Troubled families and individualised solutions: an institutional discourse analysis of alcohol and drug treatment practices involving affected others

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Abstract

Research shows that members of the families with patients suffering from alcohol and other drug-related issues (AOD) experience stress and strain. An important question is, what options do AOD treatment have for them when it comes to support? To answer this, we interviewed directors and clinicians from three AOD treatment institutions in Norway. The study revealed that family-oriented practices are gaining ground as a ‘going concern’. However, the relative position of family-orientation in the services, is constrained and shaped by three other going concerns related to: (i) discourse on health and illness, emphasising that addiction is an individual medical and psychological phenomenon, rather than a relational one; (ii) discourse on rights and involvement, emphasising the autonomy of the individual patient and their right to define the format of their own treatment; and (iii) discourse on management, emphasising the relationship between cost and benefit, where family-oriented practices are defined as not being cost-effective. All three discourses are connected to underpin the weight placed on individualised practices. Thus, the findings point to a paradox: there is a growing focus on the needs of children and affected family members, while the possibility of performing integrated work on families is limited.

Keywords: addiction/addictions, family/kinship, health services research, discourse analysis, medicalisation, management/managerialism

Introduction

The aim of this study is to examine what options in alcohol and other drug (AOD) treatment are available to those who are affected indirectly. There is a growing international awareness and concern about the situation of the children and other members of families living with substance-use problems in their everyday life (hereafter referred to as ‘affected family members’ – AFMs) (Battams and Roche 2011). AFMs are exposed to stress and strain as a consequence of impaired family functioning and deteriorating relationships within their families (e.g. Barnard 2007, Orford \textit{et al.} 2005). The issue of ‘harm to others’ is now receiving an increased amount of interest in the field of research and policy, focusing on the adverse effects of addiction and substance-use problems at a societal level (Room \textit{et al.} 2010).
Simultaneously, close relations in families represent an important resource and a central target point for addressing AOD problems. Therapies and interventions that address families, or particular family members, have proven to be effective in reducing drinking and drug-taking issues, entering treatment, bettering family functioning and meeting AFMs' own needs (Copello et al. 2006, O’Farrell and Clements 2012). However, treatment services in this field have been criticised for failing to act on the available evidence and provide support (Orford et al. 2013).

In the social democratic welfare regime setting of Norway (Esping-Andersen 1990), a concern for families and AFMs, and especially children, is highlighted in policy documents. Health professionals are obliged, by law, to assess and attend to the needs of these children (Helsedirektoratet 2010) and the next of kin is entitled to information and involvement in treatment, as long as the patient permits it (Helse- og omsorgsdepartementet 2001). Such involvement is now strongly recommended on a national level (Helsedirektoratet 2015a). An AFM is also entitled to individual rights to treatment in AOD institutions (Helsedirektoratet 2015b). In 2013 cooperation with AFMs was established in approximately 20 per cent of treatment cases, and consultation with the patient, together with family members, was performed in 8 per cent of the cases in outpatient AOD treatment (Osborg Ose and Pettersen 2013).

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

Analytical framework

Foucault used the term ‘conditions of possibility’ to describe how salient discourses, and their interrelatedness and discontinuity, constitute the conditions in a given setting, within which, some social relationships and realities are more likely to emerge than others (Foucault 1981, Miller 2001). In a study of therapeutic environments Miller, following Foucault, noted how members’ creativity is bound by the opportunities and resources available in any particular institutional setting (Miller 2001), and that therapists change the focus of the encounter, in response to the available discursive options (Miller 2001). Certain settings make some opportunities for interventions more available than others and correspondingly, ‘open up different actor positions, and thus also call up different clienthoods’ (Hall et al. 2003: 17). Peoples’ troubles are made into institutionally defined problems (Gubrium and Järvinen 2014). Hacking (1986) uses the terms ‘making up people’ or ‘making up kind’ to describe this process.

In examining institutional talk within the setting of AOD treatment, with regards to family-oriented treatment practices, we will identify discourses at work and how they relate to each other in providing conditions of possibility for both treatment and support. Discourse is here understood as particular ways of understanding the world, and as an integral part of social practice (Fairclough 1992, Holstein and Gubrium 2000).

Hughes (1984) introduced the term, ‘going concern’, as a interactionist way of conceptualising institutions; representing an ongoing commitment to a particular moral order and patterns of concerted activity (Gubrium and Holstein 2000). A going concern is essentially the discourses at work. Instead of defining institutions traditionally, as established clusters of conventions, Hughes emphasises the value of examining the processes in which social values and collective arrangements are made and unmade and how things arise and change. In giving attention to the ‘not yet’s’, the ‘didn’t quite make its’, the ‘not quite respectable’, the ‘unremarked’, and the openly ‘anti’ going on in our society (Hughes 1984: 53), the interactive and
negotiating character of social life can be illuminated. In everyday clinical interaction the going concern of family-oriented practices may be challenged, negotiated and reproduced in relationship to other concerns, drawing from available resources that together constitutes treatment options for the people involved.

Conditions of possibilities are related to a certain ‘order of discourse’ (Foucault 1981). Chouliaraki and Fairclough (1999) elaborate upon this term, as the specifically discursual order of a field, representing the variety of discursive practices that are present in a certain setting, which, in our case, is AOD treatment, and focuses on how they are combined. One aspect of this ordering is dominance: some ways of meaning making (discourses) are dominant or mainstream, others are marginal, oppositional, and alternative (Fairclough 2001), and hence, have relatively different impact upon practice in general. The boundaries between elements (of an order of discourse) could be one of complementarity, of contestation, as well as struggle and contradiction (Fairclough 1992). The boundaries also apply to the different orders of discourse, which are more or less bound, and also adopt discourses from other ‘orders of discourse’ (Chouliaraki and Fairclough 1999: 114–5). In analysing relations between different discourses, we can analyse the relationship between different social practices, and hence going concerns (Chouliaraki and Fairclough 1999).

The multidisciplinary field of AOD treatment has over the years been subjected to shifting boundaries between fields and orders of discourse. The Norwegian Substance Treatment Reform took effect in 2004, transferring the state’s responsibility towards drug users and therapeutic institutions from the field of social care legislation to ordinary health service under health legislation (Nesvåg and Lie 2010, Willersrud and Olsen 2006). ‘Clients’ became ‘patients’ and this shift represented a field transition from social work to health care. In this way, AOD treatment in Norway was rearticulated within the medical order of discourse. Although the field of addiction is broadly recognised as both multifactorial and multidisciplinary (Watson 2014), in the wake of the new legislation and organisation and, in parallel with the increased use of medication-assisted treatment, and a stronger focus on evidence-based practices, going concerns were moving into the field in a medicalised direction (Willersrud and Olsen 2006). This process is aligned to international trends in the field of AOD (Berghmans et al. 2009, Midanik 2008).

Adams (2008) elaborates upon the distinction between a particle and a social paradigm to capture some of the underlying discursive tension in the field of addiction. The particle paradigm, based on a dominant bifocal psychological and medical tradition, represent assumptions that identify human beings as distinct objects with their own boundaries, attributes and potentials, and as the focal point of interest (people-as-particles) in understanding addictive processes (Adams 2008). Whereas in the social paradigm identity is understood as fundamentally social, and the primary focus is human beings in relationships, including their relationship to an addictive substance or process (people-in-relationship). In the social paradigm intimacy is identified as the primary site of the addictive processes and it is where the destructiveness of addictive relationships is most active but it is also the primary site for opportunities for change (Adams 2008). The two paradigms represent different ways of making up people within this institutional setting.

Another distinction that is made in the literature in the wider field of health practices is that between clinician-centred and patient-centred care. Mechanistic biomedical (scientific-bureaucratic) discourses focus on examination and treatment from a clinician-centred perspective, and this discourse is dominant. Phenomenological reasoning, where the perspective is more patient-centred and context-centred, coexists with the former, but more as an underground practice (Mattingly and Fleming 1994, White 2002).
Another central component that is related to current trends is the introduction of the market-oriented governance of welfare institutions, a process that in the Norwegian AOD happened in conjuncture with the Substance Treatment Reform. Mattingly and Fleming (1994) note how individualised medical and mechanistic discourse and the management discourse combine to focus upon control systems and procedures that would reward the easily measurable, in contrast to all those factors that may be viewed as important from other aspects but are more difficult to grasp, count and measure (Mattingly and Fleming 1994). This new organisation of medical practices can be seen in relation to processes of biomedicalisation, a term describing the emergent social forms and practices of a highly and increasingly techno-scientific biomedicine involving managed care system-dominated organisations (Clarke et al. 2003). Fish and Higgs considered that management discourses now quite inappropriately dominate the way that professionals see their practice at a wider field of the health service (Fish and Higgs 2008: loc. 1156), and how metaphors from industry, manufacturing, and training, have become so familiar that they are no longer challenged (Fish and Higgs 2008: loc. 1172).

Methods

In this article we draw on data collected from three AOD treatment institutions in Norway, which are connected to a city centre and offer in patient, outpatient and detoxification treatment. The primary focus of this study was on the practices conducted in outpatient departments. The three institutions represent a variety of traditions in family-oriented practices – from focusing on joint interventions in families to separate interventions for AFMs – and, thus, have different constructs of addiction in families (Selbekk et al. 2015). All three institutions employ staff who are specialists in working with families but also with a variable number of such specialist clinicians.

In-depth interviews were conducted with 18 participants; the director from each institution and 15 of the clinicians who apply family-oriented interventions in outpatient departments were questioned. The clinicians were chosen to provide a comprehensive insight and reflection on these practices. The interviews were conducted by the first author (ASS), either individually (eight interviews), or in small groups of two (two interviews) or three (two interviews) people. The interviewees had different professional backgrounds: the directors were all psychologists (n = 3) and the clinicians were family therapists (n = 8), psychologists (n = 5) or specialists in nursing or social work (n = 2). The number of interviewees was evenly divided between the three institutions. All interviews were conducted in Norwegian, audio-recorded and transcribed verbatim. The participants were allocated pseudonyms and any identifiable details were removed from the interview transcripts. The interview texts were analysed in Norwegian through multiple readings and coded in NVivo 9/10.

The interview situations were seen as specific interactional moments that reflexively document contemporary ways of understanding, experiencing and talking about a certain subject, and how the interviewees talked was intimately tied to the local interactional context of its production (Rapley 2004). Group interviews had the advantage of showing the lines of argument more clearly, where different ways of producing and reproducing the world were challenged more directly. The interviews were analysed as institutional talk, in the sense that they were connected to the core goals and tasks associated with the institutional setting and its specific framework and constrains (Holstein and Gubrium 2000). The analysis process was inspired by elements in Fairclough’s critical discourse analysis (Fairclough 2001) in: (i) identifying which discourses (going concerns) were drawn upon and how they related to each other, and (ii) analysing how they were combined, and their relative impact on treatment practices.
and conditions of possibility (order of discourse). These findings were, in turn, coded and discussed among the authors. Quotations from the interviews that were cited in this article were translated into English and, in some cases, retranslated.

In the analysis, the going concern of families and AFMs was identified as being constrained and shaped by three other going concerns that were related to a discourse on health and illness (a particle – medical and psychological discourse), a discourse on rights and involvement and a discourse on management. All three combined in underpinning the gravitational pull towards individualised practices, and are presented as such in the results section.

Results

*Family-oriented practices: a going concern that didn’t quite make it?*

All the directors, who represented the leadership, highlighted the going concern of AFMs and families, emphasising a relational or social focus in treatment – a focus not only on the individual patient but also on the consequences of addiction and substance-use problems for both children and family members:

We shouldn’t limit ourselves to an individual perspective. If we did, we would be going counter to the current. It is recognised in many parts of the specialist health service that we should address children better than we do today. We should see the relatives. Serious, life-threatening chronic diseases are not individual. (Director)

Addiction is not only something that you have alone in your mind and body, it is also something that is shared. Reducing understanding of the problem to what is purely individual is also known as going counter to the current. Another director expressed the relational perspective even more clearly as a going concern:

The institution has a long tradition of understanding the disease, whereby you look at both the patient and the people surrounding the patient affected by the disease. Sometimes this seems to be the sustainable direction and sometimes this is the health-promoting direction when it comes to disease. (Director)

Offering family-oriented treatment is seen to be a way to increase the number of hypotheses (what should be done) and treatment possibilities. It is also seen as a way to reduce stigma in both families and their networks. Yet they see family-oriented practices as one among several treatment tools:

But it’s not certain … some of it is individual; you can’t find everything in the collective, in the systemic perspective, as was the belief in my day … Well … today I think it is a useful perspective, the intervention part of it. But not in all cases. (Director)

This interviewee referred to a previous time in which there was a tension between those who advocated systemic or relational solutions and those who advocated individualised solutions to problems. Nowadays, both perspectives are, in this quote, seen to be complementary parts of a broader set of possible solutions, and this interviewee observes there is a generally very positive attitude towards including families in treatment. How this complementarity can be carried out within the institutional environment is yet unclear.
The directors emphasise how taking children into consideration has resulted in the family perspective gaining ground as a going concern in the way in which institutions organise their services. One of the directors explained how this ‘new’ situation was a part of a longer negotiation of views and dialogue between the health authorities and the clinical setting:

There have been major discussions between healthcare enterprises and clinical environments on early intervention . . . So we had a long discussion, first we demonstrated that there was evidence for family therapy, and then we showed that there was a group both within psychiatry and within addiction services that suffered from the patient’s illness. This was fairly uphill at the start, but after a bit we managed to succeed so that there is now legislation in this area. (Director)

This quote refer to a change in the law that was effected in 2010, making health professionals responsible for providing children of patients with information and for addressing their needs. One of the directors explained that this is widely recognised in AOD treatment, where we see children more than we used to. The clinicians reported that the children of patients are now more in the forefront of treatment in comparison to in times past. Children of patients have emerged as ‘a kind’, using Hackings terminology; gained growing attention and recognition. The children’s living situation is assessed and their needs are discussed. This change in the law makes the welfare of children paramount.

The situation of adult family members is also emphasised as being important, and their need for service provision either individually or together with their relatives is highlighted in the interviews. In this way we can see how discourses about the social consequences of addiction in families have manifested themselves in the institutional practices in AOD treatment. One of the clinicians was asked what they were treating at the clinic; the answer places AFMs close to the core mission of AOD treatment:

ASS: What do you treat?
Clinician: People with alcohol addiction and people with gambling problems. And relatives of those addicted to alcohol or gambling.

A certain level of consensus with regard to the social consequences of addiction has thus been reached; namely, that a problem exists that needs to be rectified (Miller and Rose 2008) and in this process several new kinds or institutional identities are emerging in the field. However, although institutions are paying more attention to children and are providing services to AFMs, their description of the family perspective in treatment is somewhat variable. One director pointed towards the gap between theory and practice while implementing a family perspective:

There is a considerable gap between asserted theory and theory in practice. Meaning that initially we say that it’s important, but then we only live up to it [the family perspective] to a varying degree. But I do think that the individual perspective is pulled by gravity in practice on the intervention side . . . I think. But I think nearly everyone has experienced working with couples and with an extended family. (Director)

This interviewee used quite a strong metaphor of the force of gravity to explain this gap. This implies a certain order of discourse where individualised practices (and thereby concerns) are dominating relational or family-oriented concerns. The ideal complementarity between the two concerns are not utilised. The discursive environment make some kinds of interventions easier than others. The going concern of AFMS and families can, using Hughes terminology, be
interpreted as a going concern that hasn’t quite made it, or has not yet made it. Other concerns, related to other discourses have a stronger impact on practice in general. Another interviewee said:

The institutions go all out and say they have a family service and that this is an important part of the job we do. But in practice there is nothing in place for us to provide it. On the contrary, there are still ... those factors that really put on the pressure, saying, ‘work differently’. (Clinician)

So, what constitutes this gap and what factors represent the gravitational pull of working differently? We identified three interrelated going concerns and their associated discourses: elaborating upon the weight placed on individualised practices, dominating the order of discourse and then, constraining and shaping family-oriented practices in treatment.

**Discourse on health and illness**

Adams (2008) distinction between a social and a particle paradigm, represent an interpretation and illumination of the underlying tension of the weight placed on individualised practices. The force of gravity corresponds with a particle paradigm emphasising the process in the body and the brain of the individual patient in understanding addictive processes. As mentioned in the introduction, the matrix of AOD treatment in Norway is integrated into the system of specialised health care, with diagnosis based on the *Diagnostic and Statistical Manual of Mental Disorders*:

Based on a strict understanding of disease with a diagnosis for the individual patient, the relatives or children are not there. (Director)

The directors reflected in different ways on the manner in which the Norwegian Substance Treatment Reform, representing the shift from social care legislation to health legislation, has affected their practices. While welcoming the stronger recognition of people with addiction problems, they simultaneously expressed their concerns about the dimensions of motivational and relational working methods in AOD services that could be lost in dealing with the logic of the healthcare system. Among these, according to the directors is a tendency towards shorter in-patient treatment, more medicalisation and higher turnover of patients, making AOD institutions more like somatic health institutions. In specialised health care the default treatment focuses on one person. As one clinician said: ‘When they come to us, it’s the patient who comes’.

In this way, family-oriented practices must be negotiated after individual patients had begun their treatment. One clinician elaborated upon the effects of individual referrals in potentially hindering family involvement:

I think that a lot of the problems we are talking about now come from the fact that it is individuals who are referred, and that family intervention is something you have to negotiate towards once you have started treatment. (Clinician)

This is an interesting statement, suggesting that defining clienthood in terms of ‘relationships-as-client’ (Kurri and Wahlstrom 2003: 849) is something that may be negotiated only after the referral of the individual patient is initiated. In this way, a particle understanding of addiction, with individuals as the focal point of interest, dominates the social understanding of addiction.
with people-in-relations as the primary concern. The clinicians did mention that in certain cases families or couples were referred together but these were infrequent.

Some clinicians strategically advocate family-oriented practices by composing their own welcoming letter inviting the patient to bring someone to their first treatment session, or negotiating with the patient to include AFMs in their treatment trajectories. However, this going concern is not promoted within the order for discourse dominated by a particle way of understanding addiction. Some clinicians suggested that working in a way that represents an alternative to mainstream logic leads to a situation of feeling powerless:

I feel powerless in relation to what it becomes and how it feels, with a view to understanding human problems. From thinking that we can find causes in the system and in society, there is an individual focus there as well ... in the form of diseases and diagnoses and that there are ... that we fight as a profession. Family therapists in the specialist health service run counter to the current. (Clinician)

This quote illustrates clinicians' experiences with a dominant particle discourse; focusing on families and systems and fighting as professionals within a system that is concerned with illness and diagnosis. The conditions for exercising family-oriented interventions are worse than for those who exercise individual consultations. The following dialogue between clinicians A and B illustrates how the going concerns of families and AFMs are handled within this order of discourse:

A: But is the diagnosis system adapted to relational and family thinking? It’s not. It’s individual ... .
ASS: Which diagnoses are used on family members?
B: On relatives it’s ... we don’t have diagnoses for families.
ASS: Family members?
B: Adjustment disorders.
ASS: Adjustment disorders.
B: I know that off by heart. F 43.2. [World Health Organization 1992] You must have a diagnosis.
A: To get help.
B: Otherwise they won’t get help.
ASS: What happens if you have a patient with an alcohol problem?
B: Or it’s a relative who has been entitled to ... ?
ASS: Yes. When you involve more people in the matter, are they then diagnosed?
B: No.
A: There is one patient.
ASS: But once the relatives get [a consultation] alone ...
A: Then there are adjustment disorders.
ASS: Then they [AFMs] need a diagnosis in accordance with the system ... does that make sense?
A: Purely scientifically, they have an adjustment disorder. Everyone understands this is just nonsense.
(Laughter)
B: Meanwhile, there are many who have ... become ill from ... living in such systems. We all do. We take things on. So that ... some fit into [the categories].
A: It is appropriate and necessary to provide a diagnosis, which is why we give one. Not because they have a diagnosis.
This passage illustrates how clinicians working from a family-oriented perspective adjust to the particle discourse, delivering diagnoses because it is necessary. At the same time, they recognise that the experience of living in families with addiction and substance-use problems in many cases may make AFMs ill in a medical and psychological sense and that makes a diagnosis appropriate.

It is also interesting to see how a particle way of understanding addiction shapes the conditions of possibilities for AFMs, according to what they are offered. When constructed as individual patients with their own rights, AFMs fit the terminology of health services and are recognised as a kind in AOD treatment. However, family members in treatment together with the primary patient and without their own referral are not recognised in the same way within the current system. For this, there are good reasons but it results in their situation being attended to in only an arbitrary manner, if at all. As one of the clinicians aptly put it: ‘The vulnerable people in this are those who are not defined as patients’.

By law the next of kin have the right to both information and involvement but this right is dependent on the consent of the patient, and to what degree the clinicians work strategically according to an alternative going concern rather than the dominating one.

In the interview texts there is a division between institutions and clinicians who primarily focus on AFMs individually, and those who aim for a more integrated approach to families. This latter group consist of those who experience the force of gravity of the field and the order of discourse more profoundly as a barrier to their work.

The treatment practices that are applied to the children vary between institutions and between clinicians, from primarily assessing their needs and giving them information about treatment indirectly to integrating children-centred family consultations in a longer treatment trajectory. However, similar individualising trends can be identified in the way in which the clinicians discussed the attention they gave to the children. They noted that while the change in the law with regard to the children of patients allocates more attention to them, this does not necessarily make the clinician see the family or its internal relations more clearly. The children of patients – and not families – have emerged as a kind: ‘You can register that this is a child, and can say that someone else has to talk to the child. But you can continue to focus on Dad’ (Clinician).

This extract highlights the distinction between the children’s perspective and the family perspective and shows how practices differ accordingly. The clinician’s obligation to the individual child can be fulfilled by assessing the child and referring them further in the system, while not having a family perspective in the treatment and still treating the patient individually.

So, the data point to an individualising trend that shapes the way both children and AFMs are attended to. Family-oriented practice that is construed as giving individual attention to children and AFMs is easier than seeing families as kind or seeing relationships as clients. This affects the conditions of possibility for troubled families, giving them a certain amount of individual but not relational options for handling their difficulties.

**Discourse on rights and involvement**

In the interviews another discourse and going concern can be identified that may elaborate on the gravitational pull towards individualised practices, combined with a health and illness discourse but focusing less on the defining problems of addiction than on the autonomy and rights of the individual patient.

The notion of patients’ rights was an important argument for introducing the Substance Treatment Reform in Norway. Part of this right is the right to make decisions on their own treatment. Some clinicians emphasised that the patients alone decided whether they wanted to bring in their relatives and underlined the value of individual consent: ‘These are adults who
decide whether they want their relatives included in the treatment or not; it’s hard to overrule it, really. That’s why there’s the consent (Clinician). Some clinicians were also concerned about the compulsory involvement of family members, which may have hindered some patients from seeking treatment:

Not everyone wants their relatives with them, the patient, that is. But when they do, we try to meet the relatives so that they can be involved. But if everyone had to bring their relatives, I don’t think that many would come here. (Clinician)

Patients who wanted to bring their relatives were welcome to do so. Clinicians told how patients asked permission to bring their relatives as their voice, and for support, with statements such as ‘I’m so nervous about coming alone’, ‘she’s good at talking’ and ‘otherwise I would have pulled out’. However, the way they talk reinforces the individual patient as the core category of AOD treatment. It was acceptable to include AFMs, if that was what the primary patient wanted. The power to define the format of treatment lay with the primary patient. In other words, the status of AFM clienthood depended on the solution determined by the individual patient. One director referred to the slogan: ‘putting the patient in the middle’ which ‘every hospital will agree on’, and noted it carried the potentials to marginalise AFMs. Putting the patient in the middle incorporates an individualised perspective on rights and involvement. Clinicians are bound by the alliance or relationship with their AOD patients. Comments such as ‘it is, after all, the patient we meet first’ and ‘my loyalty lies with the patient’ illustrate this alliance.

Some of the clinicians strategically positioned themselves differently in relation to the patient, in line with a family-oriented concern:

Sometimes it is even more important to help family members and children than the primary patient.

I chose the young person.

They [the patients] are not allowed to decide everything.

Sometimes I can be quite insistent [about getting consent].

In these quotes, two sets of discourses and concerns can be recognised: one on the social consequences of addiction and substance use, along with family-oriented treatment practices, the other concerned with the rights and involvement of the patients, potentially leading in two different directions. Both discourses are highlighted in policy documents, and are seen as important and integrated parts of developmental work in the field (Helsedirektoratet 2012). Similar competing agendas between consumers and careers have been identified in the mental health services (Goodwin and Happell 2006). One of the interviewees highlighted this dilemma thus: ‘By giving patients more rights and opportunities to define the format of their own treatment, many don’t want their families involved because it’s too uncomfortable’ (Director).

The going concern of families and AFMs challenged the institutional identity of the AOD patient. It involved recasting the patient as a part of a larger system, (providing more people with both rights and involvement) and these are both determined by and determine how troubles evolve and diminish. One of the clinicians who provided family involvement in treatment sessions said that the patients who are most resistant to family involvement are those who have a long experience of being a patient and who look upon the idea of including their close
relatives in the therapy setting as a threat. Including relatives also challenges their identity and the complementary positions of clinicians and patients.

However, as noted in the analytical framework, the going concern of patient-centred treatment, based on rights and involvement, is, in many cases, also contested and dominated by the clinician-centred biomedical discourse in the field of health practice (Mattingly and Fleming 1994). There is also common ground and complementarity between discourses on families and AFMs and patient-centred discourses. Both challenged clinician-centred care in that they would emphasise general collaborative practices in treatment involving both patients and AFMs (Madsen 2007).

A central consideration, particularly when involving children, is whether AFMs are best helped in AOD treatment or whether they could perhaps get better support outside it. The interviewees generally had positive attitudes towards any services that would support AFMs. The argument for keeping this concern within AOD treatment is that meeting AFMs affects the attitude of clinicians, whose special knowledge about addiction and substance-use problems may be appreciated among the AFMs, specifically given that these kinds of problems still carry a stigma in many contexts. Another line of argument pertains to the importance of coordinating some services for different family members and how the encounters open up a wider repertoire of solutions for the individual family members and the relations within the family. As one of the clinicians said: ‘Meeting affected family members facilitates couples therapy’. Thus, leaving AFMs outside the scope of AOD treatment practices is potentially a lost opportunity to work in an integrated manner with families.

**Discourse on management**

The third going concern that the data identifies as constraining and shaping family-oriented practice in treatment and elaborating on the gravitational pull towards individualised practices is related to the discourse of management. One clinician reflected on the easy and hard ways to work within the system:

> It is initially so individually focused . . . and I think I could have worked like that. Bringing in [patients] without asking [if they wanted a family member involved], and if they asked if they could bring their spouse, then they were allowed to. You can work like that all the time without taking anyone else in. Then you can register. (Clinician)

The act of registration, and the concern of producing enough consultation, overrides treatment practices with regard to families. Involving family members in consultations and providing therapy sessions for couples or families is generally described as being more intensive, requiring more preparation, coordination and follow ups, being harder to administrate and offering less financial compensation for the efforts involved. Family-oriented practices were described as being paradoxically ‘therapeutically more effective, but organisationally and operationally less effective’. Similar barriers to family work were documented among clinicians in alcohol services in the UK (Lee et al. 2012). This can be aligned with the response of White (2002), who claimed that the protocols and procedures of scientific-bureaucratic rationality, which represent the dominant discursive approach, offer a poor fit for the ambiguities and complexity of these cases, which are more than merely medical in nature.

Some clinicians noted that, when it comes to the coordination of family-oriented practices, working in teams and having more than one therapist in family sessions, to represent different family members, and to be able to discuss processes within the family is needed. In the current situation, this is not prioritised:
But we have talked a lot about it, and it is terribly sad that we don’t get acceptance for the value of working in a team. [As a team] you can see several relations in the family system, you support one another and become better at looking after the children and their relatives. We don’t get acceptance, and we don’t get answers from the health authorities or anyone else. The problem is pushed down to the individual person providing the treatment. (Clinician)

The responsibility for families is transmitted to an individual clinician, and becomes a subordinated concern. This is connected to how effort is rewarded within the institution, and the fact that the role of the co-therapist in family sessions is not financially rewarded:

I wish that it was ... better appreciated in relation to production, having two [therapists] when you need to ... Because now the situation is that I am reluctant to ask a colleague as they have to do it out of goodwill ... I know that this influences me so much that I think less [of working with families]. (Clinician)

Working as a co-therapist means that you are working for free, and clinicians say that this has significantly changed the system. Clinicians within the system can offer family consultations and no one stops them. They are encouraged to do so but in many cases, they do so on their own, with fewer opportunities to take care of the AFMs in a coherent manner. On the contrary, clinicians who work with an AFM individually or in groups do not experience these barriers; providing AFMs with an individualised approach fits the payment structure.

The devaluation of the work performed by co-therapists in family sessions is a concrete example of the going concern of cost and benefit – making individual consultations the most cost-effective way of performing clinical work, which influences the way clinicians think about and perform their work, and, in turn, influence the conditions of possibility for including AFMs in the therapeutic process. In addition, there is a general pressure to deliver cost-effective services by utilising the resources of the welfare state. Fish and Higgs (2008) note how professionals have adopted the language of management using terms like production, working for free and manufacturing, and the material analysed for the present study corroborates this observation. Furthermore, the way cost-effectiveness is defined within the system is based on a particle, and not on a social understanding of addiction as a phenomenon.

Discussion: the force of gravity

Recent research focusing on the needs of children and AFMs in cases of addiction and substance-use problems are challenging the view that treatment is necessarily an activity engaged in only by individuals. Analysing everyday treatment practices through the reflections of directors and clinicians shows how policy is substantiated through going concerns or through institutionalised discursive activities. Discourses emphasising the social consequences of addiction in families are gaining ground as a going concern and are altering policies and practices within the field of addiction and substance-use problems. However, three other going concerns and related discourses affect the conditions of possibility for the people involved, as has been identified in our data.

The data show first how a discourse of health and illness is combined with a discourse on rights and involvement and a discourse on management in underpinning the gravitational pull towards individualised practices in treatment and, in this way, dominate and constrain the attention and support of families and AFMs. (The amount of consultation with families and
AFMs within this discursive setting is generally quite low. The going concern of AFMs and family-oriented practices in day-to-day clinical life can be interpreted as one that hasn’t quite made it, or, as having not yet done so. The going concern is present within the setting, but its potential has not been utilised so far.

The data indicate that these discourses also shape the way in which children and AFMs are attended to, where the easiest option within the discursive environment is to attend to them individually. A more integrated way of working with families by facilitating consultations involving both patient and AFMs is more demanding, and, according to a particle paradigm, not the best way to utilise resources. It appears that intervention services that are organised according to a particle understanding struggle to incorporate social approaches (Adams 2008). This individualising trend – this force of gravity – shapes the practices of treatment and support for both the patient and AFM. By managing AFMs as individuals, policy can be aligned with the current discursive environment. This illustrates the institutional power associated with medical, political and economic approaches to the individual’s troubles, shaping both the frames of reference and the institutional remedies available (Emerson and Messinger 1977). Miller (2001) points out that certain social realities are more likely to emerge under specific institutional circumstances; in this discursive setting, seeing people in a particle way, in terms of their qualities, attributes and potential is the dominant social reality.

It is of ontological significance to address the social mechanisms of addiction in treatment, given the multilayered character of the phenomenon (Selbekk et al. 2015). An individualised approach to addiction is important, but by standing alone it becomes reductionist in defining problems and solutions. Copello and Orford described this challenge as follows:

"Despite the accumulating evidence for the important role of families, on the whole, service delivery remains focused on the individual drinker or drug user, with families and other members of the user’s social network playing a very peripheral role, if any." (Copello and Orford 2002: 1361)

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

A basic question is whether AOD treatment should also provide some services for children and AFMs. The strongest argument for not leaving the care and support for children and AFMs to agencies outside AOD treatment is the interrelatedness of problems within close relations. However, the diversity of patients and their families calls for a set of different solutions, so that a variety of treatment and support options needs to be available, including the options for individually supporting and working with AFMs. Different interventions can be coordinated in ways that can represent better solutions and are sustainable for more people, by incorporating the social paradigm into AOD treatment. However, the present findings indicate that the conditions of possibility for doing so within the current framework are limited.

Our data also show how there have been several developments within the institutional setting, highlighting the adverse effects of addiction in families and the fact that the field is in the process of negotiation. Clinicians working within a social paradigm have the possibilities for strategic interaction while adjusting to the dominant system. Yet they are in an exposed situation, having been delegated responsibility for families but in many cases lacking the necessary institutional support.
What can be done to fulfil the potential of family-oriented practices and make the impact of the relational and social perspectives more applicable? Hardy et al. (2000) emphasised the way discourses can be mobilised as a strategic resource. The present findings call for such a strategic mobilisation, advocating the insights from the social paradigm and balancing the dominant position of the particle paradigm along with a wider bio-political significance of the individualising impulse of biomedicine (Clarke et al. 2003). Adams has provided some suggestions as to how this can be accomplished within the institutional setting of AOD treatment; for example, by focusing on the team culture, maximising the first contact by inviting more people in, performing social assessments, developing reintegration plans involving families and social networks, and facilitating meetings that include families and social networks (Adams 2008: 247–63).

Another line of action is to take a closer look at the systems of referral and cooperation with general practitioners, discussing the potential to refer whole families alongside individuals, or more systematically including family and social issues in the referrals. Furthermore, this study has identified, not only the potential tension but also the common collaborative potential in the intersection between the discourse on rights and involvement, and the discourse on families and AFMs, which still needs to be adequately addressed. Finally, our data call for a revision of the ways in which services are quantified and, more specifically, a re-evaluation of family-oriented interventions. In this way, the order of discourse can be re-articulated in line with the insights from a social paradigm. Thus, interventions that are highly recommended therapeutically would also be sustainable organisationally and operationally.

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