense relationship with the object of their addiction, and this intensification involves the deterioration of other social relationships within the social system. In this way fragmented intimacy is theorized as part of how the phenomenon of addiction unfolds in a social world:

“Instead of viewing addiction as an attribute attached to a particular addicted person, the central idea involves understanding addiction as a social event. (...) When people become addicted, they enter into a very intense relationship with the object of their addiction. Since, as social beings, most people maintain a broad range of relationship with other objects (including people, processes and things), the intensification of one particular relationship has consequences for other relationship within that social system (Adams, 2008, p. 27f).

Adams supports a shift in paradigm in the way addiction is understood and handled, and proposes a change in the vocabulary accordingly. He argues that the dominant understanding of addiction as psychological and medical (the particle), and the social paradigm given limited space within the given institutional setting, reduces the treatment possibilities and limits the possibilities of support to intimates. The particle paradigm in itself is not the problem, since “its many theories and strategies have contributed positively to a broad range of approaches to intervention” (Adams, 2008, p. 244); the problem is its dominance.

The distinction between the two paradigms constitutes Adams critical remarks on approaches

to families such as in the SSCS model. Adams sees promising signs in the way the SSCS model focuses on the needs of intimates, but still argues that the model appears to be individualistic and does not explore the social potential:

“These approaches (SSCS) and the coping skills approaches show promising signs in the way they focus specifically on the needs of intimates, but their methods remain primarily individualistic, falling just short of exploring the potential of a social orientation.” (Adams, 2008, p. 210).

He stresses the point that addressing affected family members individually limits the potential to work relationally with the problems: “The clients are either ‘addicts’ or ‘significant others’, who are treated as individual cases in their own right” (Adams, 2008, p. 244). In this he points out that there are no tools within the SSCS model to focus directly on the relationships between affected family members and their intimates. He notes what can be viewed as the methodological individualism and the particle way of thinking that underlines the SSCS, with its primary focus on change as something that can be accomplished within the body and mind of the individual person, without taking into account the potential for change at the social level of reality. The SE model seeks to offer solutions that intervene in the social world, in interpersonal relationships. While the opportunity to change has been located in the intimate cycle, the responsibility for change has been located across the various layers of connectedness to people both inside and outside the addictive system (Adams, 2008, p. 160).

The SE model has many similarities with family system theory in its ontological presumptions, since it views the family unit as something with its own life, and interventions focus on relationships and interactions. Adams mentions three salient points regarding the usefulness of family system theory and the way it is elaborated by Peter Steinglass in his work on the “alcoholic family”. The first is the recognition of families as systems that operate in

dynamic and interactive ways, such that changes in one part of the system will induce changes in other parts. The second is that social interactions between people work differently from those of the individual (i.e. the family has a life of its own). The third is how family responses can be divided into early, middle and late phases (Adams, 2008, p. 103f).

Still, Adams points out that socially inclusive practice is not the same as family therapy. Working within a social orientation is different, in that it views the practitioner as entering into the social system as a participant working to facilitate the family's own process, with the expectation that "wisdom will emerge in a negotiated fashion from the experience and understanding of the people present within the system" (Adams, 2008, p. 264). Adams also points to the danger in family therapy of attending to the family as the new "particle" (Adams, 2008, p. 208). Adams sees opportunities for people affected, by focusing on systems and on the social processes within them:

"Since social processes have played a critical role in the emergence of addictive relationships, this book contends that social processes also offer opportunities for restoring people into an interconnected, nonaddictive social world." (Adams, 2008, p. 149).

A social ontology

The SE model is based on a social ontology, a social paradigm. The answer to the question: "What is addiction?" would be that it is a social relationship that evolves in a social world, encompassing the mechanism underlying the social level of reality. In this way the SE model represents a social theory of addiction. By introducing a new vocabulary that focuses on the person in the addictive relationship, the addictive system and on reintegration, Adams highlights the social ontological positioning in his theorizing. Still, Adams acknowledges the

multilayered nature of addiction:

“Particle change focuses on what is possible within the body and mind of the individual. Social change focuses on the system of interconnected relationships and assumes that changes at one point, particularly changes in power and strength, will leads to reaction in other parts of a system.” (Adams, 2008, p. 163)

When considered within the framework of critical realism, the particle paradigm and the social paradigm both represent layers of reality. However, Adams has questioned their relative power and status with regard to the implementation of policy and actions, such as interventions, support, arrangements and the building of institutions. Using critical realist terms, some strata of reality and some layers of knowledge have a greater impact on the construction of reality than others in the contemporary context. Some explanatory models and theories of addiction have a greater impact on the design of treatment services. Adams advocates the situation of intimates by delivering a critique of the basic presumptions upon which AOD services are generally built. His critical remarks on the SSCS model can be seen in this light, as remaining in the particle way of thinking, individualizing affected family members.

Adams is not alone in advocating a stronger focus on the social ontology of addiction. Several scholars in the field have stressed the dominance of a perspective that focuses on the individual in a medical and psychological tradition. Graham et al. point to how the view that addiction resides solely within the individual continues to significantly hamper addiction theorizing, research and treatment, and how “conceptualizations of addiction stubbornly remain housed in the individual as an illness or disease” (Graham et al., 2008, p. 121). Granfield criticizes the medicalized construction of addiction and its methodological individualism in focusing on individual experience to the conclusion of social context

(Granfield, 2004, p. 29), which highlights the need for alternative ways of theorizing in the field. Alexander supports a shift to a social paradigm in the field, in terms of the way we theorize and act accordingly (Alexander, 2012, p. 1475). Adams' term "reintegration" (as opposed to "recovery") equates to Alexander's term "psychosocial integration". However, whereas Adams' focus is at the social micro-level and the effects of fragmentation on close relationships, Alexander explains fragmentation and dislocation as a by-product of the globalized free-market society at a macro-level, and his view is that dislocation leads to addiction (Alexander, 2008). Their solutions are similar: reintegration and psychosocial integration; they both support the need to balance the dominant biomedical understanding with a social understanding of the phenomenon, which calls for different sets of solutions.

Adams asks from two standpoints whether it is possible for the social and particle world views to work side by side, because they offer quite different ways of looking at addiction (Adams, 2008, p. 273): (i) from a theoretical standpoint, whether the social paradigm would be submerged and disappear into the dominant paradigm (the particular), and (ii) from a practical standpoint, whether strong differences in viewpoints could lead to misunderstandings and conflicts between professionals in ways that negatively affect those they serve (Adams, 2008, p. 273). He sees three possibilities for coexisting: integration, separation and complementation, with the third appearing to be the most realistic. Thus, complementation involves some degree of separation between the two paradigms, but at the same time opportunities are created to connect the paradigms, and the strength of strategies belonging to each are implemented as appropriate, intertwined and separate (Adams, 2008, p. 274). Adams highlights the social way of thinking as something containing its own properties and powers, and the importance in giving this layer of reality its separate status understanding the phenomenon and in making way for possible solutions for the people involved.

DISCUSSION—ESSENTIAL COMPLEXITY AND CONSEQUENCES FOR PRACTICE

Both of the models described in this article have been developed out of a need to address how families are affected by problems with addiction and substance use problems, and question the basic assumptions that underlie practice in this field. They share a common concern and provide concepts to aid the understanding of and shed light on the situation for families and family members affected by AOD, and challenge the mainstream way of dealing with addiction when it comes to support and interventions. Still, their conceptualizations of the phenomenon differ in some interesting ways, by exploring addiction in families from two distinct viewpoints.

These two viewpoints can be related to the distinction between psychological and social mechanisms of reality, and between agency and structure as separate strata. The SSCS model operates within a psychological ontology in which addiction is viewed as a psychological phenomenon with social consequences. The 5-Step Method provides support for intimates addressing affected family members primarily at the individual and psychological levels, focusing on their agency and coping capacity. The SSCS model presupposes a social ontology, by addressing the social consequences of addiction, but these consequences are theorized at a psychological level of reality. Furthermore, the SSCS model relates to support systems outside the individual, and focuses on helping the affected family members by mobilizing existing resources. However, the model does not indicate how to focus on the relationships between affected family members and their intimates directly, or provide direction as to how to ameliorate the harm by focusing on relationships or systems. Instead, the model focuses primarily on the individual needs of affected family members. In this way the SSCS model is based on a methodological individualism that highlights mechanisms at the individual level and on individual agency for affected family members. In terms of

interventions, the outcome of the 5-Step Method is very concrete, practical and accessible, and mainly directed towards individual family members.

In contrast, Adams operates within a social ontology, addressing the phenomena of addiction at a social level of reality, explicitly addressing the whole theorizing of the field of addiction in general. In this approach the phenomenon of addiction is not related to a single individual, but instead is something that unfolds in a social world, in relationships, systems and communities. Adams' social ecological framework is per se a social theory of addiction with intimacy as a primary concern, and where intimates are those who are most profoundly affected by the relationship between a person in an addictive relationship and the addictive substance or process. By conceptualizing the distinction between the social and particle paradigms, Adams highlights the essential differences between different layers of reality, and the power relationships between different theories at different levels of reality, dominated by the particle way of seeing the phenomenon (psychological and medical). The SE model refers to a mechanism at the psychological level of reality as being relevant, but is limited to considering the way change can be accomplished by the individual person. The SE model provides general guidelines for socially oriented interventions, and represents to a larger degree an overarching framework rather than a concrete method of intervention.

The two models challenge each other in taking different approaches to the subject. The SSCS model challenges the way the SE model conceptualizes family members as part of an addictive system, and provides an alternative way of understanding and supporting them as individual cases, while the SE model challenges the way the SSCS model reduces affected family members to individuals, without contextualizing them with respect to their intimacy or addressing their relationships directly.

A basic presumption for this analysis is that the way we theorize the field forms the basis and

direction for our practices (Koski-Jännes, 2004, p. 51f). The present article has shown how the SSCS and SE models highlight the relationship between agency and structure in different ways, focusing on different aspects and addressing the phenomenon of addiction from different viewpoints. Focusing on agency or structure when searching for solutions in the field of addiction in families leads to different treatment practices. When focusing on the individual agent, the affected family members are seen as individuals who are in a difficult situation in which they need support, and help so that they are able to cope with their present life situation independently of their current relationship to the person in the addictive relationship (to use Adams' terminology). Individual and group interventions for affected family members are reinforced in the associated addiction treatments. However, focusing on relationships and structure emphasizes the importance of intervening in relationships and in systems, with a view to improving family relationships, family functioning and network relationships. Furthermore, integrated interventions for families and network are reinforced in the associated addiction treatments.

If agency and structure are viewed as being connected to mechanisms at different levels of reality, it is necessary to find treatment solutions that incorporate both levels, intervening both at a structural level in relationships and networks, as well as at an individual level, because family life involves both possibilities and restrictions for the individual simultaneously, as individuals reproduce and transform their family life. These different treatment approaches can also be useful at different stages during a treatment trajectory, such that focusing on relationships can be useful in a phase where the family is "standing up to it"³ or still wants to be reconnected with their intimates, whereas individual-focused interventions for affected family members are vital in a phase of hopelessness and long-lasting strain, or where affected family members are no longer in a direct relationship with their intimates, or where the person

in the addictive relationship is not amenable to any change in the situation. Both integrated and separate interventions could be useful at different stages of a trajectory in most cases, thereby attending to the needs of both the individuals and their families.

The concept of the necessarily laminated system points to the complexity of the phenomenon of addiction, and the need to apply flexible interventions and approaches. In an article published in 2010, Room and his colleagues provide a good example of this complexity, whereby they elaborated upon the distinctions between health problems and social problems, and on the interrelatedness of the different layers of reality. In the following quotation they focus both upon how a problem with addiction is a health problem (individual somatic or psychological) as well as a social problem both for the drinker and intimates, and how these domains overlap:

“A loose equation is sometimes made between health problems as problems for the drinker and social problems as problems for others besides the drinker. But this equation is flawed. Some alcohol- related health problems occur to others than the drinker. This is the case for injuries, for foetal alcohol effects, and for mental disorders to family members resulting from the drinker’s behaviour. On the other side, a social problem may be a problem for the drinker, whether or not there is a problem for someone else: defaults in one’s work because of drinking may result in the drinker being fired, whether or not there is a loss of productivity for the workplace....

However, most social problems with drinking involve some harm, perceived or tangible, to another person. Someone other than the drinker is perceived or perceives him/herself to be adversely affected by the drinking, and a social problem with drinking often involves some response by the other person which in turn adversely affects the drinker. Most social problems with drinking are thus inherently

interactional.” (Room et al., 2010, p. 1858)

This statement by Room et al. highlights the complexity of the phenomenon in terms of how different levels of reality must be taken into account when searching for solutions. It also represents a good example of how the mechanisms underlying the psychological and social aspects are merged, thereby broadening the understanding of the phenomenon. In our case the SSCS model responds to how addiction affects the health of the family members, and the SE model responds to the social problem of drinking as inherently interactive. From an ontological viewpoint, both models represent vital contributions to the field. Where the SSCS model is a model for affected family members, the SE model is a model for affected intimacy. Using the concept of a necessarily laminated system, emphasis upon both the psychological and social mechanisms, and focus on both agency and structure and the interplay between them are important in addressing the situation experienced by families and family members affected by AOD. Reducing the phenomenon to one level of reality will not take into account the essential underlying complexity.

Concluding remarks

In a way the SSCS and SE models are addressing slightly different but equally important battles within the field and discourse of addiction and its treatment. On the one hand there is the battle to recognize and provide agency to a neglected group, the affected family members, while on the other there is the battle to advocate the relative position of social solutions in the field of addiction. Both battles can be seen as part of emergent processes, which will widen the scope of addiction research and theory, and extending existing discourse and practice.

Both models offer descriptions and explanations of the phenomenon of addiction that unfolds in close relationships, and of what can be done to accommodate the situation. They can be

seen as two pairs of binoculars: one that zooms in on the situation for affected family members and introduces possible strategies for coping with the situation; while the other focuses on how addiction can lead to fragmented intimacy, and how “recovery” involves the process of reintegration, focusing on the social opportunity of change within the intimate circle.

The two models provide different directions for how specialist services can meet the needs of families and family members. The SSCS model forms a basis for individual or group interventions for affected family members, and the SE model forms a basis for integrated meetings with intimates and networks. Within their respective scopes the models also cross the borders between the arenas of specialist treatment, community services and public health.

When viewing addiction as a phenomenon that is a necessarily laminated system, the mechanisms underlying the different layers of reality must be taken into account in order to develop the best solutions. The SSCS model focuses primarily on the mechanism underlying the psychological level of reality, while the SE model focuses primarily on the mechanism underlying the (micro-)social level of reality. These two models therefore provide different directions for treatment practices, and in combination they will balance the focus on agency and individuals, systems and structure in families.

With respect to theorizing on addiction in families, the power dimension between different mechanisms connected to the phenomenon in practice and policy is particularly significant. In general, there is a need for theories that involve implementation of the social mechanism and that are complemented in the area of AOD treatment, in order to highlight the importance of intervening in relationships rather than just individuals, and to address the multidisciplinary characteristics of the phenomenon. In that case the SE model is a good option, representing a framework for social thinking, clarifying the social mechanism at a micro-level. This model

can be combined with a model like the SSCS model to enable visualization of the situation for the affected family members. Both models and their practical guidelines for interventions should be used as tools in different types of case and at different stages of treatment, combining the level and emergence in the interaction between agency and structure, for the betterment of families and individuals.

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¹ Step 1: Listen, reassure and explore concerns. Allow family member to describe the situation. Identify relevant stresses. Identify the need for further information. Communicate realistic optimism. Identify the need for future contact. Step 2: Provide relevant, specific and targeted information. Increase knowledge and understanding. Reduce the stress arising from a lack of knowledge or from misconceptions. Step 3: Explore coping responses. Identify current coping responses. Explore the advantages and disadvantages of current coping responses. Explore alternative coping responses. Explore the advantages and disadvantages of alternative ways of coping. Step 4: Discuss social support. Draw a social network diagram. Aim to improve communication within the family. Aim towards a unified and coherent approach. Explore potential new sources of support. Step 5: Discuss and explore further needs. Is there a need for further help? Discuss possible options with family member. Facilitate contact between family member and other sources of specialist help.

² To integrate the social world in service setting different aspects are highlighted: 1. *Focusing on the team culture*—and the readiness to incorporate a social perspective (Adams, 2008, s. 247). 2. *Maximizing the first contact*—establishing an expectation of social inclusion, by either developing a service policy that declares that clients will only be seen if they attend with other people in their lives or a representative from a community club, or make a strong recommendation for this (Adams, 2008, s. 248f). 3. *Responding to safety issues*—assessing the risks and being aware of controlling tactics and counter-reactions in the session (Adams, 2008, s. 249f). 4. *Preparing the environment*—establishing a family-inclusive service environment, with a venue design and room layout that is welcoming to families (Adams, 2008, s. 251). 5. *Social assessment*—assessing how the person in the addictive relationship connects to the addictive social system with the participation of intimates (Adams, 2008, s. 252f). 6. *Reintegration plans*—determining the strengths and capacities within the social system and setting up a framework for achievable steps in a process of social reintegration, where the “case” is the addictive system. The goal in the plan is based on a negotiation outcome of all participants, with an appropriate timeline (Adams, 2008, s. 259f). 7. *Facilitative meetings*—where expertise is seen as emerging from within the social environments itself. Participation in meetings with several people from an addictive system; meetings with couples, meetings with families, community meetings, multiple family groups, one-to-one sessions and volunteer networks (Adams, 2008, s. 263ff).

³ Orford et al. refers to three main ways in which family members cope with addiction: “becoming independent”, “putting up with it” and “standing up to it”. Standing up to it involves an active engagement and effort to pursue change in the family environment (Orford, Velleman, et al., 2010: 54).

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Region: REK vest	Saksbehandler: Øyvind Straume	Telefon: 55978497	Vår dato: 07.10.2011	Vår referanse: 2011/1234/REK vest
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Deres dato: 21.09.2011	Deres referanse:
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Vår referanse må oppgis ved alle henvendelser

Anne Schanche Selbekk

2011/1234 Hvordan virker familieorientert rusbehandling

Det vises til tilbakemelding, datert 21.9.11.

Vurdering

REK Vest v/ leder behandlet søknaden. Komiteen hadde tre merknader som søker skulle kommentere. Spissing av inklusjonskriteriene, klargjøring av hva studien innebærer for deltakerne og en ettersending av intervjuguide for de forskjellige gruppene.

Rekruttering

Prosjektleder presiserer at en vil inkludere familiecaser der det er alkoholproblematikk, og peker også på flere spesifiserte inklusjonskriterier i protokollen. REK har ingen innvendinger til disse.

Informasjonsskriv

Prosjektleder har ettersendt et revidert informasjonsskriv der det går frem at også betydningen av familiedynamikk skal være et tema i studien. REK påpeker at forskingsansvarlig sin logo må fremkomme på informasjonsskrivet.

Intervjuguide

Intervjuguide for henholdsvis pårørende, familien, pasient og faglig ledelse er ettersendt. REK har ingen innvendinger til disse.

Informasjonssikkerhet

Prosjektstutt er satt til 9.1.2015. REK legger til grunn at informasjonen om deltagerne slettes senest denne dato, slik det fremgår av informasjonsskrivet.

Vedtak

Prosjektet godkjennes i samsvar med forelagt søknad og tilbakemelding.

Prosjektet skal sende sluttmelding til REK Vest på fastsatt skjema senest 9.7.2015. Dersom det skal gjøres endringer i prosjektet i forhold til de opplysningene som er gitt i søknaden, må prosjektleder sende endringsmelding til REK. Vi gjør oppmerksom på at hvis endringene er "vesentlige", må prosjektleder

sende ny søknad, eller REK kan pålegge at det sendes ny søknad. Vi ber om at alle henvendelser sendes inn via vår saksportal <http://helseforskning.etikkom.no> eller på e-post til post@helseforskning.etikkom.no. Vennligst oppgi vårt referansenummer i korrespondansen.

Med vennlig hilsen,

Jon Lekven
komitéleder

Øyvind Straume
seniorkonsulent

Kopi til: forskning@sus.no; rasmus.sand@ras.rl.no

Saksbehandlingen følger forvaltningsloven. Komiteenes vedtak etter forskningsetikklovens § 4 kan påklages (jfr. forvaltningsloven § 28) til Den nasjonale forskningsetiske komité for medisin og helsefag. Klagen skal sendes REK Vest (jfr. forvaltningsloven § 32). Klagefristen er tre uker fra den dagen du mottar dette brevet (jfr. forvaltningsloven § 29).

De regionale komiteene for medisinsk og helsefaglig forskningsetikk foretar sin forskningsetiske vurdering med hjemmel i helseforskningsloven § 11, jfr. forskningsetikkloven § 4. REK Vest forutsetter at dette vedtaket blir forelagt den forskningsansvarlige til orientering. Se helseforskningsloven § 6, jfr. § 4 bokstav e.

Forespørsel om deltakelse i forskningsprosjektet:

”Hvordan virker familieorientert rusbehandling?

En studie av pasienters, pårørendes og terapeuters historier”

Bakgrunn og hensikt

Dette er et spørsmål til deg om å delta i et doktorgradsprosjekt der formålet er å studere virkningen av rusbehandling i et familieperspektiv. Gjennom prosjektet er målet å få ny kunnskap om rusavhengig og pårørendes erfaringer med familieorientert behandling, i tillegg til å se nærmere på betydningen av familiedynamikk på behandlingsforløpet. Studien er basert på samtaler med pasienter og pårørende om erfaringene de har med den behandlingen de har fått ved ruspoliklinikken, samt terapeuters vurdering av den samme behandlingen.

Det er en ansatt ved den ruspoliklinikk der du har mottatt behandling, enten som pasient eller som pårørende, som formidler denne forespørselen til deg. Forsker kjenner ikke til din identitet.

Det er Regionalt kompetansesenter for rusmiddelforskning i Helse Vest (KORFOR) som finansierer prosjektet, og forsker er tilknyttet Universitetet i Stavanger som doktorgradskandidat.

Hva innebærer studien?

Deltakelse i studien innebærer

- en samtale med deg og din partner/pårørende sammen (et familieintervju, der dette er mulig) og
- en samtale med deg alene (et individuelt intervju)

Tema for samtalene vil være dine erfaringer med og vurderinger av den behandlingen du har fått, i forhold til deg som person og for din familie, i lys av mer generelle spørsmål om familiehistorie og familiedynamikk i tilknytning til bruk av rus. Intervjuene gjennomføres etter at behandlingen eller deler av behandlingen er avsluttet. Intervjuene vil tas opp på lydbånd, og familieintervjuene tas eventuelt opp på film hvis informantene er komfortable med det.

Ved å gi ditt samtykke gir du forsker lov til å ta kontakt med deg og avtale nærmere tid og sted for gjennomføring av intervjuer. En tilsvarende forespørsel vil bli gitt din partner/ektefelle/pårørende (der dette er mulig). Intervjuene vil gjennomføres i frem til våren 2013. Til sammen vil pasienter og pårørende fra ca 15 ulike familier inngå i studien. Prosjektet avsluttes våren 2015.

Mulige fordeler og ulemper

Gjennom samtaler, vil du kunne bidra i utvikling av behandlingstilbud som gis til pårørende og pasienter. Dette vil også innebære at du bidrar med din tid, ca. 1,5 timer for hver samtale.

Hva skjer med informasjonen om deg?

Det du forteller om dine erfaringer, skal kun brukes slik som beskrevet i hensikten med studien. Alle opplysningene vil bli behandlet uten navn og fødselsnummer eller andre direkte gjenkjennende opplysninger. En kode knytter deg til dine opplysninger gjennom en navneliste som blir oppbevart i et atskilt låsbart, brannsikkert skap. Det er kun autorisert personell knyttet til prosjektet som har adgang til navnelisten og som kan finne tilbake til deg. Informasjonen om deg vil slettes når prosjektet er ferdig. Resultatene fra intervjuene vil presenteres anonymt, og det vil ikke være mulig for andre å gjenkjenne deg. Forsker er underlagt taushetsplikten, og alle data vil bli behandlet konfidensielt. Rogaland A-senter, ved administrerende direktør, er databehandlingsansvarlig.

Frivillig deltakelse

Det er frivillig å delta i studien. Du kan når som helst og uten å oppgi noen grunn trekke ditt samtykke til å delta i studien. Dersom du ønsker å delta, undertegner du samtykkeerklæringen på siste side. Om du nå sier ja til å delta, kan du senere trekke tilbake ditt samtykke uten at det påvirker din øvrige behandling. Om du svarer nei til å delta i studien eller velger å trekke deg vil ikke ha noen konsekvenser for din relasjon til behandler eller andre ansatte på ruspoliklinikken. Alle data om deg vil da bli slettet. Dersom du senere ønsker å trekke deg eller har spørsmål til studien, kan du kontakte prosjektleder Anne Schanche Selbekk, Vestringen 1, 4352 Klepp, på telefonnummer 99 619 617.

Samtykke til deltakelse i forskningsprosjektet

"Hvordan virker familieorientert rusbehandling?"

En studie av pasienters, pårørendes og terapeuters historier"

Jeg er villig til å delta i studien

(Signert av prosjektdeltaker, dato)

Jeg bekrefter å ha gitt informasjon om studien

(Signert, rolle i studien, dato)

Intervjuguide til faglig ledelse

Bakgrunn:

Stillingsnivå

Utdanning

Arbeidserfaring

Innhold:

Definisjon av rusproblematikk/avhengighetsproblematikk generelt og i et familieperspektiv spesielt

- Hva arbeider dere med her?
- Hva er det å ha et rusproblem?
- Hvordan vil du definere rusproblematikk/avhengighet?
- Når blir rus et problem?
- Hva legger du i begrepet "familie"?
- Hvordan vil dere definere rusproblematikk/avhengighetsproblematikk i et familieperspektiv?

Konkrete behandlingstilbud

- Hva tilbyr denne institusjonen, og poliklinikken spesielt, rusmiddelavhengige og pårørende til rusavhengige av behandling eller andre intervensjoner? (videre: hva defineres eventuelt som behandling og hva defineres som intervensjoner eller informasjons- og støttesamtaler?)
- Hva er målsetningen med behandlingen/oppfølgingen?
- Hvilken teoretisk forankring/behandlingsfilosofi ligger til grunn for den behandlingen eller for de intervensjonene som gis? (Evtnt divergerende teoretiske forankringer)
- Hva er det man diskuterer mest i forhold til hvordan rusbehandling tilretteleggelse generelt og rusbehandling i et familieperspektiv spesielt?
- Hva er slik du ser det institusjonens rolle i forhold til arbeid med pårørende/familier?
- Hvordan er dette med barn og familie tematisert spesielt inn i behandling?
- Hvordan skal rusbehandlingsinstitusjonene forholde seg til barn?
- Hvilke utfordringer møter institusjonen når de skal forholde seg, ikke bare til pasientens, men også til pårørendes og barns behov?

Praksis, utvikling, endring

- Hvilke institusjonelle barrierer ligger i implementeringen av teoretisk forankring/utvalgte metoder?
- Hvilken betydning har refusjonsordninger og andre strukturelle og organisatoriske forhold for utføring av valg av behandling?
- Hva har slike forhold å si for prioritering av oppgaver?
- Har tenkning rundt behandling og de metoder som blir benyttet endret seg i den senere tid? (I lys av rusreformen 1994? lovendringer i forhold til oppfølging av barn i 2010?) Evtnt - på hvilke måter?

Intervjuguide til terapeuter

Bakgrunn:

Stillingsnivå

Utdanning

Arbeidserfaring

Innhold:

Definisjon av rusproblematikk/avhengighetsproblematikk generelt og i et familieperspektiv spesielt

- Hva arbeider du med her?
- Hvordan vil du definere rusproblematikk/avhengighet?
- Hva er det å ha et rusproblem?
- Når blir rus et problem?
- Hva legger du i begrepet "familie"?
- Hvordan vil du definere rusproblematikk/avhengighetsproblematikk i et familieperspektiv?

Familieorientert behandling

- "Hva" er det som behandles på poliklinikken?
- Hvordan løses rusproblemet på en best mulig måte?
- Hvilke metoder arbeider du etter i din praksis som terapeut?
- Hva er forskjellen på familiesamtaler og familierapi?
- Hvilken teoretisk forankring/behandlingsfilosofi ligger til grunn for den behandlingen eller for den terapien du gir? (Evtnt divergerende teoretiske forankringer)
- Står dette i kontrast til institusjonens behandlingsfilosofi eller tenkning?
- Hva er familiens rolle i tilknytning til behandling?
- Hvordan forholder man seg til pårørende utenfor og i behandling?
- Hvilke behov ser dere hos familiemedlemmer? Hva er bestillingen fra individuelle familiemedlemmene?
- Hvilke behov ser dere hos familiene? Hva er bestillingene?
- Hvilke behov ser dere hos pasient? Hva er bestillingene?
- Hva er fordelene med å behandle familiemedlemmer sammen eller hver for seg?
- I hvilke saker er det hensiktsmessig å gjøre hva?
- Hvilke relasjoner er det som i praksis blir inkludert i behandling enten individuelt eller i familiesamtaler?
- Hva tenker dere om begrepet medavhengig?
- Sees forhold i familien på som en årsak til rusproblemet?
- Hva er det man diskuterer mest i forhold til hvordan rusbehandling tilretteleggelse generelt og rusbehandling i et familieperspektiv spesielt?
- Hvordan er dette med barn og familie tematisert spesielt inn i behandling?
- Kan dere si om utfordringer i spennet mellom at pårørende blir tatt med inn i behandling som en ressurs kontra at pårørende får hjelp for sin egen del?
- Er samtidighetene i tilbudene viktig? Er det viktig at de behandles samme sted?
- Hvordan er forholdet mellom ideologi (ønsket behandlingspraksis) og hva man i realiteten får gjennomført? Hva er eventuelt barrierene for at man ikke får gjort det man ønsker å gjøre? (Hvilke institusjonelle barrierer ligger i implementeringen av teoretisk forankring/utvalgte metoder?)
- Hva er slik du ser det institusjonens rolle i forhold til arbeid med pårørende/familier?
- Hvordan skal rusbehandlingsinstitusjonene forholde seg til barn?
- Hvilke utfordringer møter institusjonen når de skal forholde seg, ikke bare til pasientens, men også til pårørendes og barns behov?

- Hvilken betydning har refusjonsordninger og andre strukturelle og organisatoriske forhold for utføring og valg av behandling?
- Hva har slike forhold å si for prioritering av oppgaver?
- Har tenkning rundt behandling og de metoder som blir benyttet endret seg i den senere tid? (I lys av rusreformen 1994? lovendringer i forhold til oppfølging av barn i 2010?) Evt - på hvilke måter?

Vurdering av praksis i forhold til konkret terapeutisk forløp

- Hva er virkningen av at flere medlemmer av samme familie, eller nettverk blir inkludert i behandling?
- Hvilke intervensjoner er gitt i dette konkrete behandlingsforløpet? (type, formater og omfang)
- Er behandlingen avsluttet slik du ser det?
- Hva var bakgrunnen for og vurderingen bak de terapeutiske valgene som ble tatt?
- Hvilke målsetninger ble satt for behandlingen?
- Hvilke utfordringer møtte du på?
- Hvordan er din vurdering av den virkningen behandlingen hadde, for pasient, for pårørende og for barn?
- Hvilken betydning tror du det har at partner også går i behandling?
- Hvilke grep ser du som spesielt nyttig eller interessante?
- Vurderer du behandlingen som vellykket? Hvorfor, hvorfor ikke?

Intervjuguide til familien (pårørende og pasient sammen)

Definisjoner av familie

- Fortell litt fra deres liv. Hvordan møttes dere?
- Hva er familie for dere?
- Hva innebærer det å være en familie slik dere ser det?

Rusproblematikk/Avhengighet

- Hvordan vil dere beskrive det problemet som gjør at dere søker hjelp?
- Hva innebærer det, slik dere ser det, å være avhengig eller å ha et rusproblem?
- Når ble rus et problem i deres liv? Hvordan skjedde det?
- Hvilke konsekvenser har rusingen generelt hatt for forholdet dere imellom?
- Hva har avhengighet/misbruk gjort med dere som familie?
- Hvilke konsekvenser har rusingen hatt for barna slik dere ser det?
- Hvordan har det sosiale nettverk rundt dere forholdt seg til rusproblematikken og til familien?

Veien inn, og tidligere erfaringer med hjelpeapparatet

- Hvilke erfaringer har dere som familie med hjelpeapparatet tidligere? (kronologi, behandlingshistorie også før siste intervensjon)
- På hvilken måte har familien vært involvert i behandling tidligere?
- Hvordan var fokuset da fordelt mellom ulike familiemedlemmer?
- Hvordan var det å gå fra å være en familie før kontakt med behandlingsapparatet, og hvordan var det etterpå?
- Hva gjorde kontakten med behandlingsapparatet med hvordan dere så på dere selv som familie?

Brukererfaringer med siste behandling

- Kan dere huske hva dere tenkte før dere gikk inn i behandling ved ruspoliklinikken?
- Hva gjorde at dere søkte hjelp? Først, pasient, så pårørende? Samtidig?
- Hvilke forventninger hadde dere til den siste behandlingen?
- Hvilke forventninger hadde dere til hvilken hjelp henholdsvis pasient og pårørende skulle få?
- Hva arbeidet dere spesielt med i terapien? (de ulike delene)
- Hvilke målsetninger hadde dere for behandlingen? Hadde dere de samme målsetningene, eller ulike målsetninger?
- Hvilke endringer har skjedd med dere som familie i perioden fra dere begynte i behandling?
- Hvilke prosesser har behandlingen satt i gang hos dere?
- Hva tenkte dere etterpå?
- Hva var dere mest og minst fornøyd med i tilknytning til behandling?
- Hvordan var denne behandlingen sammenlignet med tidligere behandlingserfaringer?
- Hva har det gjort for relasjonene dere i mellom at dere har gått i behandling?
- Er posisjonene endret?
- Hvordan er måten dere tenker om hverandre på og måten dere tenker på dere som familie på, endret gjennom behandling?
- Hva er de viktigste tingene som har skjedd?
- Hvilke deler av behandlingen har vært de viktigste?
- Hva har dere fått hjelp til som dere hadde behov for?
- Hva har dere ikke fått hjelp til som dere hadde behov for?
- Hva har dere fått hjelp til som dere ikke hadde behov for?

Foreldres perspektiv på barna behov

- Hvilken nytte tror dere barna dine har hatt av at dere har gått i behandling?
- Hvordan vurderer dere barnas behov i denne situasjonen?
- Har de fått noen hjelp for sin egen del?
- Har de behov for mer oppfølging enn det de har fått?

- Hvilke behov har deres barn for oppfølging slik du ser det?

Forbedring av tjenestene

- Hva trenger dere som familie i møte i rusproblematikk?
- Hva trenger enkeltmedlemmene i familien?
- Hva vil være den beste måten å møte familier på fra behandlingsapparatet sin side?

Intervjuguide til pårørende (Gjennomføres etter familieintervjuet)

Innhold

Oppfølging fra familieintervju

- Hvordan opplevde du familieintervjuet?
- Er det noe du vil oppklare eller justere i forhold til det som kom frem der?

Definisjoner av familie

- Hva er familie for deg?
- Hva innebærer det å være en familie slik du ser det?
- Hvilke relasjoner har du til storfamilien; besteforeldre, tanter, onkler, søskenbarn osv?

Rusproblematikk/Avhengighet

- Hvordan vil du beskrive det problemet som gjør at du søker hjelp?
- Hvordan vil din partner beskrive problemet som gjør at du søker hjelp?
- Hva er det å ha et rusproblem?
- Når blir rus et problem?
- Samsvarer måten behandlingsapparatet forstår rusproblemet på, med din forståelse av det?

Veien inn, og tidligere erfaringer med hjelpeapparatet

- Hvilke konkrete erfaringer har du med behandlingsapparatet (eventuelle støttetilbud utenfor regulær behandling (som pårørende)?

Brukererfaringer med siste behandling

- Hvordan er det å komme som pårørende til ruspoliklinikken?
- Hvordan opplevde du den behandling som du har fått gjennom ruspoliklinikken?
- Hva er målsetningen med behandlingen?
- På hvilken måte er den nyttig for deg som pårørende/partner? Treffer behandlingen deg og dine behov?
- Er det noen elementer i behandling som du opplevde som spesielt nyttige? Evnt på hvilken måte?
- Hvilke endringer har skjedd med deg som individ i perioden fra dere begynte i behandling?
- Har det skjedd noen endringer i måten du tenker om deg selv på? Evnt hvilke?
- Hva er de viktigste tingene som har skjedd?
- Hvordan er det å motta behandling sammen med eller parallelt med (primær/identifisert) pasient? På hvilken måte påvirker dette behandlingen din?
- Hva er hjelpeapparatet sin rolle i forhold til pårørende og familie slik du ser det?
- Samsvarer behandlingsapparatets måte å "løse" problemet på, min hvordan du tenker at det bør løses? (Virkemidler, metoder osv)
- Hvordan er fordelingen mellom oppmerksomheten som rettes henholdsvis mot pasient og pårørende i behandling? Hvordan oppleves dette for deg?
- Slik du ser det – hvilke behov har du og hvilke behov har din partner?
- Hva trenger du som pårørende i møte med rusproblematikk?
- Det som har skjedd for deg – hvordan tar du det med inn i familien?
- Hvordan har nettverk utenom familien vært involvert i de prosessene som har funnet sted?

Foreldres perspektiv på barna behov

- Hvilken nytte tror du barna dine har hatt av at du har gått i behandling?
- Hvordan vurderer du deres behov i denne situasjonen?
- Har de fått noen hjelp for sin egen del?

Forbedring av tjenestene

- Hvilke behov har henholdsvis pasient, pårørende og barn i tilknytning til rusproblematikk slik du ser det?
- På hvilken måte kan disse behovene på best mulig måte ivaretas?
- På hvilken måte kan tilbudene som gis forbedres?

Intervjuguide til pasient (primær) (Gjennomføres etter familieintervjuet)

Oppfølging fra familieintervju

- Hvordan opplevde du familieintervjuet?
- Er det noe du vil oppklare eller justere i forhold til det som kom frem der?

Definisjoner av familie

- Hva er familie for deg?
- Hva innebærer det å være en familie slik du ser det?
- Hvilke relasjoner har dere til storfamilien; besteforeldre, tanter, onkler, søskenbarn osv?

Rusproblematikk/Avhengighet

- Hvordan vil du beskrive det problemet som gjør at du søker hjelp?
- Hvordan vil din partner beskrive problemet som gjør at du søker hjelp?
- Hva er det å ha et rusproblem?
- Når blir rus et problem?
- Samsvarer måten behandlingsapparatet forstår rusproblemet på, med din forståelse av det?

Veien inn, og tidligere erfaringer med hjelpeapparatet

- Hva er dine erfaringer med behandlingsapparatet?
- Hva var bakgrunnen for at det ble søkt om hjelp første gang?

Brukererfaringer med siste behandling

- Hvordan opplevde du den behandling som du har fått gjennom ruspoliklinikken?
- Hva er målsetningen med behandlingen?
- Er det noen elementer i behandling som du opplevde som spesielt nyttige? Evnt på hvilken måte?
- Hvilke endringer har skjedd med deg som individ i perioden fra dere begynte i behandling?
- Har det skjedd noen endringer i måten du tenker om deg selv på? Evnt hvilke?
- Hva er de viktigste tingene som har skjedd?
- Samsvarer behandlingsapparatets måte å "løse" problemet på, min hvordan du tenker at det bør løses? (Virkemidler, metoder osv)
- Hva tenker du om at din partner også mottar behandling (enten for sin egen del eller gjennom familierapi)?
- På hvilken måte er det annerledes sammenlignet med hvis bare du mottar behandling?
- På hvilke måter er det nyttig for deg?
- Snakker dere mye om behandlingen hjemme? På hvilken måte påvirker dette eventuelt behandlingen din?
- Hva tenker du om at din partner får hjelp på samme behandlingsarena som deg selv?
- Hva var din rolle i behandlingen? (der det er integrerte løp)
- Hvordan er fordelingen mellom oppmerksomheten som rettes henholdsvis mot pasient og pårørende? Er det en likevekt? Hvordan oppleves dette for deg?
- Slik du ser det – hvilke behov har du og hvilke behov har din partner?
- Det som har skjedd for deg i behandling – hvordan tar du det med inn i familien?
- Hva er hjelpeapparatet sin rolle i forhold til dere som familie slik du ser det?

Foreldres perspektiv på barna behov

- Hvilken nytte tror du barna dine har hatt av at du har gått i behandling?
- Hvordan vurderer du deres behov i denne situasjonen?
- Har de fått noen hjelp for sin egen del?

Forbedring av tjenestene

- Hvilke behov har henholdsvis pasient, pårørende og barn i tilknytning til rusproblematikk slik du ser det?
- På hvilken måte kan tilbudene som gis forbedres