Helpers in chaos:
Conflicting ideals and ideological dilemmas in handling substance abuse

Maren Falch Skaret

and

Marthe Sofie Øhra

PSYPRO4700 Graduate Thesis

Clinical Programme in Psychology

Department of Psychology

NTNU

Spring 2017

Preface

First and foremost, we would like to say thank you to our informants. We are thankful for being received with open arms by all our informants, and for that you dedicated time and energy to answer all of our questions about your work. Our gratitude also goes to our brilliant supervisors Tonje and Anne, for their guidance in the process of conducting this thesis. We have greatly appreciated your steady encouragement and helpful advice over the past year. Secondly, thanks to our boyfriends Ole and Jonas for your love and support while we have been mentally absent in our symbiotic bubble. Finally, we are glad to have had the courage to do this project together after six years of friendship and proud to have completed it together - still as friends - only closer and wiser.

Abstract

The way substance abuse problems have been handled, have changed significantly over the last century. Historically, abuse of psychoactive substances has been regarded as immoral behaviour, and the use of some of these substances is still illegal by Norwegian legislation. At the same time substance abuse is an issue of health, and people with substance abuse problems received status as patients in 2004. These diverging views have made moral dilemmas common in the practice of help-giving, and may lead to ambiguity regarding both what goals to obtain in the helping and the chosen approaches. We investigated how helpers' talk was used to make sense of their practice. Both semi structured in-depth interviews and focus groups were carried out. The theoretical positions guiding our work were social constructionism and discursive psychology, and we analysed our material with tools from positioning theory. We were able to differentiate three different discourses helpers drew upon, namely the 'good' helper, caregiving and healthcare. These discourses were simultaneously overlapping and conflicting, and represented ideals of helping. They were drawn upon when helpers accounted for their practice. Some created ideological dilemmas, and those of 'abstinence' and 'coercion' were found to be highly relevant in our helpers' work. In meeting these dilemmas, our helpers expanded the discourses with linguistic strategies as they shifted subject positions during conversations of different topics. Our findings suggest that a discursive approach may generate new knowledge of practices and ideals for helpers working with substance abuse problems. This knowledge may make possible more pragmatic ways of helping. Based on our findings, we suggest that a focus on cultural awareness of a familial approach of belonging should be further explored, as it seems especially fruitful in the work of helping people with substance abuse problems.

Table of contents

1 Introduction

1.1 Background and Intention

In this thesis, we explore how helpers make meaning of their experiences and practises of helping people with substance abuse problems. We have interviewed employees at three different workplaces with distinctive mandates for working with substance abuse problems. The helpers came from different professional backgrounds, mostly within healthcare, and will henceforth be called **helpers**. We define **the field of substance** abuse as the helpers' practices and professional handling of substance abuse problems. This field is known to be demanding to work within (Rise, 2014) as it consists of competing and overlapping ideologies that renders several constructions of helping-practices possible. Accordingly, several approaches to help-giving exist within this field, and in this thesis, we explore how the helpers themselves constructed understandings of their work with people struggling with substance abuse problems.

Substance abuse problems are multifaceted, and the approaches to helping people with these problems have evolved rapidly the last century. Traditionally, substance abuse was seen as a social problem, related to crime and antisocial behaviour. In Norway, people with substance abuse problems have been in the care of the criminal administration system (Kriminalomsorgen) up until 2004 when the political act of the 'Drug Reform' gave this group of people rights to be treated as patients by the public healthcare system (Helsedepartementet, 2004). This signifies that although substance abuse problems are now treated within the healthcare system, other areas of expertise and traditions have been important in shaping practices and ways of thinking when handling substance abuse problems. Hence, helpers of people with substance abuse problems have to integrate different traditions in order to carry out their mandate. In this thesis, we use the term substance abuse problems to refer to both misuse and addiction of different substances (World Health Organisation,1992). The National Institute for Alcohol and Drug Research in Norway (SIRUS) defines addiction as strong and lasting desire which significantly weaken the control of the intoxicated person and leads to substantial malfunction (Rise, 2014). In accordance with this definition and the guidelines of the International Statistical Classification of Diseases and Related Health Problems (World Health Organisation, 1992), ICD-10, we understand substance abuse problems as problems that affect function and well-being for the person and/or his or her surroundings to such a degree that help from professionals is required.

Our theoretical approach is social constructionism and discourse analysis, and we have used positioning theory as our method. In using analytical terms from positioning theory in our method we explored how helpers positioned themselves within and between discourses when they talked of their work with helping people with substance abuse problems. This is relevant to psychological science as how people construct their reality will affect behaviour and possibilities of actions. These perspectives can be particularly useful when investigating psychological phenomena, and they may provide a unique possibility to shed new light on how people who work in the field of substance abuse organise their talk and how they account for their understanding of the work they do. More specifically, the approach aims at investigating what discourses people make use of and how they use them. We will throughout the thesis look at how the helpers constructed and organised their experiences and circumstances with broad reference to discursive and cultural resources (Holstein & Gubrium, 2002).

Positioning theory should, like other discourse analytical methods, not be used separately from its theoretical background, as these are inextricably connected. The underlying theoretical premises of positioning theory facilitate examination of assumptions that previously were taken for granted, and this thesis attempts to question some of the assumptions within the area of handling substance abuse related problems. Positioning theory can consider both how social organisation is produced through speech and interaction, as well as how people are positioning themselves in relation to specific discourses (Harré, Moghaddam, Cairnie, Rothbart, & Sabat, 2009). This last point is relevant, as it implies that certain discourses are chosen over others depending on how available they are, and certain positions may be taken up due to conflicting ideologies between and within the discourses. Increasing awareness about reproduction of discourses is important, because it can open our eyes to possible unfortunate consequences of certain ways of using language. Several discourses may coexist in the same field or may be considered as too narrow to fit existing practices, and thereby contribute to maintain ambiguity in a field. Knowledge of how we use discourses as individuals, professionals or as a society can help and guide us towards discourses that creates more possibilities and are more liberating (Crowe, 2005).

By interviewing helpers who work with people with substance abuse problems, and viewing this material through a discourse analytical lens, we can investigate their way of talking about the group they work with and their problems, as well as what this tell us about the current discourses available to these helpers. Applying this framework enables us to

investigate a complex field without trying to find one single truth, rather expanding our understanding of phenomena and aspire new knowledge and practices (Gergen, 2001). In this way, social constructionism can provide some pragmatic and useful implications to a field with ongoing dilemmas, confusion and contradictions.

1.2 Our Understanding and Point of Departure

Reflections and discussions of the crucial relevance of relational competence and communication skills to mental health, made us curious of how this topic was implemented in existing practices of helping people with substance abuse problems in Norway. We came across Alexander and colleagues' research, which found that isolated rats became addicted to heroin, while rats placed together with other rats did not (Alexander, Beyerstein, Hadaway, & Coambs, 1981). This experiment provided a scientific basis to look at belonging as vital to human mental health, and more recent theories on basic psychological needs claim that the need to belong is vital to human motivation (Ryan & Deci, 2010). However, little is known about implementation of this understanding in practice when it comes to managing substance abuse and addiction in the Norwegian society. Alexander and colleagues argued that criminalization of substance abuse isolates people even more from the society, and that the key to meet substance abuse problems is to establish solid belonging to other persons through an including and healthy environment. Therefore, we wanted to investigate the helper's point of view, to see how they constructed their work and if this made space to focus on 'the need to belong'.

Researchers within a discourse analytical approach play an active role in the creation of meaning, and cannot be seen as an objective observer of this (Taylor, 2001). Our point of departure has been central to the design of our interview guide and probably also to the construction of meaning in the interview situation. Through the meaning making we did with our informants and the process of analysis, our focus was not whether belonging is a useful focus in the work of giving help to people with substance abuse problems. Rather, we chose to turn the question upside down to whether the existing practises make possible a focus on belonging in the helpers' work. Hence, the helper became more central later in the research process as we found it relevant to question how regulations and the system affect the role of a professional helper.

1.3 Problem description and Demarcations

In the literature, many researchers accentuate the complexity of substance abuse and the related problems (Rise, 2014). A discourse analytical perspective is found especially

fruitful due to the constant referral to different and sometimes conflicting theory traditions overlapping both historically and politically. From this perspective, we can presume that helpers create meaning around their role from the different relevant discourses when they are accounting for their own practice and positioning themselves within a discursive landscape. This laid the foundation for asking the following questions:

1. What discourses are drawn upon when helpers construct help-giving in the field of substance abuse problems?
2. Which positions are made available for helpers that work with handling substance abuse problems, and how do helpers position themselves through their talk?

In the thesis, we do not separate helpers based on their different professions, however they do have different educations and different tasks at the workplace. Our reason for lumping all our informants together as helpers, is that these professions work towards the same goal, namely helping people with substance abuse problems to function better in daily life. The main object of the interviews has been focused around the helper's own practices'.

The many different substances available for use and misuse can make the field of substance abuse problems a confusing field. We have chosen to not go into depth when it comes to discussing different kinds of substances, although these vary greatly in their pharmacology, how they are used and how it affects behaviour. When mentioning substances in this thesis, we will be referring to substances in general, including alcohol, different prescription drugs and narcotics. Multiple drug use is more common in the Norwegian society today than earlier, and the health problems related to substance abuse account for psychological difficulties as well as somatic diseases (Mørland & Waal, 2016). In addition to significant health problems, problems that often coincide with substance abuse include difficulties with employment, housing and relationships. These problems vary greatly in their degree of seriousness.

2 Help and Handling of Substance Abuse Problems in a Historical Perspective

In this section, we aim to provide a context to our findings, by giving an outline of how the view of substance abuse has developed during the last century. We find it appropriate to highlight some historical approaches and connect them to the helper's mandate, as we assume that tendencies in society influences the helpers' perspectives appearing in the interviews.

Different practices of helping are based on a variety of ideologies of care. Burke and Clapp define ideologies of care as 'specialized sets of beliefs about the nature of client problems and the best practices or strategies for preventing or alleviating such problems' (1997, p. 553). Caregiving as help can further be constructed in multiple ways, and it is difficult to reveal one uniform ideology of care in this field. This may be due to the heterogeneous group of people struggling with substance abuse problems, the diversity in type of problems and the historical changes when it comes to handling this group of people. In the following, we will present some ways society has handled substance abuse problems throughout the last century in connection with different ideologies of care. This is done with a special focus on how these historical and cultural trends have made, and still make, themselves available to helpers when they position themselves in the discursive landscape of helping.

2.1 Decadence, Abstinence and Prohibition

The history of work aimed at helping people with substance abuse problems has been (and still is) closely linked to social, political and religious changes. Not until the 1960s was *treatment* of substance abuse an issue in the Norwegian society (Christensen & Gran, 1994). However, alcohol has been a moral question over centuries, closely linked to values of sobriety. 'Drinkers disease' was defined as a social disease and understood as a moral deficit, and was one of the main areas of concern for the social medicine in the late 19th century (Schøitz, 2017). Abstinence supporters and the medical profession had both significant influence on the politics at the time. Different regulations and pedagogical means were implemented with the aim of reducing the general use of alcohol in the society (Fekjær, 2009; Schøitz, 2017), such as monopoly and expensive fees; even prohibition of liquor and fortified wine was attempted between the years of 1916 and 1926. Fekjær (2009) writes that the focus was on limiting access to the substance itself, much due to the ruthless behaviour caused by drunkenness and the social implications that were entailed. By engaging the population in a nationwide movement that endorsed the struggle against drinking, influencing the cultural

moral values, this also stamped substance abuse with a profound social stigma (Schøitz, 2017). Hence, it enabled the view of substance use as improper, caused by a moral deficiency within the user.

2.2 From Social Problem to Internal Disease

After the Second World War the theory of alcoholism (Jellinek, 1946) contributed to a paradigm shift of how to understand substance abuse problems. The theory relocated the earlier focus in several ways. Firstly, the use of alcohol shifted from being something anyone could become addicted to towards something that would most likely happen to a vulnerable minority. Secondly, drunkenness was no longer viewed as an occurrence, but rather a condition named alcoholism. Lastly, the focus of handling substance abuse problems shifted from deviating behaviour and the problems drinkers inflicted on others to the individual problems relevant to the drinkers themselves (Fekjær, 2009). This change towards individual treatment and information around health damages for heavy drinkers also changed the focus of the support system towards individual explanations of why precisely this person struggled with substance abuse. The changes described above was both reflected and opposed in the medical research on substance abuse at the time (Schøitz, 2017). The research maintained an individual focus, but shifted the perspective from moral decay to an understanding of substance abuse as an illness. A specific series of experiments gave empirical support to this change, and became important in the later understanding of addiction (Weeks & Collins, 1979). These experiments found that if a caged rat got the choice between pure water and water laced with heroin or cocaine, the rat would drink the drugged water until it killed itself. This led to the assumption that the substance itself caused addiction. This view is still vital to the understanding of addiction today and a key feature of the illness model of substance abuse (Tessand, 2016). The advance of the illness model had another advantage: by changing the view of people with substance abuse problems to patients, the social stigma was alleviated. This enabled support systems to care better for people with substance abuse problems. An implication of this was that the blame no longer rested with the person him- or herself. The argument was that because they were subjected to mechanisms stronger than their willpower it could not be their fault (Rise, 2014).

A lot of the literature on lasting substance abuse explains both psychiatric damage and physical disease by using the illness model. The central element of the illness model is the compulsive intake of substances, leaving the individual without any control, guilt or responsibility (Morse, 2004; Rise, 2014). Brook and Stringer (2005) highlight how politicians

rhetorically use this health perspective as an argument in favour of statutory abstinence. When substance abuse problems are described as compulsive and weakening willpower, one way of handling this is through regulations, for example criminalisation. During the 1970-80', use of narcotic substances increased in Norway, and abstinence organisations who earlier had been focused towards alcohol, came out against these as well (Fekjær, 2009). The increased use and misuse was seen as an alarming problem. The political environment became even more intense when, in 1971, the American president Richard Nixon declared substance abuse to be 'the public enemy number one'. This attitude was intensified some years later, when president Ronald Reagan introduced the term 'war on drugs'. New Norwegian policies had to be shaped from scientific findings and existing knowledge, and policy-makers turned to the fields of medicine and psychiatry for a better understanding (Schøitz, 2017). Here they found the illness model, which appealed to a need for expertise and justified a health agenda by following a strict line of prohibitions inspired by the ideal of the drug-free society (Blindheim, 1999). Criminalization of people using illegal substances is still valid today, as Norway has quite restrictive policies and legislation on this point, specified by The Act on Pharmaceutical Medicines (Lov av 4.desember 1992 nr.132 om legemidler m.v.: Legemiddelloven).

As mentioned above, handling of substance abuse problems has deep roots of moral values in the society, reinforced by attitude campaigns and criminalization policies. At the same time, treatment facilities and the health perspective founded the understanding of what substance abuse is. This interlocks a model of moral with one of illness rhetorically, and makes approaches to handling substance abuse problems challenging (Brook & Stringer, 2005). According to the moral model, the person with substance abuse problems is responsible for his or her own action, and can be sent to jail if using illegal substances. On the other hand, because the illness model sees substance abuse as a disease, the drug(s) have taken control over the person's brain and behaviour and he or she can therefore not be held responsible. Seemingly, these views are quite incompatible, still they are used to support each other in the politics and practices of handling substance abuse.

2.3 A Social Focus: Harmful Environments and the Need For 'Education'

A more socially oriented approach sees substance abuse problems the other way around, not emphasizing how the people with substance abuse problems is a burden to the society, but rather how society contributes in maintaining substance abuse problems. This socially oriented approach uses among others the research of Alexander (1981), mentioned in

the introduction, to substantiate the importance of focusing on social interaction and close relationships in the development and the recovery of substance abuse. The study of Vietnam veterans that were rapidly recovering from heroin addiction was also used as an argument to this view: in a safe and caring environment, there is 'no need' for substance abuse (Robins, 1993). It is possible to argue that this is reflected in research on risk and protective factors, which gives an overall impression that people with lasting substance abuse problems come from a background with fewer possibilities, making them more vulnerable to lasting substance abuse problems (Pickard & Pearce, 2013). According to the social focus, the structure of society as central to the explanation of how substance abuse problems develop and are maintained. In other words, substance abuse problems were regarded as a symptom of society's treatment of marginalized groups. Hence, the best solution to substance abuse problems would be to facilitate an inclusive environment, helping the person suffering to connect to other people instead of drugs. According to Burke and Clapp (1997), social learning theory is a relevant influence, as it brings with it the assumption that experience and education are important aspects of the way help is given.

Along the lines of these mindsets, treatment of substance abuse problems developed in private institutions, termed communes. The number of communes in Norway increased from 4 in 1980 to 30 in 1993 (Christensen & Gran, 1994), and their focus was to remove people from harmful environments and to avoid social contamination by isolating the sick from the healthy (Fekjær, 2009; Schøitz, 2017). The ideology of care based itself on 'common sense' and social education where fresh air, community, work training, accountability, democracy and solidarity were central ingredients (Fekjær, 2009; Ravndal, 2007). Treatment in communes and private organisations are historically based on ideology and idealism. The people receiving help is often called pupils (Tyrilistiftelsen, 2015), and in this way the helper's role can be regarded as a teacher or supervisor. This small community should also give a feeling of an extended family that is including and gives a sense of belonging (Ravndal, 2007). In this way, the helper's role can be interpreted as a family member.

For the last decades, there has been a general tendency of deinstitutionalization in the handling of substance abuse problems (Christensen & Gran, 1994; Corman, 2013). The discursive understandings of the healthcare systems responsibilities towards people with substance abuse problems has changed, especially regarding where and how they should be cared for. Earlier, it was more accepted to move people with substance abuse problems to an institution or commune, but this changed as an ideology of care that emphasised

normalisation got more prominent (Heaney & Burke, 1995). The ideology of normalisation involved an assumption that people with difficulties should be able to live a life as normal as possible. In addition, it had as a premise that care ought to foster independence. With these underpinnings, politicians increasingly supported deinstitutionalization by decreasing financial support to communes the last years (Ravndal, 2007). One of the main critics of the communes has been that institution-based care is in risk of using over-protective policies and that programs that are designed to protect, watch over, and comfort people may end up limiting people instead (Heaney and Burke, 1993). Another critic has been that the new way of life acquired in the institution is too difficult to generalise when the treatment is completed (Ravndal, 2007). Many fall back into habitual tracks, when they move home without defined frames and external motivation.

The governing guideline in treatment and rehabilitation of substance abuse problems today, is about making the patient able to live a good life (Helsedirektoratet, 2017b, p. 10). The overall responsibility to follow-up people with substance abuse problems, before, during and after treatment, is today placed with the local municipality. Part of the mandate, for both municipality services and specialist health services, is to coordinate the transition from treatment to independence, as help should facilitate autonomy and an ability to live a meaningful life together with others (Helsedirektoratet, 2016). With a more community-centred system of care, it is now expected that people with substance abuse problems should be able to live in the community. This often includes being able to live in their own home, to work and to form and maintain relationships on their own (Corman, 2013). Hence, it is now common for helpers to take a somewhat different part in the person receiving help's life; the helper is to work more long term and promote the person's function in his or her local environment (Burke & Clapp, 1997; Helsedirektoratet, 2017b).

2.4 Humanism, Client Cooperation and Harm Reduction

In the 1990's the humanistic approach got a foothold in the field of substance abuse. Rogers' Person-centred Therapy (PCT) and Motivational Interviewing (MI) are often mentioned in existing literature as functional approaches to handle substance abuse problems in care and treatment (Christensen & Gran, 1994; Woldseth, 2016). These approaches have gained ground much because they focus on how therapeutic and behavioural change is made possible (Miller & Rollnick, 2004; Rogers, 1992). Within both PCT and MI, the helper is viewed as an important factor in the work of facilitating change. Rogerian psychotherapy

focuses on the relational climate by looking at the therapist's attitude towards the person he or she is helping.

Firstly, unconditional positive regard is seen as a condition for successful helping. Here, the therapist offers the person he or she talks with an acceptance for who they are regardless of what the person being helped contributes with during the encounter. This is done without displaying disparagement and has as its purpose to demonstrate an intention to listen attentively without interrupting, judge or give advice (Moyers & Miller, 2013; Rogers, 1992). Secondly, an important assumption from PCT is that the therapist communicates empathy, through a desire to understand and appreciate the other party's perspective. The heavy focus on alliance and empathy is coherent with findings pointing to a positive early alliance as desirable or even essential for clients to become engaged in treatment (Luborsky, Barber et al. 1997). Through PCT it could be said that the helper has a special responsibility to attend to the quality of the therapeutic relationship (Moyers & Miller, 2013).

The drug treatment literature emphasises the successful engagement of the client as an important factor of positive treatment outcomes (Fiorentine, Nakashima, & Anglin, 1999; Simpson, Joe, Rowan-Szal, & Greener, 1995). MI uses many of the therapeutic methods originating from PCT to focus on encouraging and motivating people (Miller & Rollnick, 2004). This is done to help facilitate motivation internally to the individual rather than using external measures to create behavioural change. Assumptions from this research maintain that the helper is responsible for initiating and maintaining the bond between helper and helped (Meier, Barrowclough, & Donmall, 2005). The importance of this bond is such that if the bond is broken, or never established properly, help cannot be given (Saarnio, 2002). In prolongation of this, it is seen as wrong to talk about 'non-motivated' patients, as it is up to the helper to locate a bedrock of motivation and further encourage its development (Mørland & Waal, 2016, p. 81). In its extremity, this could implicate that a helper should be able to find and facilitate motivation in any person in need of help, if just the helper is good enough.

Gravdal and Bjerke (2016, p.1011) describes the responsibilities of the helper to take into consideration ideas and reflections from the person receiving help, by stating that change requires that the helpers go along with the patient in his or her direction and tempo - not in each own direction so the patient becomes uncertain of the road, not too far ahead so the patient loses courage, and not too far behind so the patient loses motivation and drive. This mandate is supported by Mørland and Waal, claiming that treatment should be adapted to the patient's own experience and own perspective (2016, p. 81). Within MI, the helped person is

made an expert on him- or herself, and is this way given responsibility and agency to make changes necessary to having a valuable life (Miller & Rollnick, 2004). In addition to the influences mentioned above, within the field of substance abuse the humanistic perspective make use of the illness model. By utilising an assumption of underlying psychological or physical damage, the humanistic perspective continues to disburden people receiving help from social stigma and blame. At the same time as giving the helped a status as a patient, humanism focuses on maintaining the agency of the individual by re-allocating responsibility for behavioural change without the normative guilt and criminalization.

2.5 Help and Handling Substance Abuse Problems Today

In 2004 people with substance abuse problems received rights as patients in Norway, which resulted in a transfer of the responsibility of treatment from private institutions to the public healthcare system (Fekjær, 2009; Ot.prp. nr.3, 2002-03; Lov av 18.desember 2009 om sosiale tjenester i arbeids- og velferdsforvaltningen: Sosialtjenesteloven [The Act on Social Services]). This has been important for several reasons. Although there still is a dichotomy between treatment of psychiatric health service and interdisciplinary specialised treatment of substance abuse, patient status makes substance abuse more a question of health than of moral, and can be understood as a step towards decriminalization (Gravdal & Bjerke, 2016). At the same time, the status as patients gives ambivalent connotations, depending on normative opinions on ideologies. On one hand, giving people struggling with substance abuse rights as patients creates equality in line with humanistic values. On the other hand, it can be interpreted as a stamp that possibly makes social solutions less available to the helping system (Brook & Stringer, 2005). The criminalisation of substance abuse makes us point at the individual taking drugs (moral model), and puts the helper in a controller function. Following this legislation, abstinence is inevitable as a goal in treatment. Literature on treatment in this field emphasise abstinence as a necessary goal in treatment also due to the illness model, arguing that treatment is difficult to accomplish if a person is intoxicated (Mørland & Waal, 2016).

As people in need of help with substance abuse problems are given rights as patients within the healthcare system, good helpers must be able to provide specialised kinds of help to their patients. One example of general guidelines on professional caregiving is that of the Norwegian Nurses Organisation's, that asserts that help should be based on compassion, care, respect the human rights and be based on knowledge (Norsk Sykepleieforbund, 2008, p. 4). The helper as professional caregiver is an expert on giving assistance on specific problems,

but the helper also needs to have a well-developed emotional competence. Although, it might not be the main aspect of the helper's work, emotional competence is an essential skill for a helper, implicit to caregiving professions. This demand on the helper's emotional capacity is greater than before as the helper now shall take into consideration what people with substance abuse problems believes he or she needs or will benefit from, as client cooperation is part of the legislation (Helsedirektoratet, 2017a).

As mentioned earlier, the current political authority based on moral values contribute to criminalization of this group, while the illness-discourse leaves them no responsibility. There is a tendency in the literature towards decriminalization, although political changes in this direction remain a controversial topic. Decriminalization may release the helper from the role as controller and remove the practice of imprisoning as a way to handle substance abuse problems. However, abstinence is found to be necessary to implement treatment, and in addition to abstinence, recovery include development of a normatively valuable life (Mørland & Waal, 2016). In a recent number of the Journal of the Norwegian Psychological Association, several articles discuss the current political and legal organisation of the field, and how this influences the mental health of people with substance abuse problems (Helmikstøl, 2016; Lillevold, 2016; Tessand, 2016). Still, it is less common to find controlled use as a goal in the research literature, and harm reduction strategies are still heavily debated because of the legislation.

In sum, literature in the field of substance abuse problems is somewhat unclear when it comes to the goals in the work of helping people, as the goals of abstinence, decriminalisation and 'helping people having a meaningful and good life' not always are easily compatible means. In elongation of the historical movements of handling people with substance abuse problems, one can expect confusions of the helper's role in this field as demands may vary depending on the ideology at the workplace and considerations of individual needs when it comes to types of help and support.

The research we have highlighted in the literature review above is relevant as we throughout our analysis found that these approaches were made part of the discourses our helpers made use of when talking about their work. When talking about their work, our helpers relied on discourses embedded with the abovementioned assumptions shaped by historical and cultural understandings. The society's view on substance abuse is continuously developing, and the discourses that helpers draw upon change, adapt and challenge each other. Therefore, a current understanding of the discursive landscape helpers' orient

themselves in, is more accessible when understood in relation to historical and theoretical traditions.

3 Scientific viewpoint: theory and method

In the following section, we will present the underpinnings of the chosen theoretical and methodological foundation. Further, we will account for our collection of data and the process of analysis.

3.1 Social Constructionism and Discourse Analysis

Social constructionism and discourse analysis forms the theoretical and methodological foundation for this thesis. In a social constructionist view the world is seen in relativistic terms, and the construction of several different versions of the world may exist and be equally true simultaneously (Taylor, 2001; Willig, 2013). Different representations of the world are produced by our inclination to make meaning of our surroundings. Thus, knowledge and research is seen as dependent on the historical and cultural settings they are produced in, and of the values and worldview of the researcher (Jørgensen & Phillips, 2002c). **Social constructionism** is seen as a broad theoretical framework with roots in various disciplines, and theorists within this tradition have different perspectives. For these reasons, we find it relevant to place social constructionism and discourse analysis in a historical and theoretical context.

Within social constructionism the concept of discourse has been used in many ways, from a broad umbrella term to having a highly specific meaning. We use a somewhat broad definition, where discourse concerns the way language is structured. This means that people's utterances follow different patterns when they take part in social life. In line with this, Jørgensen and Phillips (2002c, p. 1) define discourse as 'a particular way of talking about and understanding the world (or an aspect of the world)'. Within social constructionism and discourse analysis the understanding of language is redefined. Language does not represent reality directly, as the modernist sees it, but constructs it. Jørgensen and Phillips describe the starting point of this in the structuralist and poststructuralist presumption that reality is accessed by our use of language. Reality is given meaning through discursive use, and is generated within human relationships. Outside these discourses reality and physical objects may exist, but the social constructionist believe that we are able to access these only through language. The potential out-there-ness of the world is impossible to reach, as all attempts to describe it will consist of interpreted meanings (Gergen, 2001; Willig, 2013).

Another premise of social construction is precisely that the world is socially constructed. Since we need language to speak of the world, the world exists to us as a shared social

structure. This linguistic participation always happens in a situation and at a given time, hence, as humans we are placed in a certain tradition (Gergen, 2001). Because we humans inhabit different parts of the world, we draw on different collective ideas, and phrase phenomena or thoughts about our self and others in various ways depending on the situations we find ourselves in (Wetherell, 2001). Specific discourses will be made available under certain circumstances, and under different conditions other discourses will evolve. These discourses may exist paralleled within the same field, and compete with each other wholly or partly in order to construct meaning in a particular way (Jørgensen & Phillips, 2002a, p. 141). How language use is a form of social action can be seen in the extension of the social constructionist way of thinking, where psychological states should be seen as social activities, not as reflections of actual processes and meaning (Harper, 1995; Jørgensen & Phillips, 2002b). The same can be said for attitudes, which are seen as products of social interaction.

Discourse analysis is a field that diverge in several directions. This signifies that different beliefs about the nature of the world (ontological) and stands of what is possible known about it (epistemological) are taken within different versions of discourse analysis (Jørgensen & Phillips, 2002b). It is crucial to use discourse analysis as a method in consistency with its theoretical and methodological foundations (Jørgensen & Phillips, 2002c). Following the previous section, discourse analysis is understood as the close study of language in use (Taylor, 2001). Discourse analysis has grown within the social psychology as a social constructionist alternative to the traditionally dominant cognitive paradigm, often referred to as **discursive psychology**. The 'turn to language' was an important change within psychology, and discursive psychology focus on how people use language actively (Potter and Wetherell, 1987). Therefore, discursive psychology begins with talk and text to investigate 'the nature of the world under description, including mental states, perceptions, motivations, dispositions, thoughts, prejudices, and so on' (Edwards, 2001, p.1). In elongation of this, memories, identities, attitudes etcetera are also understood as something people do, rather than something people have. When people talk of their memories and attitudes, this is seen as a social action performed to achieve something in social interaction.

It can be useful to look at social constructionism as a supplement to traditionally modernist science, perhaps particularly when it comes to investigating social behaviour. In some fields, it might be more useful to assume an objective reality than others, still a constructionist viewpoint on the matter can provide gradations and humility to a finding without making the finding less significant. Also, we believe that an overview of how one is

historically and culturally situated may enable engagement in dialogues that are more productive than if one has to defend a certain point of view (Gergen, 2001). This enables a possibility to prioritise which versions of reality has more sustainability. Thus, the questions become pragmatic, and are oriented around investigating who are being helped or hurt when certain discourses are given greater place in our society. Particularly, we found this perspective to be relevant due to the ambiguity of practical guidelines of giving help to people with substance problems.

3.2 Positioning Theory as Methodology

As we study helpers 'talk about people with substance abuse problems', our aim is to find patterns within the talk. We hereby understand 'talk about substance abuse' and 'help' as the topics of the study, not merely resources for studying something else. Examples of this way of approaching the topic would be how references to substance abuse are located within interactions and how other speakers respond (Taylor, 2001). Discursive psychology focuses on people's everyday practice, it searches to find what the everyday discourses are. Although this is the main focus, discursive psychology continuously implicates the general societal structures which people make use of, or convert, in discursive practice (Jørgensen & Phillips, 2002c).

A particularly relevant strand of discourse analysis used by discursive psychologists is positioning theory (Andreouli, 2010; Tirado & Gálvez, 2008). The concept of position and positioning was introduced by Davies and Harré (1990) and through discursive practices positioning theory looks at the social realities of speech acts. According to Tirado and Gálvez (2008) social reality arises from three discursive practices: conversations, institutional practices and the use of rhetoric. Within these practices reality is reproduced and transformed. In using positioning theory, we are particularly interested in looking at the normative frames within which people act, think, feel and perceive. By looking at how informants use language to position themselves, this method may highlight how different positions provides different possibilities of action and degrees of agency (Harré et al., 2009; Tirado & Gálvez, 2008).

Within discursive psychology making use of discourses has specific effects, in the way that we are drawn into particular positions and identities. As Gergen and Gergen (2008, p. 176) puts it, this concern is a question about 'how individuals largely position and define each other through their discursive actions'. For example, we are positioned by others utterances, and through this we are claimed to be certain kinds of individuals or subjects (Edley, 2001). Hence, the self is seen as a discursive subject - a product of discourses. This is only true to a

certain extent as both a poststructuralist understanding and an interpretative understanding of the self is utilised in discursive psychology. The self is therefore also explained as a producer of discourses (Edley, 2001). This means that people use discourses actively as resources. Discourses are not pre-formed and static, but in dynamic development as they are being used (Jørgensen & Phillips, 2002b). This reflects an interactionist take on discursive psychology, in the way that the subject is not only the object of investigation of how discourses are used, but at the same time the investigator which make use of discourses. As seen, discourses can be both constitutive, a component having the power to establish or give organized existence to something, *and* constituted, part of existing structures.

Edley (2001, p. 210) defines subject positions 'simply as "locations" within a conversation'. By specific ways of talking, different identities are made relevant, which can change both within and between conversations. Another aspect of position is defined by (Harré et al., 2009, p. 9) as 'clusters of beliefs about how rights and duties are distributed in the course of an episode of personal interaction and the taken-for-granted practices in which most of these beliefs are concretely realised'. This is to say that every position is associated with sets of rights and duties, which gives the position a 'moral quality'. Positions are this way features of a moral landscape, and it is possible to delimit what can be said and done from these positions (Andreouli, 2010). Whether rights or duties are emphasised rhetorically depends on the person's position. The adoption of a position is a process that always involve both self and other positions (van Langehove & Harré, 1991). In our thesis, we have endeavoured to investigate what a given statement or a set of statements says about the person's possibilities to make specific utterances.

Positions are not static features, but are actively and implicitly ascribed to someone. This implies that in the course of conversations, positions can be contested, refused and assigned - positions can be redefined (Davies & Harré, 1990). Within the framework of positioning theory, we see talk as strategic and constructive. By doing this we need to use the context the talk occurred in as a starting point. Accordingly, the contexts in which the interviews took place was the result of 'interactional events' (Harré et al., 2009). As participants, our informants were placed in a context where they were invited to talk of, and in a way account for and justify, their current practice. As interviewers, we gave information and contributed with a relational focus as we questioned whether and how this was a part of the informants' existing practice. The interview as a social context is important for the purposes of the analysis, because it was assumed that the helpers had a stake in talking about their

practice, namely the quality of their help. This has consequences for assumptions made of the reality as it is constructed through meaning-making activities (Corman, 2013). This way we may argue that our helpers create space for themselves and ensure the foundation for themselves as helpers by contesting cultural commonsensical assumptions.

Another relevant concept at this point is *ideological dilemmas*. Positions are rapidly shifting, depending on what discourse is drawn upon. In addition, it is possible to see conflicting ideologies make ground for different positions. Discourses can be seen as a part of a culture's ideology, and different constructions of discourses of the 'same' social object indicates that they are in themselves rhetorical constructions. In order to illustrate the concept of ideological dilemmas it is useful to pause at the notion of ideology, which can be divided into 'intellectual' ideology and 'lived' ideology (Billig et al., in Edley, 2001 p. 203). A society or culture may have beliefs, values and practices that are its 'way of life'. Together this make up what defines 'lived' ideologies - it is the common sense of a culture. This rather contrasts the coherent and integrated 'intellectual' ideology of the same culture, which are integrated and coherent sets of ideas governing a society (Edley, 2001). The lived ideologies are seldom unitary in their meaning, and may often exist paralleled although they might be competing or contrary arguments. The proverbs of a language reflects arguments like this in an excellent way, for example they tell us that we are 'better safe than sorry' at the same time as 'fortune favours the bold'; it encourages us to be quick by claiming that 'if you snooze, you lose', whilst warning us that 'haste makes waste'; it informs us to speak the truth because 'honesty is the best policy', although sometimes it is better to keep secrets from someone because 'what they don't know, won't hurt them'. This cultural diversity of arguments provides a platform of many possibilities for users of these resources in their everyday organisation and meaning-making of what happens around them.

As mentioned earlier, everyday practices are important in shaping discourses. In the context of looking at ideological dilemmas it is relevant to elaborate some on the discursive practice of *institutional talk*. What is meant by this, is that specific institutional or work related settings often have certain practices connected to them that sets them apart from normal conversation (Wooffitt, 2001, p. 69). Heritage (1997) formulates three central aspects of this concept, and assert that institutional talk is concerned with specific sets of tasks and goals, has normatively appropriate forms of participation and that the practical tasks influence the understanding of interaction. The first of these assertions is tangent to the 'businesses' of the institution, in our case the helpers provided assistance in handling substance abuse

problems. As this is a form of caregiving, different ideologies of care make themselves relevant to our helpers in connection to the specific institution the helper works within. Differing ideologies of care may place emphasis on different aspects of caring, as an example ideologies may range from professional detachment to a surrogate family model of care (Heaney & Burke, 1995). This will again constrain participation within the institution as it makes available certain ways of behaving, while excluding others. An institution characterised by a family ideology of care, will to a greater degree allow for discipline as a form of constructive caregiving than if the said institution was more characterised by an ideology of normalisation. The third point touches on social perception, which asserts that the practical tasks of the institution will shape what kinds of inferences are made about and how ongoing interaction is understood (Heritage, 1997). The concepts accounted for in the section above, will provide a foundation of understanding for the reader throughout the findings and discussion of this thesis.

3.3 Practical and Ethical Aspects of the Study

3.3.1 Sample selection. Our sample was selected strategically, as the use of our theoretical and methodological framework presupposes this (Howitt, 2010c). The only inclusion criteria in the selection of our sample was that participants should be working in an institution, unit or group that aims to help people with a substance abuse problem. As we wanted to investigate the diversity of this group, we did not exclude participants on basis of experience, type of unit, method, or profession. By using a broad approach when selecting our sample, we expected even more dissimilar findings than if we had used more strict criteria.

In our research, we made use of two in-depth interviews and three focus groups. The sample consisted of participants from three different institutions. In total, 15 different people were interviewed for this project, ten women and five men. The three focus groups varied in size between four and five people. The two in-depth interviews were conducted with the leader of two of the units, and followed its respective focus group. The informants had experience from working with people with problematic substance abuse problems ranging from about two months to 15 years. Our sample included people from different professions, mainly from the health care sector: nurses, psychologists, social educators, occupational therapists, social workers, and also professional trainers.

3.3.2 Recruitment of participants. In order to find potential informants for our sample we investigated different institutions and groups, which fit with our criteria. Using this overview as a starting point, an assorted sample was chosen for the recruitment. Contact

information was gathered from the respective home pages of the different institutions and groups. The first contact with the participants was made by phone to the leader, with an inquiry of sending an e-mail with information on participation in the research project. The following e-mail included a formalised inquiry about participation and a sheet with information about the project and a declaration of consent, see Appendix A. As the information sheet was distributed in Norwegian, it is enclosed in the appendix in its original form. All three workplaces that we contacted were positive to participate in the project, and is part of our study. The participants for the focus groups were selected with the help of the leader at the unit. This was done for multiple reasons, most importantly to ensure that no direct pressure to participate in the study was placed on the informants by us. Voluntary participation was also emphasised in the information sheet. Other reasons for having the professional director recruiting informants were more practical, and concerned how the unit organised their work day. It was necessary to take this into consideration, as several people from the same unit was to be engaged at the same time.

3.3.3 Data protection. The study was registered at the Norwegian Center for Research Data (Norsk Samfunnsvitenskapelig Datatjeneste, NSD/Personvernombudet). The approval from NSD is enclosed in Norwegian, see Appendix B. Specific guidelines were followed to ensure confidentiality. These guidelines included how to safely store, and finally delete, the gathered information. This information consisted of sound recordings, transcriptions and consent forms. The interviews were recorded on a dictaphone, and all the tapes was transferred to a memory stick and deleted from the dictaphone directly after the interviews. The memory stick and the consent forms were kept separate in locked filing cabinets at the Clinic of Psychology at Dragvoll, an area which requires special admittance. The names of the informants were never written down, and an identifier was deemed unnecessary as the researchers found the coded letters signifying the informants easy to remember. All names of direct and indirect identifying information, such as people and places, were removed in the process of transcribing the interviews. This information is also removed in the presentation of the thesis, and no individuals should be possible to identify in the completed product of this study.

3.3.4 Ethical reflection. One of the most important ethical reflections in our study, has been to get across the discourse analytical mindset underlying this thesis. As this theoretical background is so different from many people's everyday way of thinking, we have been concerned with conveying our investigation in a way that is as comprehensible as

possible for the readers. In addition, we have felt a special responsibility to familiarise ourselves with this framework in order to increase our understanding and this way raise the quality of our work. Discourse analysis aims to investigate the construction of meaning in a given moment, not the participants' *actual* meanings or experiences (Taylor, 2001). This is a point that cannot be stressed enough. We do not claim to have any insight into the informants' inner worlds. Rather, we attempt to look for how these informants make use of different discourses as they spoke in the interviews, and what the implications of these discourses might be.

The information sheet handed out to the participants was made in the first phase, before the sample selection was decided. After the sample group was chosen, some of the wordings used in this sheet turned out to be incorrect. The main example of this is the word 'therapists', when in fact the selected group of informants consisted of a wider range of occupational groups. This was a commented on and corrected in the beginning of the interviews. Another ethical dilemma relating to the informants was concerned with the degree of voluntariness. All the informants gave the impression that they wanted to participate in the study. However, by going through the professional leaders to find suitable informants there is always the risk of informants feeling pressured to take part in the study (Willig, 2013). Our responsibility as researchers in this case is to ensure that the participants has access to the information they need and want. We also informed of this in the information sheet, and underlined in the interviews, the voluntariness of the participation, to ensure that the informants were aware of their opportunity to withdraw at any time.

The study had some limitations regarding selection of informants. Because of the mandates of the different workplaces deviates, one can assume that there will be drawn upon different discourses depending on the culture on the specific workplace. Hence, it can be problematic to compare the data as one group. On the other hand, we are interested in exploring different constructions and therefore deviations in the data is compatible with a discourse analytical framework.

When it comes to anonymity, some ethical considerations arose in both the recruitment and the implementation phase of the interviews. Firstly, the sample selection was strategic, and in order to attain informants for our study we had to make contact with the leaders of various relevant units. As the leaders was responsible for picking out our sample, they would have knowledge of parts of our sample. Also, given that all the units we interviewed are in the same local community working within the same field, the internal

anonymity is problematic to guarantee. This was made clear to the informants in person, although no sensitive information is revealed in the thesis (Howitt, 2010b, p107). So, all the participating informants in each focus group would have insight into what the other participant of this particular focus group disclosed. This being noted, we had to conduct our research in accordance with the guidelines for data protection, and made anonymous any direct and indirect personalised data in order to ensure the external anonymity of the informants. All of our informants received written information that the external anonymity would be strictly adhered to.

3.4 Method: The Qualitative Interview

We wanted to use qualitative interviews in forms of in-depth interviews and focus group interviews as methods to investigate how helpers created meaning of their own experience and role in their work. In addition, we have used literature on the field as framework to our analysis. Interviews are useful to these types of research questions, because they fit with discourse analysis and positioning theory. Here, it is also important to note that discourse analytical theory assumes that researchers themselves contribute to construction of meaning in a social meeting with the interviewee(s). Throughout the analysis, the researchers ought to remain aware of this active role in their own research findings, and aim at presenting their research as one possible reading of the data material (Willig, 2013).

3.4.1 The Interview as a Way to Gather Data. The qualitative interview is not occurring naturalistic, and hence, many researchers prefer to gather data in different ways, for example by analysing newspaper articles or an ordinary conversation (Howitt, 2010a). Naturalistic data can be preferable in the way that it gives direct access to actual observed action, while interviews are secondary information; conversation *about* action. On the other hand, the benefits from interviews is that the researcher can be active in regard to the topic he/her wants investigate, looking for patterns in use of words. Another reason we are comfortable using interviews, is that although the interview is a specialised form of conversation, it is at the same time a form of conversation that exists in everyday life. Furthermore, a qualitative interview may be conducted in a more conversational way to achieve more naturalistic data (Howitt, 2013a). This will also happen more easily within a focus group, where several different people have the opportunity to act and react to each other. When we chose to combine qualitative interviews and focus groups this was at the centre of that decision.

3.4.2 Literature review. The literature review (section 2) contains a body of information from the field of substance abuse that is thought to be a useful supplement to our interview data. These documents are not analysed based on positioning theory. Rather, it constitutes a basis and framework for our interest in this study and represents some ideas about what kind of positioning and institutional talk that is plausible to find related to this topic. We have found relevant literature and guidelines in the field that is likely to somehow be references to our informants. The selection of literature is done simultaneously as we have worked on the data, and is therefore a product of our own attempt to create meaning. Our pre-understanding and agenda is inseparable to our research and should therefore be understood in light of this.

3.4.3 Framework for the in-depth interviews and focus groups. The qualitative interviews were semi-structured for both the in-depth interviews and in the focus group. We focused on questions that could bring forth specific examples, describing the previous day etc. We created a fairly detailed interview guide in Norwegian, see Appendix C, but constructed the guide around certain central themes. This allowed us to use the interview guide as an instructive document, without keeping rigorously to specific questions. Using the interview guide flexibly allowed the conversation to flow more naturally, all the while helping us constrain the discussion to the topic in question.

Central themes in the interviews were the organization of different responsibilities at the workplace, experience of helpers working with substance abuse and their reflections of this practice. In addition, descriptions of people with problematic substance abuse and how the work was structured were relevant topics. Many of our questions were related to the practice at the workplace, which encouraged the informants to describe autobiographical events. This was a way to identify subject positions and to see how descriptions varied in different contexts.

The qualitative interviews and the focus groups took place at different locations connected to the workplace of the unit. As these two methods differ in number of participants, different time frames were set for the qualitative interviews and the focus groups. When it came to the in-depth interview one hour was deemed appropriate. The time frame for conducting the focus group interviews was set to a maximum of two hours, and the actual duration varied between one and two hours. The limitation of the time frame was set with considerations to the participants' schedule, and considerations of how much time we had available time to transcribe the interviews. The location of all the interviews were held at the

informants' workplace. One can assume that this influenced the availability of discourses to the informants and a tendency of institutional talk.

3.4.4 The focus groups. Because of the dynamic quality of groups, we chose to include three focus groups in our study. Interviews of groups can also be argued to be more naturalistic. According to Howitt (2010b), three groups is generally what is required to reach a tolerable level of saturation. The size of the focus group can be of relevance to what information you get. If there are too few members in a group a focus group may lack stimulation, on the other hand, if a group has too many group members this could discourage people from speaking their mind. We aimed to have between four and six members in our groups, and ended up with two groups with four persons and one group with five persons.

3.4.5 Pilot interviews. Before we began interviewing our sample group we conducted a pilot interview with a group of students. The student group consisted of participants with and without relevant experience from workplaces similar to the ones selected as appropriate for our sample. The pilot interview served two purposes, both testing the interview guide and giving us (the researchers) an experience of how an interview could unfold and what our role would be in a focus group.

3.4.6 Transcription. All the interviews were recorded on a dictaphone, and transcribed from verbal to written form in a text program on the computer. As we are interested in investigating discursive practices that appeared during the interviews we needed a detailed transcription system. At the same time, we aimed for a certain level of readability, as we wanted to investigate subject positions on discursive levels (Taylor, 2001). This is to say that we have not included details beyond the audible material, and this we have also been somewhat pragmatic in our approach. The interview was transcribed in its entirety, as the creation of meaning in the given moment is dependent on all of the speakers, including the interviewer (Willig, 2013). We decided to use the Jefferson transcription system as a basis, and modify this list of symbols in order to adjust the level of details needed for our transcription. The Jefferson transcription system is one of the most used systems, and has symbols that intercept speech production and timing as one of its strengths (Taylor, 2001; Wooffitt, 2001).

In addition to transcribing the words, we marked the pauses and the length of these. We transcribed speech verbatim, meaning that the transcripts are dialect. We were careful to get sound like audible breaths and changes in tone of voice. Overlap of utterances were

specifically emphasised in the focus group interviews. The complete overview on how we transcribed the interviews is found in the Appendix D.

3.4.7 Coding and analysis. According to Wiggins and Potter (2008) an analysis is not, and should not be a step by step process in discursive approaches. However, we started by repeatedly reading the data material over time, looking for patterns without making conclusions of how these patterns would look like or what they meant. The parallel process of coding and analysis were done in cooperation and we alternated between reading transcriptions separately and going through multiple possibilities for further investigation. We sorted and categorised our material to find patterns, and placed it related to what we found to be specific categories in one document, a process called coding. Here, we compared the categories, as part of the strategy of triangulation properly used to validate interpretations in qualitative research (Taylor, 2001). After several readings of the material a few categories became the basis for more detailed analysis. In the end of the coding process we identified categories of 'motivation', 'coercion', 'abstinence' and 'shared activities'. We looked at the construction of discourses through these categories, and investigated how our helpers used certain strategies when they drew on the discourses in their talk. From this we specifically considered how our helpers constructed different positions in their way of accounting for their work. In line with Potter and Wetherell (1987), we found patterns in our material and compared these with existing literature on the field to identify possible constructions of discourses. We elaborated the analysis further by hypothesising on how these were constitutive related to different versions of situations described in the data material. These hypotheses dealt with the discourses functions and effects in different and similar versions of situations, and how the strategies contributed to positioning. The following questions were relevant to us in the process of conducting the analysis: *Why this particular utterance? What function does this utterance have in the helper's possibility to positioning him/herself? What does the historical, social and cultural situation tell us of these helper's available linguistic resources?*

We present our data with a selection of the most illustrative examples of our findings. The format is attempted to be intuitive and easy to read. Short utterances or words will be in italics and enclosed in quotation marks in the running text, to illustrate wording used in interviews. Excerpts of longer sentences are separated from the rest of the text. Our informants are randomly numbered from H1 to H15, where the H stands for helper. The researchers are numbered as I1 and I2, where the I stand for interviewer. This marking is used

if more than one informant is talking in the same excerpt. These numbers are connected to the initials used in the transcription in a separate document, but no links exist to the informants' name.

3.5 Reflexivity: The Researcher's Position and Construction of the Analysis

When conducting a discourse analysis, the position of the researchers come into view. This approach views the researcher as inseparable from the research (Taylor, 2001). Discourses and the way people use them are not intuitively understood in what they signify and how they function, and anyone trying to analyse the processes of language, will at the same time be embedded in meaning-making (Jørgensen & Phillips, 2002b). Billig (1999) points out that it is impossible to understand people's talk solely on their own terms, as all analysis of the world is based on particular assumptions. Hence, any account of how people's language use are constructed, is in itself a construction (Potter & Wetherell, 1987). Although we do not view this as a hindrance of analysis, it is important to underline that the talk we discuss may be understood in other ways, or have other meanings and functions than the ones we place emphasis on in this thesis.

As two students of psychology, we have chosen a topic of our own interest and our position in the research must be acknowledged. When it comes to the collection of data, our presence may have influenced how and what participants shared with us. We wanted to approach our participants as honestly as we could, and will here account for the possibility that the status of education and the fact that we were students (who lack experience), could have influenced the interview situation. Our questions influenced the participants as we raised certain topics and discouraged others. We wanted our talk to be as conversational as possible, and arranged for coffee and some fruit and cookies to be served as we spoke with the participants. In addition, we encouraged the participants in the focus groups to discuss with each other, and voice their opinion if they had something to add or disagreed. In addition, the informants' background can be influential of their utterances. The researchers' double role as interviewer and analyst make possible a discussion of how the interview was experienced by the researcher and own connection to the topic and the participants.

The aim of the analyses in discursive psychology is not to discover one truth, rather to generate 'interpretative statements'. Jørgensen and Phillips (2002a) therefore point out the importance of making the process of analysis visible to evaluation. This can be done by including broader excerpts from the transcriptions, considering to ensure the informants anonymity. Both small and large excerpts from the transcriptions represent choices done by

the researchers. Even if our findings cannot be regarded as something that ‘exists’ beyond our construction, we still find it useful to investigate assumptions taken for granted about helping and how problems should be handled in the field of substance abuse.

4 Findings and Implications

In this section, we present findings based on our data material. Firstly, we present an identification of three discourses in the language of our informants and how we constructed and defined their content. Next, strategies of shifting blame and makings claims actualise the helper's possibilities to shift between different subject positions and to negotiate where and with whom the responsibility for the improvement of help lays. In parallel to describing our results, we will discuss some direct implications of these findings to make visible the possibilities of actions this language use creates to our helpers. It is further relevant to highlight how our helpers talk visualises the apparent ideological dilemmas in this field, especially that of abstinence as goal in the help-giving and second the use of coercion as method to provide help. The overall implications of these findings will be accounted for in the concluding section.

4.1 Discourses of the 'Good' Helper, Caregiving and Healthcare

Our informants drew on a variety of discourses to organise their talk about their work with people with substance abuse problems. These differed depending on whether the informants talked of their own personal role as a helper (the 'good' helper); the ideal practice of helping in this field (caregiving); and the helper's framework for helping, represented by the overall structural system (healthcare). The latter discourse represents political regulations rooted in legislations and guidelines to the different helping institutions' practice. These three discourses were found to represent resources in the spoken language of our informants, which also were in accordance with the historical tendencies described in the literature review. Our construction of the discourses is analytically cultivated as pure and distinctive by us, but they may be seen as more integrated and fluid in the lived lives of our helpers. Anyway, we found that our helpers talk was characterised by flexibility, and that they expanded the discourses in their application of them. The helpers varied their talk in correspondence to the different topics, and managed to unite contradictory roles by taking up different subject positions within the discourses. At the same time, the discourses made different subject positions available to our helpers. The three discourses overlap when it comes to the helper's aim in their work, which is helping. The discourses also have in common that they draw attention to the relationship between the helper and the person receiving help. More specifically, how this bond should be constructed to make provision of good help possible. However, the three discourses represented different ideologies of care, which involved distinctive connotations that possibly implied conflicting conditions in relation to moral dilemmas and practice.

4.1.1 The 'good' helper. A central finding in our data was that our informants drew on the discourse of the 'good' helper when they talked of the work they did. One topic within this discourse was that the helper should have an unconditional regard for the person being helped. The helper's personal role was constructed as particularly demanding when it came to being non-judgemental in the meeting with people in need of help. Our informants identified with this aspect of the helper's role, and as one informant said '*I also think that that we have learned to see beyond what is by others might be perceived as negative [I1: yes mhm] we look past what is criminal or take their side sort of'*[1]. This is in correspondence with humanistic ideology of care where the helper is expected to be empathic and unprejudiced (Rogers, 1992), and hence, overlook both social stigma and illegal acts. The discourse of the 'good' helper suggests that helpers are to support and motivate people with substance abuse problems without prejudice if they are to be autonomous and healthy. Another important aspect that makes up the discourse of the 'good' helper, is the focus on the helper's role in advancing motivation. In all five interviews, both in-depth and focus, our helpers talked about how to facilitate motivation is an important part of their job. One helper formulated this mandate in the following way:

> *No one wishes for a very bad life, but I think that you have given up on oneself when you come here and, well, it is certainly part of our job to show that (.) there is something else [I1:mm] there are other options.*[2]

One way to interpret this excerpt is that the helper positions him- or herself as a strong and capable party in relation to the person receiving help, being viewed as on the verge of giving up. A consequence of taking up such a position, is an accompanying duty of the helper to facilitate inner motivation as a part of the help-giving. To the question of what helpers are left with in their work, another helper made clear that motivation was a substantial part of the work by focusing on the initiating role of the helper:

> *To motivate them not only to get the best results but just to get started and take part in activities and even if it may be a bit scary too.*[3]

[1] Interview 1 – focus group
[2] Interview 1 – focus group
[3] Interview 5 – focus group

This excerpt illustrates how our helpers talked about facilitation of motivation as something that permeated their mandate as helpers. This assumption is in consistency with existing treatment literature, where the helper in many respects is described as assisting with holistically rebuilding a life through facilitating *inner* motivation. The way our helpers talked about facilitation of motivation included a variety of different goals, as a continuing process that ranged from specific activities throughout more fundamental aspects of living.

It became evident in our data that a relational focus was important, as the relationship between the helper and the person being helped was emphasised in all five interviews. In their talk, our helpers often emphasised emotional contact and joint activities as a natural part of the relational work. When describing how this was done, helpers said that they were *'trying to get to know each and every one'*[4] and *'to spend a lot of time together'*[5]. This talk substantiated the necessity of a bond between helper and the person being helped to accomplish the help successfully. The discourse of the good helper suggests, in line with existing research on the field, that the helper is primarily responsible for making possible interactions that are thought to be helpful. Following this logic, it is reasonable and important to focus on the helper's contribution to the relational process. In addition to emphasising relational work as important, our helpers saw this as part of their domain. During an interview, one helper said that helpers *'think sort of (.) that our strength in the meeting with patients is the relational part'*[6]. By accentuating the relational aspect as a speciality, helpers drew on the discourse of the 'good' helper in displaying how they separate themselves from others meeting those with substance abuse problems. This ties in with how the helper is positioned as especially trained, when it comes to creating and maintaining the essential relational bond.

Further, a central part of the 'good' helper was the emphasis helpers placed on individual autonomy. One way helpers accentuated this autonomy was to decrease the distance between the helpers' expertise and the helplessness of the receiver. One helper talked of how people with substance abuse problems often devalue themselves and underestimate what they can achieve in life:

> *Why do you have to be there [dependent on welfare]? Well, because I have no job (.) but if you took a part time job then, let's say I was in the same situation without a job, I would*

[4] Interview 5 – focus group
[5] Interview 5 – focus group
[6] Interview 2 – in-depth interview

just take a part time job [...] what is the difference between you and me? Why can't you do the same?[7]

By presenting an idea of equality in the relationship, the helpers created a peer principle as fundamental to helping. By positioning themselves this way, our helpers were constructed as appropriately generous as they erased any assumptions of differences in value and rank. In acknowledging autonomy, the helpers showed that they are responsive to the contributions of the other's part in the relationship. This aspect of helpers' work of motivating people can be seen as a continuation of the focus on dialogue, which coincides specifically with thoughts from humanistic psychology and motivational interviewing (Miller & Rollnick, 2004; Rogers, 1992).

In sum, talk drawing on the discourse of the 'good' helper orients the helper towards understanding, empathy, individual autonomy and inner motivation, reflecting a more general psychotherapeutic discourse existing in the society at large.

4.1.2 Caregiving. When our informants talked of the ideal of professional care, the discourse of caregiving was constructed as something close to 'parenting' and 'family affiliation'. When talking about what people with substance abuse problems struggled with, our helpers pointed out misunderstandings caused by a lacking capability of social competence:

H10: *If I don't understand that you can be angry in a situation, you don't necessarily need to be angry with me [I2: yes] if you haven't <u>learnt</u> precisely that*
H7: *Well they lack the ability to read signals.*[8]

As socialisation initially happens within a family structure, the secure frames resembling those of a family was by some helpers seen as necessary ingredients in the help because this was something that had been lacking in their lives. This was specifically exemplified by one of the helper's reply to the question 'in an ideal world, what should caregiving in this field look like?'. The informant said that '*I have often thought of, that to be integrated in the society they should almost be adopted (small laugh) to a family, a reinforced family'*[9]. Our

[7] Interview 5 – focus group
[8] Interview 3 – focus group
[9] Interview 1 – focus group

helpers drew on ideas of family, not only in talking about their ideal practices, but also when describing how they currently conducted their work:

> *We are often referred to as an extended family, a new family to our members (.) one [person] said, "you are almost like a separate society", and maybe is that what we have, a small society where you can practice before going out in the larger society.*[10]

In the discourse of caregiving, 'to care for' or 'take responsibility for' someone is done with a collectivistic mindset, where help is given in line with shared norms and a principle of equality. An important goal within the discourse of caregiving is to raise decent citizens in line with ethical guidelines, similar to the task of a parent raising a child (Corman, 2013).

In all five interviews, professional caregiving in the field of substance abuse problems was constructed as a substitute equal to *'upbringing'* and *'teaching'.* In the lack of sufficient upbringing in the lives of people with substance abuse problems, teaching social skills were accentuated as a central ingredient in helping them to develop better and more meaningful lives:

> *Then we return to him that is training on building a network here before he goes out in the world to do it there because he have practiced here [I1: yes you said that earlier] yes, what they do are to learn a new language, they learn how to behave [across different situations]*.[11]

This excerpt exemplifies how help is constructed as social education and how this is learned through social interaction. When focusing on social skills as possible to train and develop, helpers drew on thoughts from a socio-psychological way of thinking (Burke & Clapp, 1997). These enabled helpers to position themselves as facilitators of learning. By emphasising the lack of social skills as crucial to the development of substance abuse problems, the responsibility to educate people and the facilitation of such possibilities, is put on helpers and society in general. This way, when our informants drew on the discourse of caregiving, substance abuse problems was often constructed as something that reflected problems in the society rather than problems internal to people.

[10] Interview 5 – focus group
[11] Interview 5 – focus group

4.1.3 Healthcare. The healthcare discourse was represented in the talk of our helpers as statutory frames for help due to national guidelines and legislation. This included both duties the helpers had as health personnel and the rights of patients fixed by law. When talking about how help was given, one helper said:

> *We [work] based on what the patient self wants [others: mm] within the frames we have to work under (1.0) that we try to explain that this is what we have to act in accordance with [others: mm] but then we very much want that you shall be able to achieve the goals you have when you're here in the first place.*[12]

In this excerpt, the helper demonstrates that help is given under certain conditions, simultaneously as the helper is considering the person's own wishes. Although the discourse of healthcare emphasises the limitation of help within support systems, the statutory rights of patients are underlined at the same time. These rights remain a way of holding people accountable for their own health, at the same time maintaining possibilities of receiving expert help for their health problems. Another underpinning of the healthcare discourse was the notion of considering substance abuse as a disease or illness. The following excerpt illustrates how a helper in one interview constructed people with substance abuse problems as physically and relationally hurt:

> *While they have lost pretty much (.) both in regard to normal development because they have been using drugs, they have lost quite a lot of .hh like education in their upbringing and the process of becoming an adult is lost because they have taken drugs. Also there can be *s: some pretty serious injuries too.*[13]

This talk was part of what constructed the healthcare discourse, and in the literature review we can see this discourse in connection to the medical tradition. One of the central elements here, is the assumption that the main objection to substance abuse is that it is injurious to health. More specifically, this discourse sees substance abuse mainly as an individual health problem rather than a social problem as in Caregiving. Further, the position of the helper as an expert in possession of knowledge is made possible as a consequence of considering substance abuse as a disease or illness. This was also done by our informants, and knowledge

[12] Interview 1 – focus group
[13] Interview 3 – focus group

was constructed as an important part of successful helping when one helper said '*success, some of the success is due to your huge amount of factual knowledge'*[14]. In providing knowledgeable help, helpers aimed to follow Norwegian legislation based on research on health. The helper was constructed as an expert within our data, with better estimates of what is useful for the person being helped, than the person him- or herself. An example of this was formulated by a helper the following way '*I believe that that it isn't always that the patients are realistic when it comes to the time-frame it takes to accomplice that change [I1: yea.h] in their life'*[15]. This statement was made in a context where the helpers discussed the practice of applying interventions while waiting for the helped person to obtain an insight into his or her need of help. In this context, rules and regulations are no longer primarily connected to the illegality of substance abuse, rather to a supposition that people are not able to take care of themselves. By their expertise helpers are given a responsibility to care for others who are less informed.

4.1.4 Narrow discourses. The talk of our helpers indicated that certain ideals were created within each of the discourses. The discourses represented different versions of help existing within the helpers' daily practices, which made themselves present as something our helpers needed to take into consideration and negotiate. We found that the ideals of the discourses not always seemed to correspond; an empathic listener cannot necessarily take up a position of an educator or expert without departing from its own ideal. Consequently, when our helpers made use of a certain discourse, they were at risk of ending up outside the ideal of another important discourse in the field.

The word *ideals* here refer to what the discourses constructs as good help. This is not to say that the ideals are directly applicable to the helper in person, rather the helpers help-giving. When the helpers make use of the help-giving ideals within a certain discourse, these ideals might be threatened in different ways. For example, ideals of unconditional regard and autonomy in the discourse of the 'good' helper would be threatened by interventions including use of coercion. On the other hand, in the discourse of caregiving, ideals of a collectivistic, familiar mindset and the validity of this kind of help-giving could be threatened by trends of deinstitutionalization and autonomy. Lastly, the healthcare discourse represents the ideals of established 'truths' in the field of substance abuse and current regulations, which could be threatened by competing assumptions that may result in changes of help-giving practices and guidelines. An example of a potential threat towards the helpers help-giving is

[14] Interview 3 – focus group
[15] Interview 1 – focus group

illustrated in the example beneath. One of our informants told us about being confronted with scepticism about the success of the helping:

> *The question to us was (.5), 'do you have, are you doing a good job when you got five out of sixteen forwarded to substance abuse treatment?' (.) right. and it is then you want to ask back 'well, dear doctor, how many of your patients with so and so somatic condition (.) .h turned out alright?' [I1: yes] for these are really serious: (.) it has come quite close to the end for those that are admitted here with us involuntarily.*[16]

In this excerpt, the helper drew upon the healthcare discourse, as the particular threat this helper seemed to face was one of being regarded as doing an insufficient job if the helper was unable to save people's lives. The ideal of saving lives would in many cases involve implementation of enforced interventions, something that is hardly compatible with the ideals of unconditional regard and unprejudiced helping in the discourse of the 'good' helper. This put helpers in a no-win situation and creates a need to expand and make existing discourses regarding substance abuse more overlapping.

In different ways, all three discourses can be seen as narrow representations of what counts as good help. This can in itself be problematic, as it may limit the helper's possibilities of action when a certain helping position is taken up. Drawing upon different discourses can lead to contradictions that again compels the helper to take up a different position, creating instability and insecurity in the actual work. As the narrow ideals of help-giving does not always overlap in the different discourses and accompanying positions, this adds an additional strain, as it makes it more difficult to strengthen the position that is taken up by drawing upon other discourses within the field. Hence, in the existing discursive landscape, the helper is continuously at risk of not fulfilling the ideals created by these differing discourses.

4.2 The helpers as strategic actors: Shifting blame and making claims

The discourses of the 'good' helper, caregiving and healthcare were used actively by our informants and permeated the conversations about their daily work. Because the discourses were narrow, and even conflicting at times, we found that the helpers made use of different strategies in order to expand the discourses and thereby position themselves less contradictory and less conflicting to possibly achieve more accept for own current practice. Specifically, the strategies were useful to negotiate responsibility with accompanying duties

[16] Interview 2 – in-depth interview

and rights when talking about different aspects of their work. We understand our helpers as strategic actors. This is not to say that they are manipulative or even that they are using strategies consciously, rather it is meant to illuminate the work that people do in building accounts of descriptions (Corman, 2013; Potter & Wetherell, 2001).

4.2.1 Shifting blame. The first main strategy our helpers used was *shifting blame*, a strategy employed to talk about experiences and morally justify and account for practices of their work. Corman (2013) used similar linguistic strategies in his analysis of mothers' talk on placement of autistic children, where responsibility and guilt was central aspects of the analysis. We are not proposing that the helpers are irresponsible or that any blame rests with the helpers. Rather, by using the term 'shifting blame' we wish to emphasise how the helpers actively use the discourses to talk about their work. The term is also meant to highlight how the helpers reacted to the cultural suggestions that they might be insufficient helpers, either if they are unable to help people improve quality of life or if they chose to help in ways which are not favoured by the specific discourses. In the following we want to display how the helpers used mainly two different strategies, shifting blame and making claims. Shifting blame happened mainly in two ways during the interviews, both by blaming the illness of substance abuse and by blaming institutional systems of services and support.

4.2.1.1 Shifting blame to the illness of substance abuse. Our helpers talked about intoxication as a hindrance of help, by constructing it as a powerful mechanism that decreased the ability of connection with oneself and the outside world. This made helping inevitably ineffective, and in one of our helper's words '*go to treatment for trauma then for example, while you smoke cannabis, well then you're not in contact'*[17]. By blaming the intoxication, the helpers drew on the discourse of the 'good' helper by positioning themselves in a situation where they were unable to give emphatic help because it was assumed almost impossible to be in emotional contact when the person receiving help was intoxicated. The assumption that it is almost impossible to change while being subordinated the substance abuse seemed to guide our informants practice. This position within the discourse of the 'good' helper, released the helpers from their duties to give help unless the person receiving help behaved in line with a demand of being abstinent during treatment. In this way, the helpers had a right to expect abstinence.

In addition to the intoxication itself, the degree of the substance abuse was seen as crucial as to how, and even if, the helper was able to facilitate recovery. Our informants talked

[17] Interview 3 – focus group

about how some people had a substance abuse problem so extensive that they as helpers needed to focus on the person not getting worse, instead of helping with improving their quality of life. One helper talked about how there was '*these lifelong courses [I2: mm] with (.) I mean where there isn't so much to gain by treatment anymore but adjustment and compensatory measures'*[18]. The excerpt describes a situation over time with attempts of help-giving, where the receiver had not been able to make use of this help as intended. This demonstrated conflicts between the good advice from well-intending people or institutions, and the actual practices of people who receive advice. Here it became clear that the positioning of the helper also involves a positioning of the person in need of help. The person receiving help is positioned as an autonomous actor, and this made it possible to claim that the person had a right to refuse advice as well as the right to treat his or her body in the way they see fit, for better or worse (Harré et al., 2009). Hence, this talk provided the helpers with a position consistent with setting limits to their responsibility, and shifted the responsibility for recovery towards the person with the substance abuse problems. Taking up a position within the discourse of the 'good' helper, made possible an emphasis on help regardless of result. This contrasts an expert positioning within the discourse of healthcare, as this would have implicated a stronger duty to heal and help, where the end to a larger degree is justified by the means. This argument will be described in greater detail later in the thesis, in section 4.2.4. According to the discourse of the 'good' helper, the helper can take responsibility to initiate, to build and uphold a relation, without the responsibility to care for the whole life of the person. At the same time, the person in need of help is not intercepted, but rather received the help in form of care and support.

In blaming the illness of substance abuse, our helpers also blamed the problematic or antisocial behaviour of the people's substance abuse problems. Hence, they assigned 'particular meanings' to the helped people's behaviour as an aspect of illness rather than a quality of the person. The loss of contact and antisocial behaviour that followed the intoxication were constructed as problematic because it prevented empathy and understanding from others (Holstein, 1987). This was again understood as something the person him- or herself was not to blame for, simultaneously as it represented a significant obstacle to help-giving. Underneath follows an example of one helpers' reaction when talking about challenging behaviour:

[18] Interview 4 – in-depth interview

> *I just came to think of him over there in the corner here, that was going on about it and hitting and well threw around himself in anger and I came to think of that (.) it's not easy to li<u>ke</u> him or not (.)like for people out in the world at least.*[19]

Here, the helper constructed him- or herself as different from other people in seeing the person 'behind' the problematic behaviour. In doing this they could be said to be drawing on coinciding elements from both the discourse of caregiving and the 'good' helper, as both postulate that the helper should be able to tolerate a lot in their help-giving. In the discourse of the 'good' helper this ideal is visible in the underpinnings of unconditional regard and a non-judgemental attitude of the helper, while in the caregiving discourse this ideal has roots in an ideal of the loving parent. As people with substance abuse problems were constructed as a demanding group to handle, to work with *'such ill people'*[20] could be emotionally challenging. A construction of problematic behaviour as an expression of illness enabled the helpers to take up a position as particularly good helpers, dismissing moralistic attitudes as unconceivable for a helper to have within this field.

4.2.1.2 Shifting blame to the institutional systems of service and support. The helpers also shifted blame to malfunctioning aspects of systems of services and support. Their talk indicated that systemic structures failed in some areas or did not provide the necessary foundation for the helper to perform his or her tasks in an ideal way. The limitations of help-giving that our helpers described, revolved around how the system often had unrealistic expectations when it came to functions of daily living. In this talk our helpers drew on the illness model in their understanding of substance abuse. In the following excerpt one of our helpers used this understanding to talk about the demands of the system as unreasonable:

> *Many started doing drugs in the age between twelve and sixteen right, and may have gotten brain damage, and we demand, I mean <u>the systems</u> demands like, that they should function like a thirty year old. But they have lost quite a lot. Both of normal development due to the intoxication and they have lost quite a lot of learning from their family home […] and I believe that we (.5) helping systems, then I mean a broad spectre, have demands based on their normal age. And I think that is a bit unfair.*[21]

[19] Interview 1 – focus group
[20] Interview 1 – focus group
[21] Interview 3 – focus group

In this excerpt our helpers constructed the people receiving help as marginalised. Such talk effectively placed blame to a system requiring a daily life function that would be unrealistic to uphold for this same group. By drawing on the healthcare discourse, the helpers were effectively placed in a position of limited capacity, subordinated by a duty to follow guidelines of organisational structures. A position as an expert, a healthcare worker with specialised competence, was often taken up by our helpers. At the same time, the helpers criticised this position by pointing out that expectations from guidelines are disproportionate compared to helpers' experiences. This counter-position as a helper who valued and relied on feedback from the person being helped as guiding the help, was also seen multiple times throughout the interviews. This drew attention to the inflexibility of the system that could be an obstacle for helpers to adapt the help individually. In this way, the helper made room to talk about their own position as one they *had* to take up, although it was unfortunate and unwanted.

Looking closer at these different positions, we can see that, at least in some respects, the counter-position 'buys back' into the dominant ideal of knowledge and expertise. When expanding their talk with a humanistic perspective, the helper in this excerpt talked about what was best for the person receiving help much in the same way as guidelines and legislation do. Indeed, what was enhanced in this opposing discourse is, not only the malfunction of the system, but just as important: the helper's expertise and competence in the help-giving.

Legislation that criminalises use of illegal substances in combination with the assumption that help is difficult to give when the receiver is intoxicated, make up the 'demand of abstinence' as a criterion for help in this field. Sometimes our informants talked of the demand of abstinence as unreasonable considering the support services that are offered to people trying to become abstinent in the first place. When describing the steps people with substance abuse problems have to take in order to find housing one of our informants said the following:

> *As the system functions, you get a residence in a drug infested environment, and you get a 'drug residence', as we call it. And how on earth are you supposed to get abstinent if you live in the middle of the nest with everything you know? I mean, it is an impossibility! And then you must enter treatment and be there for a really long time*

> *and <u>prove</u> that you can manage to stay abstinent, everything before you might be so lucky as to get an ordinary local residence for example.*[22]

The excerpt above shows how paradoxical regulations made the helping difficult. Here the helpers made use of the discourse of caregiving in shifting the blame towards the system. The caregiving discourse implies that the environment that people live their life in, must be healthy and nourishing for people to develop. To become abstinent *'without a chance to practice first'*[23] was named as an *'unfair'*[24] demand, and remaining abstinent as a treatment goal was presented as an *'utopia'*[25] to many of the people struggling with substance abuse and addiction. A disparity appeared between what a helper can offer to the person in need of help and what the systems demands as conditions to receive help. In the excerpt above the helper displayed a frustration regarding this, in lack of no obvious way to solve this obstacle, by positioning themselves as powerless bricks in an insufficient system.

Abstinence as a goal specifically seemed to come into conflict with discursive ideals within the discourse of the 'good' helper. One informant portrayed abstinence as something '*difficult to achieve for everybody'*[26] while another informant described the demand of abstinence as *'a higher demand than being prime minister in Norway'*[27]. In one interview, a helper touched upon how legislation in the field was done in other countries, displaying curiosity on how potential legalisation could work differently than current systems:

> *That model they have in Portugal, I wasn't aware of it and I was quite fascinated by it [...] so I think that it sounds like a really a really (whistle sound) right way [...] it was that you won't be punished [I1: yes] but you (2.0) have to go through treatment if they consider you to have a substance abuse problem.*[28]

In this utterance, the helper questions the existing ideals of the discourse of healthcare. Guidelines and associated laws were contrasted with other thoughts on help-giving, and at some point, they were negotiated to such a degree that their utility was questioned. The positioning of this talk opened new perspectives of viewing our helpers work. At the same

[22] Interview 3 – focus group
[23] Interview 3 – focus group
[24] Interview 1 – focus group
[25] Interview 3 – focus group
[26] Interview 3 – focus group
[27] Interview 5 – focus group
[28] Interview 1 – focus group

time, this position was rarely taken up by our helpers as a group, and when it happened the conversations often died out or the topic was changed.

The descriptions our informants gave were good exemplifications of the interpretative work they did while talking about helping others. Our helpers organised their talk by using the discourses of the good helper, caregiving and healthcare to portray morally acceptable and accountable versions of help-giving within this field. Their talk was strategic in that it offered a preferred version of reality by shifting blame and thereby disqualifying other accounts. In sum, this section shows how helpers constructed themselves as submitted to paradoxical practices due to legislation and guidelines in the system.

4.2.2 Making claims. *Making claims* was the second strategy we found that our helpers made use of, and can be understood as statements used to achieve a specific task (Edley & Wetherell, 1997). In our material, the helpers made claims to account for their practices. Our helpers' talk pointed to that their practice sometimes could be in conflict with discursive ideals. When practices conflicted with discursive ideals, it became apparent that making claims was a particularly important strategy for our helpers as it enabled them to negotiate both the practices and ideals with their talk. Our informants used rhetorical dimensions of language to construct their situation as part of a social problem that required distribution of responsibility. Our helpers made effective use of lived ideologies during this talk, in the purpose of pulling listeners to their sympathetic stances (Ibarra & Kitsuse, 1993). This 'commonsensical' talk can be applied intelligibly in claims-making by highlighting specific aspects of social problems and can have the function of amplifying and justifying claims regarding their practice. Helpers were making claims in mainly two ways, by using rhetorical dimensions of dignity and compassion, as well as endangerment and responsibility.

4.2.2.1 Making claims of dignity and compassion. Historically, deinstitutionalisation and humanism have brought with them an ideal of normalisation. This ideal was hereby connected to an idea of what dignity is comprised of. Today, common sense dictates a dignified life to be in line with an ideology of normalisation, and as mentioned in the literature review, this is often a life where a person is able to live autonomously and independently. One of our helpers talked about dignity the following way:

> *They are at the mercy that we feel sorry for them but there is no dignity in that […] I don't know if it helps to be pitied […] I think we must have normal expectations to*

> *people, to start with at least to display the resources that contribute to making choices.*[29]

By claiming to hold normal expectations, the helpers were positioning themselves within the discourse of the 'good' helper, signalling that they believe in people with substance abuse problems. Our informants argued that by having certain expectations to people with substance abuse problems, one also gave them agency and a possibility to experience mastery in achieving things they themselves believed to be impossible. This evolvement of giving trust and expectations in the helping process were described like this by one helper:

> *We shall detoxify and stabilize and motivate, earlier we:: were as shadows to the patients being here involuntarily, and now we can give them trust, we look at the patients in a totally different way.*[30]

In this abstract the helper constructed this new approach in contrast to earlier practice as a positive change, a change that has led to more dignity for the person receiving help. Because of this positioning, our informants could be said to have a duty to uphold certain expectations and demands when meeting with people in need of their help. Because of this, our informants strived to eliminate the differences of rank and value as part of their work, emphasising the peer principle as an important feature in the relationship between the helper and the person in need of help.

In line with these historical trends and the discourse of the 'good' helper, we found in our data that facilitation of inner motivation was constructed to be essential in order to make lasting changes. Our informants listed help to find inner motivation as part of their job, but only if the people receiving this help wanted to get motivated. This was a point that was recurrently made, exemplified with phrases like *'you cannot force anyone to become motivated'*[31] and '*you won't stop using drugs because I want you to stop, you must want it yourself'*[32]. The need to make rhetorical claims of dignity becomes apparent when seen against the duties helpers have within the expert position of the healthcare discourse. The possible disadvantage of the expert position is the accompanying positioning of the other as ill

[29] Interview 4 – in-depth interview
[30] Interview 1 – focus group
[31] Interview 4 – in-depth interview
[32] Interview 5 – focus group

and without impact on his or her process of recovery. In positioning the person being helped thus, he or she is not only relieved of blame and responsibility, but also agency, which is seen as problematic within an ideology of care that favours normalisation and autonomy. By expanding on the idiom of dignity, the expert role was limited and our helpers could give more responsibility to people in need of help without being at risk of looking irresponsible in their trusting help-giving.

As noted above, the peer principle conflicts with the expert position. We found that claims of compassion were used when our helpers talked about situations where they had to provide expert help, either positioned as professional caregivers or educators and parent figures. Claims of compassion were used strategically to integrate these practises with ideals from the discourse of the 'good' helper. In alignment with trust and expectation, the helpers were talking of possibilities for changes through learning and social interaction. Here, the helpers positioned themselves in a teaching role although borrowing language consistent with the discourse of the 'good' helper. Following is an example of how one of our helpers described their usual practice when educating as an aspect of helping:

> *When you have not been included before, then you <u>have to</u> learn a new system for different cognitive, in a way, paths and thoughts and and and opportunities to learn that here, because we mean, there is an idea of upbringing, or like, they get a lot of education [in social situations] on how they should behave when they get angry for example. We take you to the side and get you to count to ten because you are not allowed to explode right, and there is a lot of exercise for aggression in that what is it called again? [H13: anger mastery]*[33]

This utterance exemplifies our helper's use of a compassionate rhetoric, as they position themselves as caring supervisors, similar to the notion of a loving parent. Hence, the helper is constructed as someone in possession of unique relational competence and as someone that has sincere intentions when applying rules on people. When talking of help as an educational process within the caregiving discourse, implementation of rules and social norms was used as means to make people better suited to live in the community. This talk is tangent to the ideology of normalisation seen in the discourse of the 'good' helper. Although the two discourses can be said to coincide with the ideal of normalisation, the caregiving discourse

[33] Interview 5 – focus group

views help-giving more continuously and long term. This made it possible to position the helper as an educator, and provided a foundation for defending the use of consequences, boundaries and rules.

Another way our informants defended coercion as an acceptable intervention was by giving examples of positive consequences to those having substance abuse problems. Their talk provided opportunities to use external measures in the beginning to build the foundation of inner motivation:

> *H7: Even if many experience it as a pain in the ass, the control (.) 'they are going to look after me and punish me' and so on (ahem) (.) that is not the idea behind.*
> *H9: No*
> *H8: .hh and someone use it, like a drive, in the everyday life, like I have a urine specimen on friday, right and then it's a mastery experience when they deliver it.*[34]

Here, coercion was described as an external motivation, ensuring that the person submitted to it received necessary help to regain a state of order in their chaotic life. Following this logic, helpers made use of controlling measures as a form of caregiving. Its intention was to safeguard a person's own good, much in the same way as parents do with their children. Their talk also enabled helpers to maintain that motivation should be internalised in a long-term perspective. At the same time, this talk provided opportunities to use external measures initially in building the foundation of motivation. Hence, coercion was constructed as something useful if submitted to someone that could make use of this involuntary help long term.

Similar findings were relevant on the topic of abstinence as a main goal. Several times during the interviews, helpers claim that *'everyone <u>really</u> want to get abstinent'*[35]. By placing emphasis on the person's own wish to get abstinent our helpers implemented the ideal of abstinence in the discourse of the 'good' helper. At the same time, as being focused on abstinence, helpers in all five interviews talked of '*ambivalence'* as highly relevant when it came to helping people with substance abuse problems. Thus, by emphasising commonsensical assumptions like '*people deep down want to have a good life'*[36] and that this

[34] Interview 3 – focus group
[35] Interview 1 – focus group
[36] Interview 1 – focus group

implies an abstinent life, our helpers were able to uphold the ideal of abstinence for treatment, even when they positioned the person being helped as an autonomous actor.

On the other hand, our helpers also talked of coercion and constraint as something unwanted and potentially harmful to those being subjected to it. The following excerpts illustrates how the helpers struggled with the idea of constraint and coercion as something that conflicted with the ideal of a 'good' helper:

> *Because it [constraint] is uh a [I1: yes?] high threshold measure (.7) a::nd the violation should be made up for, in that, the admittance should have a purpose […] one should discuss the purpose all the way and then (.) other ways the municipality initiates [I1: yes] here you know so it's they who are the trigger and that's pretty nice for us so that we are released from initiating the constraint.*[37]

Implicit in this kind of talk was an assumption that use of coercion was culturally and morally unacceptable. In addition, the helpers talked here of how constraint was a violation that could be damaging to the helper (e.g. through damaging the alliance), and not something they wanted to initiate. Despite these difficulties, the majority of the informants had to work with people subjected to different kinds of coercion, such as regular urine samples and involuntary admission to treatment. By talking this way, the helpers were showing compassion with people who were admitted to coercion. Thus, the helpers were enabled to signal that coercion was something they came out against in effect of being a helper. When permeating their talk with rhetoric of compassion, helpers could express their steady empathy for people with substance abuse problems, despite the challenges of the problematic substance abuse in itself and the failed systems of support.

4.2.2.2 Making claims of endangerment and responsibility. By virtue of being part of the healthcare system, 'the duty to save lives' became a central part of the ideal of helping. This included the duty to help people avoid harming themselves, although resorting to unwanted measures, like going against a person's own will by using force. One of our informants said that '*these are people that most likely would have died (.) if they had not been placed here involuntarily*'[38], pointing to the lifesaving mandate of the healthcare system. As seen in previous sections, our helpers spoke about how the substance abuse as an illness and lack of systemic structures led to a situation where they experienced to be helpless and in

[37] Interview 1 – focus group
[38] Interview 2 – in-depth interview

positions of little executive power as helpers. These domains of blaming can be seen as an attempt to convince listeners of the helpers morally justified position that use of constraint sometimes was the only option. This claim was reinforced by drawing on rhetoric's of endangerment. When confronted with the possible life threatening situations people with substance abuse problems could end up in, our helpers turned to an argumentation where the end justified the mean. The excerpt above specifically exemplifies the helper taking up a position within the healthcare discourse. This expert position involves the duty to use necessary force to help. This way our helpers made use of a rhetoric of endangerment to justify use of coercion.

Another way of substantiating the necessity of using constraint, was when the helpers constructed people with substance abuse problems as potentially dangerous to others, drawing on the discourse of healthcare. Our helpers placed emphasis on how these constrictions were used in order to protect, amongst them the paragraph of involuntary hospitalisation found in the Act on Health and Care Services (Lov av 24.juni 2011 nr.30 om kommunale helse- og omsorgstjenester m.m.: Helse- og omsorgstjenesteloven.) When talking about this, our helpers emphasised the importance of the legal aspects concerning use of coercion: '*so now when acting out [we can] initiate to transfer them because they [other treatment facilities] have better opportunities to shield than we have'*[39]. The risk of a person becoming uncontrollable was talked about as a danger, not only to the person itself, but also to the helper. In the excerpt above, the helpers refer to another institution, with other possibilities to legally apply the amount of force 'appropriate' to the situation. By placing themselves in this position, they invoked rhetoric's of endangerment that effectively made use of ideas of social protection. This contributed to make sure that the helpers were positioned as morally decent, and that they had the society at large's best interest as their highest priority.

Another finding regarding the complexity of providing help in this field, was the helpers talk considering the organisation of their responsibilities as professionals. As mentioned, the field has changed a lot the last couple of years and the helpers' role has therefore needed negotiation:

> *H7: Talking of responsibility and being alone, we have that kind of job, but if we go back to earlier drug treatment care, perhaps ten, fifteen years ago we were very*

[39] Interview 1 – focus group

> *focused on care, as employees we took very much responsibility. Took responsibility for almost the whole life of the addict. So we felt at least. I think that we have - (.)*
> *H8: changed*
> *H7: Substance abuse care has changed to passing the responsibility back (to the person receiving help), if you had a drug problem, you have to work with it yourself but we are with you on the way. You must do the job yourself and we have become much clearer on that point.*
> *H11: One compensated much more for the shortcomings in the system, it didn't exist that good options as today.*[40]

This kind of talk positioned the helpers of the old day as the supporting pillar in the system of help, which the person receiving help depended upon to improve their quality of life. By portraying this comprehensive structuring as unfortunate, our helpers shifted the responsibility from themselves towards the person receiving help, again drawing on the discourse of the 'good' helper, specifically the ideal of autonomy. Our informants explained that this was rendered possible, much because of the organisational shift towards *shared* responsibility. Additionally, this shift was talked about as something that had affected distribution of responsibility between the helpers as well:

> *The last year we have [...] worked together two and two with cases. In the beginning I was against it because I thought it would demand too much time to coordinate [...] We have been close on in a period, made plans together, organised meetings and everything has been cooperative. So when it comes to the long term wear and tear I've noticed that I have been much calmer the last year. Much less sense of the "big" responsibility [...] new experience to me.*[41]

In their talk, our informants could construct a system of shared responsibility as a more trustworthy way of organising help. A sharing of responsibility was pictured as more reliable to the person receiving help. This was talked about in a matter-of-factly way, as helpers that themselves were 'calm' and 'organised' would be able to give better and more effective help. In addition, colleagues sharing responsibility was described as a quality assurance of the job, for the benefit of the person receiving help. This talk provided an opportunity for the helpers

[40] Interview 3 – focus group
[41] Interview 3 – focus group

to share their responsibility openly, without looking like they lacked in competence or courage when performing their work tasks.

At the same time as people with substance abuse problems act in a way that is understood as criminal, they are placed within the healthcare system. This provided our helpers with a paradoxical role in their work of helping, which made balancing their role and responsibilities a challenging task:

> *[...] to have empathy for her, and at the same time feel most empathy for her children. Er, and simultaneously be a watchdog for the system to coordinate her support services. These are pretty difficult things to be in.*[42]

The quotation above illustrates that the positions of the helper and the controller are challenging to unite. The function of a controller can potentially disturb the alliance and trust that is crucial in helping. This put helpers in a no-win situation (Canam, 2008).

In sum, the two strategies of shifting blame and making claims enabled the helpers to position themselves flexibly within and between discourses. On one hand, the strategy of shifting blame was used by our helpers to negotiate responsibility by shifting blame away from themselves. In addition, the blame-shifting strategy refer to external factors as outside the helpers' control. On the other hand, the strategic use of claim-making happened when our helpers accounted for their current practice. One way the helpers made use of these two strategies that became apparent to us, was that they most often used the strategy of shifting blame when they touched upon topics that were deeply rooted within one of the discourses, while the strategy of making claims became more activated in the transitions between discourses, where commonsensical ideals were less obvious.

[42] Interview 3 – focus group

5 Concluding discussion

Our informants used the discourses of the good helper, caregiving and the healthcare system to organise their talk and understanding of work with people who struggle with substance abuse problems. By placing themselves within these discourses as well as expanding them, the informants mobilised support in favour for their existing practices, while constructing their work as morally justified. Our most central finding was that helpers made use of strategies of shifting blame and making claims to place themselves within the landscape of helping in a way that made them able to maintain their integrity and to illustrate that the work they did was meaningful or good even though the field was displayed as chaotic and complex. In doing this they made place for the work they did and their practices as good. Our informants' flexible positioning within different discourses, and the way they positioned themselves enabled our helpers to preserve their appearance as good helpers as well as moral persons complying with the existing rules and regulations governing the field of handling substance abuse (Jørgensen & Phillips, 2002a).

5.1 Ideological Dilemmas

In our helpers talk there was especially two topics that stood out, namely abstinence and coercion. Our data material was plentiful in examples of different positions, and shifts between these, when our helpers talked about their practices on these two topics. The helpers changed and transcended positions by making use of the strategies described above. Language can demonstrate the existence of diverting discourses within different topics on a field. As described earlier, this is a normal feature of language use and meaning making, and something we would expect to see. Our helpers often seemed to rely on ideologies of care to guide their help and provision of services. The shifting positions our helpers used to describe their work, was used strategically to account for distribution of responsibility, sometimes in contradicting ways. It is common that ideologies of care are multitudinous and dynamic in human services arenas. Burke and Clapp (1997, p. 553) writes that 'the pressures emanating from this dynamic institutional environment may become embedded in the formal and informal rules that dictate what are regarded as appropriate approaches to service delivery'.

As the discourses in our material overlapped and were conflicting at the same time, an interesting finding in our data was that some discourses and aspects of these were richer than others. With richer we mean that our helpers had more linguistic recourses available in favour of certain aspect of a specific topic. Examples of this may be that some cultural views are more common and accepted than others, providing specific wordings and readymade

arguments and explanations which make them more accessible for the user. Partly depending on what discourses they were positioned within, our helpers had variable possibilities and availability to explain richly without getting 'fixed' or making circular argumentations. When people switch back and forth between various, and sometimes contradictory, aspects of a culture's common sense, it is an indication of the presence of an ideological dilemma (Edley, 2001). As the discursive talk constructed ideological dilemmas, new, less evident linguistic resources became available to our helpers, and they also shifted more quickly between different positions in their talk. In the following section, we will elaborate on this looking at our helpers' talk of abstinence and coercion.

5.1.1 The ideal of the autonomous and abstinent 'addict'. In our data, abstinence was often presented as a premise for our helpers' work, as well as it was found to be a functional goal in helping. Our helpers returned to abstinence as a cornerstone in helping with substance abuse problems by strategically drawing on the three discourses. The discourse of the 'good' helper presented abstinence as serviceable, with the argument that abstinence was necessary in order to form a therapeutic alliance and help with underlying causes of substance abuse. The helpers also talked about abstinence as helpful to the person being helped by drawing on the discourse of healthcare. In line with this, abstinence was typically constructed as a key to a healthy life, and upholding abstinence was supposed to increase the quality of a person's life. Further, the consequence that followed lack of abstinence was portrayed as relapses to problematic substance abuse. As mentioned in the literature review, substance abuse is historically regarded as both a social problem because of the problematic behaviour that often comes with it (the moral model) and as a trouble as it is injurious to the person's own health (the illness model) (Morse, 2004). Occasionally, our helpers made use of a social understanding by drawing on the discourse of caregiving, focusing on community, family and shared activities. The illness and the moral models have preserved their standing also today, at least to some degree, as they together provide the foundation to view abstinence as necessary. In our material, abstinence was found to be compatible with some ideals in all three discourses.

At the same time, zero tolerance of substance use was found to be a topic that created conflicts between discursive ideals both between and within the discourses. The ideal of abstinence seemed to disconnect with the practices of the helpers that were dominated by a focus on humanistic values. The discourse of the 'good' helper was frequently drawn upon in the helpers' description of their practices, where a heavy emphasis was placed on individual

variables and the autonomy of the person's receiving help. One way our helpers handled this ideological dilemma was by expanding the discourse of a ‘good’ helper, as seen in section 4.2.2.1 where the helpers’ positions the wishes of the person receiving help in line with the ideal of abstinence (i.e. claiming that everyone wants to be abstinent). Simultaneously, we saw that the discursive talk drawing on empathy and client cooperation constructed abstinence as an unreasonable goal in treatment and in helping, as it conflicted with the helpers’ ideal of being unprejudiced and open-minded, as described in 4.2.1.2.Our helpers were at certain points forced to choose between rivalling ideologies of care. The ideologies of care focusing on the expert’s competence or the safety of a family, were contrasted with the ideology of normalisation connected to the empathic and understanding helper. Simultaneously trying to uphold different ideals, that also were conflicting with practices was portrayed as difficult, and a potential consequence of this could be feelings of guilt and inadequacy on the helper's side. Canam (2008) had similar findings when studying nurses. When the nurses came in situations where they had to perform practices that were not in line with their identity as caring professionals, unable to develop trusting bond with their patients, they got frustrated and dissatisfied with their work.

It was when our helpers moved within this varying discursive talk of abstinence, that they sometimes questioned the goal of abstinence in itself, and drew on alternative available resources of the subject. When elaborating on the discourse of the ‘good’ helper our informants opened up for a helper position that in turn gave the person being helped autonomy. A consequence of this autonomy was a limitation in the helpers’ capacity for making changes, and gave the person with the autonomy power to govern it for both good or ill. This positioning made it possible to assert that the person being helped ought decide for him- or herself whether they wished to continue their use of psychoactive substances. As mentioned earlier, this individual agency was brought to the front in the helpers talk about controlled use and that abstinence not necessarily was a goal for everyone. This perspective can be seen as coherent with thoughts from the harm reduction perspective mentioned in the literature review, and represents an expansion of the existing discourses that appeared in our helpers talk with the active use of the strategies of shifting blame and making claims. In the ideological dilemma between talk of autonomy and talk of expertise, legislation presented itself as an important factor. In addition, talk of legalisation and controlled use was less rich than talk of abstinence, pointing to these concepts as less available to our informants. As seen in section 4, the conversation often died out when talking of changes of legislation and

alternatives to coercion, suggesting that informants had limited discursive resources to draw upon. An ideological dilemma on the topic of abstinence can be said to exist in the discursive talk of our helpers, due to the contrasting ideals and positions made available by the discourses they most often drew upon.

5.1.2 The ideal of the controlling helper. When helpers in our data talked of their practice, they talked of different methods for helping. When it came to use of coercion, they talked of this as a method in various ways. Coercion was described as negative to alliance and as a violation of the integrity of people being submitted to it. At the same time, it was highlighted as a necessity in the work of giving help to people with substance abuse problems, as it was argued that they sometimes were unable to know their own good. Burke and Clapp (1997, p. 553) writes that 'shared beliefs or ideologies of care have substantial influence over the way in which problems are perceived and the types of service technologies used'. Arguments regarding coercion varied depending on what discourses the helpers drew on and how they positioned themselves within ideologies of the field.

The position helpers took up within the discourse of the 'good' helper, where the helper was understanding and unbiased, contrasted the position of the expert helper within the healthcare discourse. In the latter, the positioning of the expert often simultaneously positioned the person getting help as incapable of knowing what was in his or her best interest. The position of the empathic helper on the other hand, suggested that the helper had a responsibility to be sensitive to the thoughts and wishes of the person receiving help, as this information was crucial to allow for in the recovery process (Miller & Rollnick, 2004; Rogers, 1992). This position made use of ideas of a peer principle, a relatively new ideology of care within the field of substance abuse and psychiatry in general, with which use of coercion and constraint is incompatible (Christensen & Gran, 1994). At the same time, our helpers talked about how facilitating inner motivation and being sensitive to the opinions of the person being helped, could be ineffective, exemplified in section 4.2.2.1. We found that our helpers talked of constraint as a 'necessary evil', and in doing this they drew on the discourse of healthcare. This positioning was characterised by descriptions of how people with substance abuse problems lost track of knowing their own good, which made available the expert position. Helpers in this field are imposed to have a controlling function due to the belief of certain methods, but also due to the legislation of illegal substances. This is a complicating factor in the helping work because it conflicts with the humanistic ideal and make alliance and cooperation difficult.

In this field, helping as use of coercion versus helping as facilitation of motivation was a question of which methods were used in helping. Certain times these methods were constructed as completely different, while at other times the methods seemed to be united. In many ways, when helpers accounted for the need of involuntary interventions, they drew upon the discourse of caregiving in a way of expanding, or bridging, the two other discourses. This talk positioned the helper not merely as an expert, but rather as a caring parent. Hence, the helper was given a parental responsibility, which entailed the duty to facilitate motivation and a right to use methods the helper saw fit to achieve his or her mandate. This way, methods of external motivation, including coercion, was accounted for as good and caring. However, in our helpers talk of methods when they defended use of coercion in the work of help-giving, they did not disclaim the importance of inner motivation for making lasting changes in the person receiving help. This brought along an acknowledgement and reproduction of the ideology of a helper who facilitate motivation, but it did not cancel out the defence of coercion when considerations of health and safety was brought up. This accentuated the dilemma of whether control could be help, and highlighted the conflict between the helper's position as the traditional expert and the helper as an understanding equal.

In the ideological dilemma of coercion, our helpers found ways of adapting the current legislation to their practices and methods when accounting for their work. At the same time, they displayed strategies for expanding and uniting different existing discourses of help-giving and ideologies of care in their talk. This work was needed, as the helpers constructed practices of their daily work in many ways. In conclusion, this points to reflections of how and why certain practices are put in place within a field or an institution. This is of outmost importance in care professions because it indicates what help-giving strategies that are possible to initiate based on which alternatives are available to helpers. On a higher level, this displays which alternatives are available in the culture of the workplace and further in the society in general.

5.2 Using the Strategies of Blame and Claim to Negotiate Placement of Guilt, Responsibility and Agency

In addition to using the strategies of shifting blame and making claims in order to expand and account for their work thematically, they also used these strategies to negotiate the overall purpose and meaning of their work. In this section, we draw attention to three points of negotiation, i.e. guilt, responsibility and agency. Helpers normative authority was presented as a recurring theme, both in our material and in the literature research. In the

literature review, the historical understanding of substance abuse problems originated from the moral model, conceptualising people using psychoactive substances as decadent and guilty of immoral behaviour. The truth of this understanding was negotiated by our helpers during the interviews in a specific way. In this field, we have seen that the risk to fail or feel helpless as a helper is highly present. Our findings indicate that the helpers tried to distribute responsibility regarding their work in reasonable ways. Simultaneously, they were implicitly negotiating agency, which is closely linked to responsibility. In addition, agency is considered to be important to both the helper and the person receiving help as to experience meaning and inner locus of control in the work and life in general.

When it came to guilt, this aspect could be seen as normative evaluations of the substance abuse problems. In many ways, the helpers discarded the moral model as a useful way of understanding substance abuse. For example, our helpers negotiated the value of this model by discussing the psychological effects of the linguistic terms employed in the field as inexpedient in their work. An example of this was a deliberation on how people with substance abuse problems are labelled. Here our helpers reflected on how people who misuse psychoactive substances often are called '*addicts*'[43], thereby being descriptively categorised as something they **are** instead of being described with a problem they **have**. By positioning themselves against the moral model, our helpers sidestepped formerly relevant questions of placing guilt. Hence, the negotiation of guilt was halted at an early stage of discussion in the interviews, as all three discourses made it possible to take up positions that evaded a deepening of the topic. The ideals of the discourses alleviated guilt as much for the helpers' sake as the person being helped. Help-giving would be made meaningless by positioning the other person as guilty of something bad and non-deserving of help, thereby eradicating this position as an option. Phrased in another way: when avoiding questions of guilt, our helpers also avoided positions that could have made the work of helping pointless.

When talking about responsibility, our helpers both gave responsibility in some positions and kept responsibility as helpers in others. In this accountability work, we found that our helpers tried to construct responsibility as something separate from guilt. On one hand, guilt was placed by blaming external factors, such as the illness and institutional structural, which our helpers were unable to control. On the other hand, responsibility was constructed as an important factor of lasting motivational change and necessary to give to the person accepting help, linking it closely to negotiations of agency. It is common that

[43] Interview 1 – focus group

ideologies of care are multitudinous and dynamic in human service arenas. When the institutional environment is fragmented and turbulent**,** helpers may be forced to choose between conflicting moral systems. In this way, helpers can adapt to emergent moral systems (Hasenfeld, 1992), or develop strategies for accommodating multiple belief systems (D'Aunno, Sutton, & Price, 1991).

One way to negotiate responsibility was between the helper and the person receiving the help, while another way regarded was between colleagues and other institutions. In other words, this encircles who is responsible for change, improvement and - in the utmost consequence - the lives of people with substance abuse problems. This negotiation can be interpreted as serving mainly two different functions. Firstly, distribution of responsibility away from helpers (i.e. shifting blame) could be understood as a way to protect oneself from being overloaded emotionally and blamed if no improvement occurs. The helpers also used the illness model to exempt people with substance abuse problems from being blamed directely, by explaining substance abuse as a physical and psychological illness. Secondly, negotiation was done by shifting responsibility to the person receiving help, which fosters more agency, possibilities for action and ownership to one's life and problems. The negotiation of responsibility is an art of balance; if the person with substance abuse problems has all the responsibility, the helper is left with neither responsibility *nor* agency. Therefore, *shared* responsibility was found to be a golden solution keeping autonomy and agency with both the helper and the receiver, leaving out the question of blame. In sum, questions of guilt, responsibility and agency was highly relevant in our data as they were aspects of the work our helpers continuously negotiated.

5.3 The use of a discursive understanding of helpers in the field of substance abuse

The conflicting ideals within and between discourses made certain ways of talking unacceptable. For example, a demand of complete autonomy and responsibility from the person receiving help would not be compatible with a 'good' helper, even if these ideals exist within this discourse. That is why accountability work is necessary to balance responsibility by positioning and drawing on different discourses. Helping in light of the discourse of caregiving is somehow balancing the ideals from both the 'good' helper and the expert in the health care discourse. This is particularly seen in the implementation of rules and constraint, as the role of an educator or parent figure would justify imbalance in responsibility and agency in situations where people do not know their own good.

We have seen that high demands in a complicated field could be seen as dilemmas that helpers continuously negotiated. As an example of this, helpers on one hand claimed the importance of normal demands to people with substance abuse problems. On the other hand, the helpers put forwards conflicting utterances blaming the system for unfairly loading this group of people with excessive demands. Ideals of autonomy and integrity put more responsibility on the person receiving help, while the construction of substance abuse as an illness put more responsibility on the helper within an expert role. It is possible to make sensible arguments in favour of both statements, depending on positioning and what strategies one make use of in placing oneself in this position.

The discourses organised our helpers talk by activating the common sense of the culture, descriptions of reality that just 'were there', an implicit knowledge (Edley, 2001). By examining this implicit knowledge, it was possible to differentiate various ideologies of care underpinning our helpers' daily practice. As ideologies of care not necessarily were mutually exclusive, a variation in and between helpers' talk would be thought to be reflective of emphasis of - rather than a total compliance to - a certain ideology of care (Heaney & Burke, 1995). In accentuating one ideology of care, our helpers did not necessarily exclude others, or even aspects of others. We found that our helpers' flexible use of discourses enabled them to expand the existing discourses' narrow ideals, and allow for pragmatic alternations between different helper positions. For example, our helpers tried to attend to the ideal of unconditional regard in the discourse of the 'good' helper, while simultaneously upholding abstinence as a prerequisite for help-giving. As described in more detail above, these positions were immediately incompatible. With strategic use of language however, our helpers managed to talk about how the necessity of a demand for abstinence specifically was useful to fulfil the ideal of the 'good' helper of motivating people and upholding alliances.

Based on which discourses our helpers drew upon, we saw that they talked about the practices as varying with the ideal. This oscillation between different descriptions and positions is an evident sign of the presence of an ideological dilemma (Edley, 2001). The fact that our helpers were torn between different ideologies of helping, was found to point in the direction that an important ideological shift has occurred in the field of handling substance abuse problems. It is our belief, that by shedding light on current challenges in our helpers talk and commonsensical assumptions it is possible to choose serviceable and pragmatic approaches henceforward.

In the interviews, we asked questions related specifically to whether the helper's work included a focus on relationships and network to improve a sense of human belonging in people struggling with substance abuse. However, our informants put forward other topics that seemed more urgent in their practice, still acknowledging the relevance of facilitating belonging in the work of improving quality of life.

5.4 Scientific contribution

Finally, we want to make some remarks on the scientific contribution this thesis provides. The unique opportunity a discursive analysis provides to the field of handling substance abuse problems, is to call attention to some of the discursive strategies and cultural resources helpers use to organise their talk about the work they do. How our helpers oriented towards each other in negotiating talk about practice, could also be seen as an expression of a social desire of consensus within the field. At the same time, by conducting a discourse analysis on interviews with helpers working in the field of handling substance abuse problems, subtleties and ambiguity in the helpers shared linguistic resources appeared. We understand the contradictions in our informants' speech and the taking up of different positions as important interpretations that gives reasons to problematize the ideological dilemmas facing helpers.

In the field of handling substance abuse problems, legislation and guidelines make themselves especially relevant as a part of the discourses. When political influences are intertwined in the discourses of the professional work this way, it is possible to assume that the discourses also are intertwined with research in the field. Hence, the same discourses might be anticipated to affect development of the research and what researchers highlight as important. As noted earlier, policies have been used to substantiate treatment, and vice versa, for example by accentuating abstinence. Because of this interconnection of moral- and the illness model, it is possible to assume that researchers design their research based on the premise that using illegal substances is dangerous, and may therefore be mainly concerned with findings that support this. Knowledge from discourse analysis contribute to highlighting how this might happen. An implication of this knowledge is that one should be careful to conclude that all rights are served the researchers when it comes to 'the truth'. When investigating research findings, it is important to understand the theoretical and discursive underpinnings of the research, in order to apply it adequately in practice. The understanding of how discourses are constructed and how they might affect both research and practices is one of the important conclusions we draw attention to by using discourse analysis.

A relevant afterthought to the thesis, is who these structures of comprehensibility were of service to. This borders on a discussion of power, and relates to who is empowered by the different ways of talking: the helper, the person with a substance abuse problem, the system or people in general. This politics of representation is relevant seen against the ideological dilemmas identified within our data, and is a point of interest that could have been expanded upon further (Edley, 2001). This, however, was not done, as it would have been a task exceeding the scope of the thesis. However, after studying helpers work in the field of substance abuse, we found that our helpers made place for themselves within the discourses of the 'good' helper, caregiving and healthcare by expanding on ideologies of care, and that their strategic talk in effect expanded the existing discourses in a way that made space for the helpers' practices.

References

Alexander, B. K., Beyerstein, B. L., Hadaway, P. F., & Coambs, R. B. (1981). Effect of early and later colony housing on oral ingestion of morphine in rats. *Pharmacology Biochemistry and Behavior, 15*(4), 571-576.

Andreouli, E. (2010). Identity, positioning and self-other relations. *Papers on Social Representations, 19*(1), 14.11-14.13.

Billig, M. (1999). Conversation Analysis and claims of naivety. *Discourse & Society* 10 (4).

Blindheim, M. (1999). 1969 - Fortellinger fra et år. *Rus & Avhengighet, 2*(6), 40-46.

Brook, H., & Stringer, R. (2005). Users, using, used: A beginner's guide to deconstructing drugs discourse. *International Journal of Drug Policy, 16*(5), 316-325.

Burke, A. C., & Clapp, J. D. (1997). Ideology and social work practice in substance abuse settings. *Social Work, 42*(6), 552-562.

Canam, C. J. (2008). The Link Between Nursing Discourses and Nurses' Silence: Implications for a Knowledge-Based Discourse for Nursing Practice. *Advances in Nursing Science, 31*(4), 296-307.

Christensen, B., & Gran, S. (1994). Det frivillige møtet: et håp om forandring. Terapeutisk arbeid med stoffmisbrukere [The voluntary meeting: a hope of change. Therapeutic work with drug addicts]. In S. Reichtel (Ed.), *Psykologi i forandring. Jubileumsbok: Norsk psykologforening 60 år* (pp. 239-250). Oslo: Norsk Psykologforening.

Corman, M. K. (2013). How mothers talk about placement of their child with autism outside the home. *Qualitative health research, 23*(10), 1320-1332.

Crowe, M. (2005). Discourse analysis: towards an understanding of its place in nursing. *Journal of advanced nursing, 51*(1), 55-63.

D'Aunno, T., Sutton, R. I., & Price, R. H. (1991). Isomorphism and external support in conflicting institutional environments: A study of drug abuse treatment units. *Academy of Management Journal, 34*(3), 636-661.

Davies, B., & Harré, R. (1990). Positioning: The discursive production of selves. *Journal for the theory of social behaviour, 20*(1), 43-63.

Edley, N. (2001). Analysing Masculinity: Interpretative Repertoires, Ideological Dilemmas and Subject Positions. In M. Wetherell, S. Taylor, & S. J. Yates (Eds.), *Discourse as Data: A Guide for Analysis* (pp. 189-228). London: Sage.

Edley, N., & Wetherell, M. (1997). Jockeying for position: The construction of masculine identities. *Discourse & society, 8*(2), 203-217.

Edwards, D. and Potter, J. (2001). Discursive psychology. In McHoul, A.W. and Rapley, M. (Eds.), *How to analyse talk in institutional settings: a casebook of methods* (pp.12-24). London: Continuum.

Fekjær, H. O. (2009). *Rus - Bruk, motiver, skader, behandling, forebygging, historie* [Intoxication - Use, motives, damages, treatment, prevention, history] (Vol. 3). Oslo: Gyldendal Akademisk.

Fiorentine, R., Nakashima, J., & Anglin, M. D. (1999). Client engagement in drug treatment. *Journal of substance abuse treatment, 17*(3), 199-206.

Gergen, K. J. (2001). Psychological science in a postmodern context. *American psychologist, 56*(10), 803-813.

Gergen, K. J., & Gergen, M. M. (2008). Social construction and psychological inquiry. *Handbook of constructionist research*, 171-188.

Gravdal, T., & Bjerke, H. A. (2016). En vei ut av kaos [A way out of chaos]. *Tidsskrift for Norsk Psykologforening, 53*(12), 1006-1011.

Harper, D. J. (1995). Discourse analysis and 'mental health'. *Journal of Mental Health, 4*(4), 347-358.

Harré, R., & Langenhove, L. V. (1991). Varieties of positioning. *Journal for the theory of social behaviour, 21*(4), 393-407.

Harré, R., Moghaddam, F. M., Cairnie, T. P., Rothbart, D., & Sabat, S. R. (2009). Recent advances in positioning theory. *Theory & Psychology, 19*(1), 5-31.

Hasenfeld, Y. (1992). Theoretical approaches to human service organizations. *Human services as complex organizations*, 24-44.

Heaney, C. A., & Burke, A. C. (1995). Ideologies of care in community residential services: What do caregivers believe? *Community mental health journal, 31*(5), 449-462.

Helmikstøl, Ø. (2016). -Ikke sett rusavhengige i bur [-Don't put people who abuse substances in jail] . *Tidsskrift for Norsk Psykologforening, 53*(12), 984-985.

Helse- og omsorgstjenesteloven. Lov av 24.juni 2011, nr.30 om kommunale helse- og omsorgstjenester m.m. [The Act on Health and Care Services] https://lovdata.no/dokument/NL/lov/2011-06-24-30

Helsedepartementet. (2004). Rusreformen - pasientrettigheter og endringer i spesialisthelsetjenesteloven (Rundskriv I-8/2004) [The Drug Reform – patient rights and changes in the Act of Specialist Health Services (Directive I-8/2004)]. Oslo: Departementet.

Helsedirektoratet. (2016). Hjelp til deg med rusmiddelproblemer [Help for you with substance abuse problems]. Retrieved 10.03.17 from https://helsenorge.no/helsehjelp/rustiltak

Helsedirektoratet. (2017a). Brukermedvirkning [Client participation]. Retrieved 10.03.17 from https://helsedirektoratet.no/folkehelse/psykisk-helse-og-rus/brukermedvirkning

Helsedirektoratet. (2017b). *Nasjonal faglig retningslinje for behandling og rehabilitering av rusmiddelproblemer og avhengighet* [National Policy Guidelines for the Treatment and Rehabilitation of Substance Abuse Problems and Addiction]. Retrieved 10.03.17 from https://helsedirektoratet.no/Retningslinjer/Behandling%20og%20rehabilitering%20av%20rusmiddelproblemer%20og%20avhengighet.pdf.

Heritage, J. (1997). Conversation analysis and institutional talk: analysing data. In D. Silverman (Ed.), *Qualitative research: Theory, Method and Practice*. London and Thousand Oaks: Sage.

Holstein, J., & Gubrium, J. (2002). Active interviewing. In D. Weinberg (Ed.), *Qualitative research methods* (pp. 112-126). Oxford, United Kingdom: Blackwell.

Holstein, J. A. (1987). Producing gender effects on involuntary mental hospitalization. *Social Problems, 34*(2), 141-155.

Howitt, D. (2010a). Qualitative Interviewing *Introduction to qualitative methods in psychology* (pp. 60-91). Harlow: Pearson Education Limited.

Howitt, D. (2010b). Focus groups *Introduction to qualitative methods in psychology* (pp. 92-113). Harlow: Pearson Education Limited.

Howitt, D. (2010c). Discourse analysis *Introduction to qualitative methods in psychology* (pp. 229-264). Harlow: Pearson Education Limited.

Ibarra, P. R., & Kitsuse, J. I. (1993). Vernacular constituents of moral discourse: An interactionist proposal for the study of social problems. *Reconsidering social constructionism: Debates in social problems theory*, 25-58.

Jellinek, E. M. (1946). Phases in the drinking history of alcoholics. Analysis of a survey conducted by the official organ of Alcoholics Anonymous (Memoirs of the Section of Studies on Alcohol). *Quarterly Journal of Studies on Alcohol, 7*(1), 1-88.

Jørgensen, M. W., & Phillips, L. J. (2002a). Across the approaches *Discourse analysis as theory and method* (pp. 138-174): Sage.

Jørgensen, M. W., & Phillips, L. J. (2002b). Discursive psychology *Discourse analysis as theory and method* (pp. 96-137): Sage.

Jørgensen, M. W., & Phillips, L. J. (2002c). The field of discourse analysis *Discourse analysis as theory and method* (pp. 1-23): Sage.

Lillevold, H. J. (2016). Mellom to stoler [Between two stools]. *Tidsskrift for Norsk Psykologforening, 53*(12), 995-999.

Legemiddelloven. Lov av 4.desember 1993, nr.132 om legemidler m.v. [The Act on Pharmaceutical Medicines] https://lovdata.no/dokument/NL/lov/1992-12-04-132

Meier, P. S., Barrowclough, C., & Donmall, M. C. (2005). The role of the therapeutic alliance in the treatment of substance misuse: a critical review of the literature. *Addiction, 100*(3), 304-316.

Miller, W. R., & Rollnick, S. (2004). Talking oneself into change: motivational interviewing, stages of change, and therapeutic process. *Journal of Cognitive Psychotherapy, 18*(4), 299-308.

Morse, S. J. (2004). Medicine and morals, craving and compulsion. *Substance use & misuse, 39*(3), 437-460.

Moyers, T. B., & Miller, W. R. (2013). Is low therapist empathy toxic? *Psychology of Addictive Behaviors, 27*(3), 878-884.

Mørland, J., & Waal, H. (2016). Behandling av rusproblemer og rusbrukslidelser [Treatment of substance problems and substance use disorders] *Rus og avhengighet* (pp. 77-107). Oslo: Universitetsforlaget.

Norsk Sykepleieforbund (Producer). (2008). Sykepleie - Et selvstendig og allsidig fag [Nursing – An independent and versatile profession] [Brochure]. Retrieved from https://www.nsf.no/Content/135904/Sykepleie%25202008.pdf

Pickard, H., & Pearce, S. (2013). Addiction in context: Philosophical lessons from a personality disorder clinic. *Addiction and self-control*, 165-194.

Potter, J., & Wetherell, M. (1987). *Discourse and social psychology: Beyond attitudes and behavior*. London: Sage Publications.

Potter, J., & Wetherell, M. (2001). Unfolding discourse analysis. *Discourse theory and practice: A reader*, 198-209.

Ravndal, E. (2007). Evaluering av behandlingskollektiver i rusomsorgen: Har de fortsatt en plass i dagens rusbehandling? [Evaluation of treatment communes in handling substance abuse: Do they still have a place in todays substance abuse treatment?] *Tidsskrift for Norsk Psykologforening, 44*(1), 17-21.

Rise, J. (2014). Hva er avhengighet? Et forsøk på en begrepsavklaring [What is addiction? An attempt on a conceptual clarification]. *Psykologisk Tidsskrift, 18*(3), 8-17.

Robins, L. N. (1993). Vietnam veterans' rapid recovery from heroin addiction: a fluke or normal expectation? *Addiction, 88*(8), 1041-1054.

Rogers, C. R. (1992). The Necessary and Sufficient Conditions of Therapeutic Personality Change. *Journal of Consulting and Clinical Psychology, 60*(6), 827-832 (Reprint of an original work published in 1957 in the *Journal of Consulting Psychology*, Vol 1921, pp. 1995-1103).

Ryan, R. M., & Deci, E. L. (2010). Self-Determination Theory and the Role of Basic Psychological Needs in Personality and the Organization of Behavior. I *Handbook of Personality: Theory and Research* (Vol. 3, ss. 654-678). The Guilford Press.

Saarnio, P. (2002). Factors associated with dropping out from outpatient treatment of alcohol-other drug abuse. *Alcoholism Treatment Quarterly, 20*(2), 17-33.

Schøitz, A. (2017). Rus i Norge – politiske og medisinske tilnærminger i historisk lys [Intoxication in Norway – political and medical approaches in a histoircal light]. *Tidsskrift for Velferdsforskning, 20*(1), 4–26. doi:10.18261/issn.2464-3076-2017-01-01

Simpson, D. D., Joe, G. W., Rowan-Szal, G., & Greener, J. (1995). Client engagement and change during drug abuse treatment. *Journal of Substance Abuse, 7*(1), 117-134.

Sosialdepartementet (2002-03). Ot.prp. nr.3 – *Statlig overtagelse av deler av fylkeskommunens ansvar for tiltak for rusmiddelmisbrukere* [Ot.prp. nr.3 - State takeover of parts of county council responsibility for measures for drug addicts].

Sosialtjenesteloven. Lov av 18.desember 2009 om sosiale tjenester i arbeids- og velferdsforvaltningen [The Act on Social Services]. https://lovdata.no/dokument/NL/lov/2009-12-18-131

Taylor, S. (2001). Locating and Conducting Discourse Analytical Research. In M. Wetherell, S. Taylor, & S. J. Yates (Eds.), *Discourse as Data: A Guide for Analysis* (pp. 5-48). London: Sage.

Tessand, H. (2016). Tilhørighet på resept [Beloning on prescription]. *Tidsskrift for Norsk Psykologforening, 53*(12), 1027-1029.

Tirado, F., & Gálvez, A. (2008). Positioning theory and discourse analysis: Some tools for social interaction analysis. *Historical Social Research/Historische Sozialforschung*, 224-251.

Tyrilistiftelsen. (2015). Tyrili Inntaksbrosjyre [Tyrili Admission Brochure]. Retrieved from http://www.tyrili.no/getfile.php/Bilder/PDF-er/Tyrili%20inntaksbrosjyre%20november%202015.pdf.

Weeks, J. R., & Collins, R. J. (1979). Dose and physical dependence as factors in the self-administration of morphine by rats. Psychopharmacology, 65(2), 171-177.

Wetherell, M. (2001). Themes in discourse research: The case of Diana. In M. Wetherell, S. Taylor, & S. J. Yates (Eds.), Discourse theory and practice: A reader (pp. 14-28). London: Sage.

Willig, C. (2013). Introducing qualitative *research in psychology*. Maidenhead, GBR: McGraw-Hill Education.

Wiggins, S., & Potter, J. (2008). Discursive psychology. *The Sage handbook of qualitative research in psychology*, 73-90.

Woldseth, A. W. (2016). Samspillsterapi på rusinstitusjon [Interaction therapy in substance sbuse treatment institutions]. *Tidsskrift for Norsk Psykologforening*, *52*(12), 1012-1017.

Wooffitt, R. (2001). Researching Psychic Practicioners: Conversation Analysis. In M. Wetherell, S. Taylor, & S. J. Yates (Eds.), *Discourse as Data: A Guide for Analysis* (pp. 49-92). London: Sage.

World Health Organisation. (1992). International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10). Geneva: WHO.

Appendix A: Information and consent sheet

Forespørsel om deltakelse i forskningsprosjekt.

Terapeuters erfaringer med behandling av rusavhengighet – perspektiver fra ulike institusjoner

Bakgrunn og formål
Formålet med studien er å lære mer om hvordan **terapeuter** innen rusfeltet tenker om behandling av rusavhengige og hvordan behandlingen foregår på akkurat denne behandlingsenheten. Vi vil utforske terapeuters erfaringer med nettverksarbeid og relasjonell kommunikasjon. Vi ønsker å understreke at prosjektet innebærer samtaler med terapeuter, men som ikke vil omhandle pasientopplysninger. Prosjektet er en hovedoppgave av to studenter på profesjonsstudiet i psykologi ved NTNU som vil gjennomføres på eget initiativ. Utvalget er trukket ut i fra ulike rusbehandlingsinstitusjoner som sier seg villig til å delta i undersøkelsen.

Hva innebærer deltakelse i studien?
Deltakelsen i denne undersøkelsen innebærer å være en del av et gruppeintervju eller individuelt intervju på henholdsvis 1-2 timer og 1 time. Dataene fra innsamlingen vil ha form av lydopptak av intervjuer, samt feltnotater. Spørsmålene vil omhandle praksisen av rusbehandlingen på enheten og refleksjoner som deltakerne gjør seg om omkring dette.

Hva skjer med informasjonen om deg?
Alle personopplysninger vil bli behandlet konfidensielt. Lydopptakene vil bli lagret på en minnepinne uten nettilgang. Lydopptakene vil oppbevares i et låst skap, inne på et avlåst område på psykologisk poliklinikk ved NTNU. Det er kun de to studentene som gjennomfører prosjektet som vil ha tilgang til dette skapet. Opptakene vil bli oppbevart frem til prosjektet avsluttes. Lydopptakene vil transkriberes på en måte som anonymiserer deltakerne. Samtykkeskjemaene vil bli oppbevart separat fra lydopptakene, hos veileder for prosjektet. Deltakerne vil anonymiseres og skal ikke kunne gjenkjennes i publikasjonen. Prosjektet skal etter planen avsluttes 15.10.16. Personopplysninger, lydopptak og feltnotater vil bli slettet/makulert ved avslutningen av prosjektet.

Frivillig deltakelse
Det er frivillig å delta i studien, og du kan når som helst trekke ditt samtykke uten å oppgi noen grunn. Dersom du trekker deg, vil alle opplysninger om deg bli anonymisert. Dersom du ønsker å delta eller har spørsmål til studien, ta kontakt med Marthe Sofie Øhra (95902038) eller Maren Falch Skaret (47643709). Ansvarlig veileder: Tonje Grønning Andersen (73591958). Studien er meldt til Personvernombudet for forskning, NSD - Norsk senter for forskningsdata AS.

Samtykke til deltakelse i studien
Jeg har mottatt informasjon om studien, og er villig til å delta

---

(Signert av prosjektdeltaker, dato)

Appendix B: Approval from NSD

Tonje Grønning Andersen
Psykologisk institutt NTNU

7491 TRONDHEIM

Vår dato: 22.04.2016 Vår ref: 47992 / 3 / HIT Deres dato: Deres ref:

TILBAKEMELDING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 16.03.2016. Meldingen gjelder prosjektet:

47992	*How does the construction of "the drug addict" contribute in creating and limiting possibilities of action for the therapists?*
Behandlingsansvarlig	*NTNU, ved institusjonens øverste leder*
Daglig ansvarlig	*Tonje Grønning Andersen*
Student	*Marthe Sofie Øhra*

Personvernombudet har vurdert prosjektet og finner at behandlingen av personopplysninger er meldepliktig i henhold til personopplysningsloven § 31. Behandlingen tilfredsstiller kravene i personopplysningsloven.

Personvernombudets vurdering forutsetter at prosjektet gjennomføres i tråd med opplysningene gitt i meldeskjemaet, korrespondanse med ombudet, ombudets kommentarer samt personopplysningsloven og helseregisterloven med forskrifter. Behandlingen av personopplysninger kan settes i gang.

Det gjøres oppmerksom på at det skal gis ny melding dersom behandlingen endres i forhold til de opplysninger som ligger til grunn for personvernombudets vurdering. Endringsmeldinger gis via et eget skjema, http://www.nsd.uib.no/personvern/meldeplikt/skjema.html. Det skal også gis melding etter tre år dersom prosjektet fortsatt pågår. Meldinger skal skje skriftlig til ombudet.

Personvernombudet har lagt ut opplysninger om prosjektet i en offentlig database, http://pvo.nsd.no/prosjekt.

Personvernombudet vil ved prosjektets avslutning, 15.10.2016, rette en henvendelse angående status for behandlingen av personopplysninger.

Vennlig hilsen

Kjersti Haugstvedt

Hildur Thorarensen

Kontaktperson: Hildur Thorarensen tlf: 55 58 26 54

Dokumentet er elektronisk produsert og godkjent ved NSDs rutiner for elektronisk godkjenning.

NSD – Norsk senter for forskningsdata AS Harald Hårfagres gate 29 Tel: +47-55 58 21 17 nsd@nsd.no Org.nr. 985 321 884
NSD – Norwegian Centre for Research Data NO-5007 Bergen, NORWAY Faks: +47-55 58 96 50 www.nsd.no

Appendix C: Interview Guide

Introduksjon:
Takk for at dere har sagt ja til å være med på dette intervjuet. Dette er en del av vår hovedoppgave som er en kvalitativ forskningsoppgave om rusavhengighet. Vi har satt av et par timer nå, så ser vi hvor lang tid vi bruker.

Vi er nysgjerrige på hva dere tenker er nyttig, hvordan dere jobber i praksis og hvordan vi kan forstå dette. Gjerne forklar ut fra egne erfaringer dere har gjort dere arbeidet.
Hvis dere har spørsmål kan vi ta det fortløpende.

Bakgrunnsopplysninger:
Antall år i arbeid med rusproblematikk.
Utdanning/yrke

Tema 1: Behandling av rusavhengighet
Kasus og konkret rundt behandling og hvordan de gjør det på akkurat dette stedet.

1. For å få et bedre inntrykk av hvordan rusbehandling foregår, hadde det vært fint om dere kunne gi en beskrivelse av en av de siste personene dere har jobbet med her. Hva skjedde, hvordan opplevde dere løpet?

Spørsmål til kasus: Kan du fortelle om …

a) Hva gjør dere når dere mottar henvisningen? Og videre i intitieringen av behandling?
b) Hvordan avgjør dere hvem behandlingsenheten her skal hjelpe? (Inklusjonskriterier og eksklusjonskriterier?)
c) Hvordan er arbeids- og ansvarsfordelingen i arbeidet?
d) Hva gjør dere for å behandle? Hva består opplegget av? Spesielle teknikker eller fokusområder?
e) Hvordan fremstod personen med rusavhenighet i behandlingen (i starten / underveis / mot slutten)?
f) Hvordan var opplevelsen av denne behandlingen for dere? Tanker, følelser?

2. Hva mener dere er **hensikten** med rusbehandling? Hva har dere fokus på i deres tilbud (rusfrihet/arbeid/motivasjon/nettverk)?
3. Hva vil bli viktig å få til i generelt i behandling?
    a. Hva opplever dere som viktig å få til hos dere?
    b. Spesifikt i dette tilfellet, hva blir viktig å få til med denne pasienten?
4. *Hva er den rusavhengige opptatt av i behandling? (Tema, utfordringer, annet?)*

Tema 2: Nettverk/relasjonell kommuniksjon

5. Fokus på den rusavhengiges relasjoner i behandlingssituasjonen?
6. Hvordan er fokuset deres på nettverksbygging med ruspasientene?
7. Hva preger forholdet mellom rusavhengige og deres nærmeste/nære relasjoner? Hva opplever dere at er strevsomt i disse relasjonene?
    a. Hvordan opprettholder rusavhengige kontakt med sine nære relasjoner?
8. Vi har hørt at rusavhengige personer ofte sliter med å kommunisere. Vi er litt nysgjerrige på det. Hva tenker dere om denne påstanden?

   a. Ser dere noen fellestrekk ved ruspasientens kommunikasjonsferdigheter /strategier?
   b. Hvilke kommunikasjonsvansker forteller ruspasienten om/ kan dere observere?
   c. Hvor mye opplever dere at vansker med å uttrykke seg preger den rusavhengiges evne til å skape/opprettholde sitt nettverk/gode relasjoner?
   d. Hvordan blir dette fokus i behandling?
9. Hvilken betydning har nettverk og relasjoner for den rusavhengige?
   a. Hvordan jobber dere med det?
   b. Hender det at dere jobber for lite med dette? I så fall hva er grunnene til det?
   c. Hva er det som hindrer dere i å jobbe med kommunikasjonsferdigheter og nettverksbygging (, hvis vi ser bort fra tid og penger)? Hva er det som gjør at dette ikke får topprioritet?
10. I en ideell verden hvordan skulle rusomsorg og rusbehandling sett ut?

Tema 3: Terapeutrollen kontrollør vs hjelper

11. Hva er motiverende i arbeidet med rusavhengighet?
12. *Hvordan er det å jobbe som terapeut i arbeidet med rusavhengige?*
   a. *Bygge en-til-enrelasjon (hvordan?) eller nettverk utenfor?*
   b. *Hvis dere skulle jobbet med nettverket, hvordan skulle dere gjort det?*
13. Kan dere nevne hvilke utfordringer dere opplever er spesielt knyttet til behandling av rusavhengighet? Hva mener dere har vært utfordrende i dette tilfellet?
14. Tvang: Hvordan er det for dere som jobber her?
   a. Praktiske detaljer (alarmer, vold, regler)
   b. Hvorfor skjermes folk?
   c. Hvem trenger det?

Tema 4: Samfunnsnivå

15. Hvorfor bruker dere … som betegnelse på gruppen dere jobber med?
   a. Hva er fordelene (eks. juridisk, sosialt, økonomisk, praktisk, kontroll)?
16. (Hva strever personer med rusavhengighet med?)
17. Overlapp mellom psykiske vansker og rusavhengighet?
18. Kriminalitet
   a. Hva er tenker dere rundt at mange av personene dere hjelper ofte også havner på kant med loven?
   b. Hvordan preger dette behandlingen? Er dette et hinder i behandling? EKSEMPEL på en slik opplevd situasjon?
   c. Fengsel?
19. Hvilken konsekvens hadde det hatt for rusbruket å ikke komme i fengsel ved besittelse og bruk? Mer/mindre?
   a. Hva ville vært positivt med legalisering av besittelse og bruk for den rusavhengige?
   b. Hvordan ville legalisering påvirket handlingsmulighetene for de rusavhengige?
   c. Ville det vært lettere å få seg jobb?
   d. Hvordan fungerer fengsel som løsning på rusbruk?
   e. Finnes det alternative løsninger? Hypotetisk?
20. Hvordan hadde disse utfordringene endret seg om det ikke var straffbart å ruse seg?
21. Det er jo behandling i et krysningsfelt av ulike områder, opplever dere noen begrensninger fra omgivelsene rundt når dere jobber med personer med rusavhengighet?

Appendix D: Transcription symbols

The transcription symbols are based on the system of Gail Jefferson. This is a presentation of the symbols used in our transcripts. We will point out that the marking […] means that text is cut and considered to be redundant.

(.)	A short pause in the talk
.hh	The speaker inhale
hh	The speaker exhale
:	Extended sound or letter
()	Indistinct wording
.	Ending tone. Not necessarily the end of a sentence.
,	Indicate continuation of intonation
?	Indicated extending modulation. Not necessarily a question.
under	Underlining of words indicates the speakers' accentuation.
BIG	Big letters indicates talk with loader volume compared to the surrounding talk.
=	Indicated adjacent or adjoining wordings. Wordings from different speakers in immediate temporal proximity.
[text]	Indicates overlapping talk.
*	Squeaking sound.