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"A Problem Like This Is Not Owned by an Individual": Affected Family Members Negotiating Positions in Alcohol and Other Drug Treatment

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Abstract

The main aim of this article is to explore the dynamics of encounters between treatment institutions and families dealing with substance use. What kind of possibilities do such encounters offer, and what kind of processes do they facilitate? Based on interviews with 10 families recruited from three alcohol and other drug treatment centers in Norway, positioning theory is used as an analytical tool to address the dynamics and negotiation (1) between service providers and families when it comes to the possibilities for treatment and support and (2) between family members during the course of treatment. Three main storylines are analyzed in interviews with families about encounters with treatment: (1) the medical storyline, (2) storylines of autonomy, and (3) storylines of connection. These storylines positioned affected family members, respectively, as outsiders, as in need of help in their own right, and as part of an affected family. The medical storyline is revealed as being insufficient to deal with the problems associated with substance use—it needs to be extended by family-involving storylines facilitating processes of reintegration and repositioning within families.

Keywords

substance use, family relations, treatment, positioning theory, qualitative research, Norway

The main aim of this article is to explore the dynamics of encounters between alcohol and other drug treatment services and families over the course of substance use and treatment. Encounters with treatment involve certain narratives that assign roles and identities to the parties involved and hence

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are subject to certain conditions when it comes to processes of change (Selbekk & Sagvaag, 2016). This can be related to current discussions about "recovery" and how we discursively define its content and success (Lancaster, Duke, & Ritter, 2015; Recke, 2017). In this article, we focus specifically on the role of affected family members in the narratives of recovery.

Background

The backdrop to the focus of our study is 3-fold. First, research highlights how members of families with substance use problems face severe physical, psychological, and social challenges (Barnard, 2007; Benishek, Kirby, & Dugosh, 2011; Hussaarts, Roozen, Meyers, McCrady, & Van De Wetering, 2012; Orford et al., 2005). Secondly, research indicates that family-oriented services can lead to improvements in patterns of substance use and family functioning, as well as reduce relapse and help affected family members in their own right (e.g., Copello, Templeton, & Velleman, 2006; Finney, Wilbourne, & Moos, 2007). This calls for flexible and effective services that take the interrelated needs of families into account (Selbekk, Sagvaag, & Fauske, 2015). Finally, there are indications that alcohol and other drug services struggle to incorporate family involvement into routine treatment practices and that a focus on individual health tends to dominate practices in the field (Selbekk & Sagvaag, 2016), despite a growing and substantial focus on children and affected family members in policy development in Norway and other countries. Some of these barriers are also related to resistance due to challenging relationships within families and dilemmas about how best to accommodate both patients' legal and moral right to choose their form of treatment and the wishes and needs of affected family members and children (Selbekk & Sagvaag, 2016).

In service delivery, families have been approached in different ways over the years (Klostermann & O'Farrell, 2013; Orford et al., 2005; White & Savage, 2005). The current article, part of a PhD project, is focused on the distinction between two theoretical family models that match practices in the field, focusing on affected family members in their own right and on families as sets of relationships (Selbekk et al., 2015). The current article reports on an empirical investigation into how family members respond to different constructs based on their experiences of being involved in treatment. This focus responds to calls in the literature for studies that focus on the link between constructs and practice (Copello, Velleman, & Templeton, 2005; Lee, 2014).

Analytical Framework

We adopted positioning theory as an analytic framework for developing an improved understanding of family issues. This framework allows a focus both on discourses surrounding family encounters with treatment agencies and on their negotiations within these agency structures. Positioning theory aims to understand the "dynamics of social episodes" (Harré & Langenhove, 1999, p. 5) and can be defined as "the study of the way rights and duties are taken up and laid down, ascribed and appropriated, refused and defended in the fine grain of the encounters of daily lives" (Harré & Moghaddam, 2014, p. 132). Positioning theory sets out to reveal the implicit and explicit patterns of reasoning that emerge in and shape people's interactions with one another (Harré, Moghaddam, Cairnie, & Sabat, 2009). Every social event involves positioning: They involve talking about others and ourselves in certain ways and applying rights and duties to each other in line with existing and available distinct storylines, and this, in turn, is contested by or negotiated in our speech acts.

Positioning theory combines three central elements of social events into a mutually determining triangle: (1) positions, which refer to the moral positioning of the participants and their rights and duties to say certain things; (2) storylines, which are the conversational history and the sequence of things that have already being said; and (3) speech acts, which are acts of talking, with the power to

shape certain aspects of the social world and its composition in terms of illocution (the intention of a speech act) and perlocution (the effect of a speech act) (Harré & Langenhove, 1999, p. 6). In using these analytical terms, positioning theory illuminates the normative frames within which "we live our lives, thinking, feeling, acting, and perceiving against standard of correctness" (Harré et al., 2009, p. 9).

Available storylines represent constraints and opportunities for action, and access is determined not at the individual level of competence but at the level of "rights and duties related to the local moral order" (Harré et al., 2009, p. 6). Positioning is a process whereby initial positioning (first-order positioning) can be questioned and the speaker can explore alternative repositioning (second-order and third-order positioning; Harré & Langenhove, 1999). Encounters might develop along multiple storylines and support their simultaneous evolution (Harré et al., 2009). Repositioning can be seen as part of a healing process, in other words, as a way of repositioning "who we are" (Harré & Moghaddam, 2014, p. 130). The use of positioning analysis highlights the processes of change and transformation within the context of close relationships by focusing on ways of redistributing the scope and content of rights and duties (Harré et al., 2009).

Positioning theory has been applied at intrapersonal, interpersonal, and intergroup levels to address the emergence and maintenance of conflict and alliances resulting from personal relations and crises (Harré et al., 2009). It has been applied to a wide range of areas within health research including aging (Allen & Wiles, 2013), dementia (Sabat, 2008), gerontology (O'Connor, 2007), psychiatry (Ziółkowska, 2009), and cancer (Williams, Christensen, Rytter, & Musaeus, 2014). Its application has focused on a range of processes including identity formation, caregiving, interpersonal relationships within families, and encounters with service providers.

In this article, we apply positioning theory to alcohol and other drug treatment processes. Harré and Langenhove (1999) describe how institutional positioning occurs when an institution actively classifies people in ways that bring with them expectations of how they should function within that institution. Analyzing these processes is analogous to research on institutional identities and categorization (Gubrium & Holstein, 2001; Hacking, 1986). The positioning of family members during encounters with treatment has potential perlocutionary effects in that these encounters represent possible constraints and openings for positioning and repositioning within families in response to their problems. Accordingly, the present study addressed the following research questions: (1) how are families positioned in encounters with treatment? (2) how are these positions negotiated? and (3) what kind of processes within families do the storylines facilitate?

Method

The data for the present analysis were obtained in interviews with 10 families that included those using substances and their affected family members, where the latter had participated in treatment interventions either alone or together with their substance-using relative. The participants were recruited from three major outpatient clinics in Norway. We sought to explore experiences when affected family members are approached both as a separate group in their own right—individually or in group consultation—or as an integrated family—in couples or family consultations.

Participation in the study was based on an informed consent procedure approved by the Regional Ethics Committee in Western Norway. Each family was invited to a joint interview (involving both the person using substances and the affected family member) and individual interviews with each party. Joint and individual interviews were conducted sequentially in order to access multiple perspectives on encounters with both treatment and interpersonal positioning. Another goal was to explore the distinction between focusing on "me" and on "us" as it relates to experiences regarding integrated versus separate treatment trajectories. According to Reczek (2014, p. 331), this approach provides a "gold standard" for gaining a full view of family dynamics and allows for previous interviews of either type to be used as an informative tool for subsequent interviews. Studies with similar designs have been

Table 1. Overview Over the Participants.

Case	Relationships	Age Range (Children or Other Family Members in Household)	Joint Interview	Individual Interview	Individual Interview (AFM)
1	Allan: husband Astrid: wife (AFM)	30–39 (three underage children)	X	X	X
2	Birk: husband (person using substances/AFM) Bente: wife (person using substances/AFM)	30–39 (two underage children)	X	X	X
3	Christian: husband Caroline: wife (AFM)	60–69 (three adult children)	X	X	X
4	Dag: husband Dina: wife (AFM)	50–59 (adult children)	X		
5	Erik: husband Emma: wife (AFM)	40–49 (one underage child)			X
6	Frank: husband Frida: wife (AFM)	20–29 (no children)	X	X	X
7	Gustav: son Grete: mother (AFM)	50–59 (mother)			X
8	Heidi: mother Hanne: daughter (AFM)	30–39 (daughter)			X
9	Isak: husband Isabell: wife (AFM)	60–69 (one adult son)			X
10	Jon: male partner Janne: female partner (AFM)	20–29 (two underage children)	X	X	X

Note. $N = 20$. Total interviews = 20. AFM = affected family member.

used to describe the roles of couples in parenting (McNeill et al., 2014) and couples where one partner is struggling with depression (Oute & Huniche, 2017).

In this study, the full potential of this approach was accomplished in only 5 of the 10 cases (see Table 1), with 20 interviews being conducted in total. Where there were only individual interviews, they were all with affected family members, as the persons using substances either did not wish to participate or it was not possible for them to do so. This means that the resulting material is more likely to reflect the views and experiences of affected family members. Nonetheless, both voices were represented in half the cases, thereby allowing a degree of insight into the ongoing processes in families during the course of treatment processes.

Table 1 gives an overview of the families involved in this study including the relationships of the participants and their given pseudonyms.

The participants in our study ranged in age from 25 to 65 years old. Alcohol was the main substance of concern in 7 of the 10 families; in the other three cases, illicit drugs were involved. The selection of participants was gendered in the sense that all affected family members were women and all persons using substances were men (except in Case 2). This is a limitation to the analysis, as mental health research suggests that the experiences and expectations of affected family members differ by gender (Oute & Huniche, 2017). Our inability to recruit more men as affected family members may reflect the Norwegian alcohol and other drug treatment population, which contains roughly twice as many men as women (Lilleeng & Bremnes, 2012). Women also seem more willing to engage in services for affected family member than men (Bancroft, Carty, Cunningham-Burley, & Backett-Milburn, 2002).

When it came to interventions, 7 of the 10 families had experienced both joint interventions/therapy and individual treatment and support for the affected family member (either in an outpatient clinic or from low-threshold support outside treatment) in addition to treatment for the substance-using relative. One of the families had only received joint therapy/intervention, and for two families, only the affected family members had received interventions. This meant that, in most cases, involvement with treatment was part of a longer trajectory involving different kinds of interventions and encounters at different points in time. All encounters with treatment and support were relevant to the aim of this study, which was not limited to encounters with the treatment institution from which subjects were recruited. In four of the families, underage children were part of the household; in three families, there were adult children. Their situations were not fully explored in this study, and more research is needed to understand the dynamics of their situations (Itäpuisto, 2014). All interviews were conducted by the first author. The themes introduced in the interviews were experiences with substance use, with treatment, and with family involvement, focusing specifically on the distinction between separate interventions for affected family members and integrated interventions for families.

The analysis involved multiple readings of the verbatim interview transcripts with a relational or interactional epistemological approach to their content. The initial analysis was performed by the first and third authors. Transcripts were first divided roughly into three nodes using NVivo 10: (1) addiction in relationships, (2) encounters with treatment, and (3) experiences with treatment. The analysis started by identifying storylines in accounts of "encounters with treatment." These storylines represented a working hypothesis to understand the "convention that has been followed in the accounts of the episode" (Harré & Moghaddam, 2003, p. 9). The other two nodes were analyzed by identifying processes of positioning and repositioning in families, in which the initial storylines had a facilitating role. Quotations from the interviews use the pseudonyms applied in Table 1, while the interviewer (the first author) is referred to by her first name.

Analysis

Three main storylines were analyzed as they occurred and were negotiated in the interviews about encounters with treatment: (1) the medical storyline, (2) storylines of autonomy (for affected family members), and (3) storylines of connection (in families). These storylines positioned affected family members, respectively, as outsiders, as in need of help in their own right (consumers/patients[1]), and as part of a family system. They facilitated different possibilities and normative frames of positioning and repositioning within families.

The Medical Storyline

The medical storyline is based on the complementary role of patient and doctor/therapist and focuses on the processes within the mind and body of an individual patient. All 10 families were recruited because of their involvement in family-oriented treatment practices. However, affected family members see themselves as positioned as "outsiders" in several of the interviews. In the medical storyline, affected family members have no "character" and lack rights and duties. In saying this, we are not referring to their "actual rights" but to their perceived rights as they are positioned within treatment. The following conversation with Allan (involved with substances) and his wife Astrid (affected family member) is an example of this storyline:

Astrid: In the beginning I felt that if this was a problem, it was between him and the therapist. Remember that I called the therapist and asked about something . . . then he referred to patient confidentiality. And I thought, what is this?

[. . .]

Allan: Because then she became an outsider.

> Astrid: I didn't feel it concerned me in the beginning. It was him [Allan] and him [Allan], precisely in that period when everything was at its worst . . . they [therapists] probably didn't have the capacity [to include family members].

Here, Astrid explained how she felt Allan and the therapist were constructing the problems associated with substance use in a way that had not occurred to her. Astrid had actively contacted the therapist to ask about an aspect of Allan's treatment and had attempted to position herself as an involved party, but this positioning was rejected by the therapist on the grounds of patient confidentiality. In the interview, Allan recognized that Astrid was positioned as an outsider and, in retrospect, had come to realize that this was wrong and that she should have been included. He also made the comment, in another part of the interview, that Astrid should be included in the treatment process, but "not too much," and that he also needed space "to pull himself together," arguing the need for a storyline where he could focus on himself in his own right.

Astrid compared her exclusion from treatment with the situation of living with substance use in the family:

> It came out wrong, I felt excluded for nine years, and in the beginning of treatment I felt the same. It was like I had nothing to do with it, and [yet] we were the ones living together.

For Astrid, not being included in treatment from the start felt like a new setback and wrong. She was initially excluded from the relationship her husband had with alcohol, and now, she was also excluded from the potential process of change occurring in relation to treatment. According to Astrid, she was treated as though she had "nothing to do with it," and her involvement in Allan's life was ignored in treatment. The quotation captured the intrinsically social character of substance use in that they involve intimate relationships in profound ways. This is consistent with the conceptualization of "addiction" as an intensifying relationship to a substance with consequences for the quality of other relationships (Adams, 2008). Astrid was at a stage where she wanted to be included. Elsewhere in the interview, she employed a metaphor to describe this stage: "a boat who hasn't left the shore." In doing so, Astrid emphasized the importance of being involved:

> If he who seeks help has a wife and kids back home who are willing to help, and they have not left, all the cards should be on the table, and they should join in from the start of treatment.

In this quotation, Astrid described indirectly the critical situation in which her family lived and the need to address it at an early stage to avoid an unwanted separation from Allan. This highlights how there is often a thin line between being willing to help and deciding to leave a troubled situation. Astrid expressed an urgent need for her and Allan to work together in improving trust and commitment within the family and described the role of treatment as a means by which to facilitate this process.

Forcing her way into treatment. One of the stories about exclusion was more indirect. Emma (an affected family member who was married to Erik) described how she "forced her way into treatment":

> I have also felt that I have forced my way in, that I have said "now I am sitting here," that I have forced my way into GP appointments.

The position of "forcing your way in" implies a storyline where the affected family member was not initially included. Emma did not accept the position of an outsider and actively repositioned herself as being entitled to be involved. She introduced a storyline where problems were interpreted relationally:

> A problem like this is not owned by an individual [. . .] I can go to my GP and talk about my things. . . . It is okay for a while, but then you start [thinking] "when are our issues going to meet?" He [Erik] goes and talks about his issues, I see things in a different way and tell my GP that it isn't going well, my blood pressure is sky high. At some point in time something has to change, and it won't happen unless the two things meet.
>
> [. . .] The essence of the matter is . . . a treatment system that focuses on the wider context early on. [. . .] It is pretty obvious that the whole family should be involved at an early stage.

Emma was suggesting that service providers should address the wider context of family relations at an early stage. If different members of a family are separately connected to health services, their needs are not interpreted in an interactive way. She was not able to explore how her and her husband's issues converged or diverged. The storyline she proposed was one in which treatment involves the entire family, a storyline of connection. She positioned herself as part of what was going on and also as someone who needed support.

These are several examples from our material of how an affected family member, although included in treatment, described themselves as positioned as "outsiders." This is consistent with research on how alcohol and other drug services struggle to incorporate affected family members' contexts and needs in their service provision (Orford, Velleman, Natera, Templeton, & Copello, 2013). What follows from this are questions regarding the value of medical storylines for families. It very much matters to affected family members that their relatives are treated for their substance use, and, in that respect, the medical storyline is also highly relevant as an important facilitator of treatment processes. However, several of the families participating in this study, when introduced to a medical storyline, repositioned themselves as involved in alternative storylines such as being part of a resource team, being in need of help in their own right, and being a family in need of assistance to improve their relationships. For them, services that restrict treatment to the positions offered by a medical storyline miss out on other potential pathways to change.

Storylines of Autonomy

One of the main themes expressed in the interviews concerned how affected family members experience receiving attention in their own right. Following Baxter (2011), we have chosen to call these storylines of autonomy (for affected family members) because they connect to the way affected family members focus on their own health and well-being and the way they seek out the best ways of coping with the situation (Orford et al., 2005).

Rejecting the position. Caroline (an affected family member) approached treatment together with her husband, Christian, and described the encounter in the following way:

> When we first came here, I was offered membership of a group of affected family members. I reacted with disbelief, since I could not understand that they could offer me an intervention which involved learning to live with a man who had a problem with alcohol. The reason we came was so that he could get help to quit.

Caroline was invited into a position where she, according to her own account, was offered help to simply "live with" the situation and take care of herself. She challenged this position and repositioned herself as someone seeking help for her husband to stop drinking. Her initial expectation for treatment was for them both to work toward him dealing with his substance use and for them not to focus on relationship issues. Caroline subsequently described how her expectations changed and she found it useful to talk to other women living in similar situations:

> It was very useful to be in a group with other women who had experienced similar and worse things [. . .] and [. . .] it was part of a process for me to understand what it is like to have a problem with alcohol.

By focusing on her situation, together with other women in the same situation, she gained a deeper understanding of and support for her current situation. Caroline also reflected on how group meetings posed a dilemma regarding how she positioned herself relative to her husband:

> But I consider it a dilemma, the focus on taking care of yourself. That you should consider the problem with drinking as your husband's. I see from myself and others that this focus makes us distance ourselves from our husbands. You start wondering if you should separate . . . that's why I stayed in the waiting room, because I heard about others who went on with their lives, and set some strict limits like telling their husbands that they cannot come home if they're drunk.

Caroline described how storylines of autonomy—taking care of herself, setting boundaries, and letting go of responsibility for his drinking—potentially distanced her from her husband. She went on to say how, when she attended the affected family member group, it felt like she was in the waiting room. After the group intervention ended, the participants were asked about their hopes for the future. She indicated she wanted couples' therapy; she wanted to deal with their problems relationally (i.e., within a storyline of connection). Accordingly, Christian, involved with substances, joined Caroline, paradoxically as both identified patient and affected family member, in couples therapy.

There are other examples where affected family members reflected in different ways on the dilemma between autonomy and connection. Astrid (an affected family member who was married to Allan) had a strong reaction to a storyline that she was presented with in a group of affected family members because it implied, in her words, that she should "learn to live with the shit." In reaction to this, she engaged with a storyline that said "get out of it together." At a later stage of treatment, she continued to refuse to receive individual consultation:

> There is no benefit to me talking about how I feel without him being present [and] listening. [. . .] For me the help was to be able to talk openly with him present.

She repositioned herself with a storyline of connection in which she and her husband would enter a process of change together.

Frida (an affected family member who was married to Frank) described how she gained from storylines of autonomy in situations where she was recognized in her own right and where she received help in taking care of herself. This occurred at a tricky point when she felt that all the attention was given her husband by both relatives and clinicians. She expressed how good it felt to be recognized as affected:

> Frida: It was good the first time to be part of it, to be allowed to be only me and think about my own needs.
> [. . .]
> Frida: He was so intensely in the middle, and his parents thought of me as foolish and stupid and everything.
> [. . .]
> Frank: People saw me as being sick, but I was not.
> [. . .]
> Frida: They [service providers] felt really sorry for me. That is not so cool either. To be immersed in empathy . . .
> [laughter]
> Frank: I totally agree.
> Frida: In the beginning, it was good to be pitied, but after three, four, or five weeks we have to start [. . .] moving on.

Nevertheless, in this quotation, we see how Frida, after being recognized and having received empathy, felt it was time to move on. She was changing or negotiating the storyline and was ready to focus on her and Frank's connection as a couple.

In these examples, the affected family members were, in different ways, negotiating the position of being in need of help in their own right and of therefore advocating for more connection-based solutions. They were at a stage where they still believed in the possibility of finding a way forward together as a family; they didn't want to focus solely on their own needs but on their relationships.

Being normal in the abnormal. In other cases, the storyline of autonomy was not negotiated. Janne (an affected family member) considered how being seen as an affected family member in one's own right can play a vital role in dealing with challenging circumstances. She had received individual consultation and had participated in joint consultations with Jon (her husband) and emphasized the importance of being empowered as an affected family member:

> That is why I have joined consultations here [on her own], because he [Jon] was telling me that it was my fault that I was down [depressed] and that it was all in my head. The best thing about this place was that when I said it out loud it wasn't strange, they understood me, and it was natural. [. . .] Many other affected family members had similar reaction. I didn't have to feel crazy.

Janne saw Jon as failing to recognize the impact of his substance use on the family, and instead, he blamed her for being depressed and tired. She viewed the staff involved in treatment as having an in-depth knowledge of her life situation and where she was considered normal rather than crazy. She felt staff managed to incorporate her perspectives in treatment and to include her in the process. She felt safe to share her feelings, to talk about fears, and to find a place from which she could deal with difficulties in the family. This echoes Orford's (2013) contention that affected family members often experience positions of powerlessness and that a sense of agency and autonomy can be crucial for their progress. In Janne's process of change, she initially felt that treatment was for her partner rather than her. Later, her fears about the focus being entirely on him did not eventuate because she was able to position herself within a storyline of autonomy.

Life in the waiting room. For other participants, their family situations were more severe and deadlocked and characterized by rapid decreases in closeness and commitment between family members. In some cases, the person using substances rejected the position of being in need of help and did not consider his or her intensifying use of substances as a problem. In these cases, joint treatment efforts were not an option. However, in sessions undertaken solely with affected family members, their own storylines of autonomy could prove relevant and useful. Grete (an affected family member who was the mother of Gustav) explained her expectations of treatment as follows:

> I expect to learn how to take care of myself better. I watch my health worsening. Because of his drug abuse I have to do something with myself. It has affected my health.

Grete's expectations were matched by the treatment she received. She joined a group of affected family members because she knew she had to do something for herself. She did not expect the problems around her to vanish and she needed help to work out her own ways of dealing with them. She used the metaphor of being in the "waiting room" to describe her repositioning process with her son. She wanted to get to know herself in the waiting room, to be conscious of what she was waiting for, and to avoid waiting for appointments that she did not book. Starting from a position of powerlessness, she gradually adopted an empowered position by taking care of herself and by being an agent in her own life. She also worked at repositioning herself, not as a mother to a small child but as a mother to an adult child:

Grete: Shall I treat him as an adult, which is not what I have done in the past? And I don't know how to do it.
Anne: How did your son react when you were treating him as an adult?
Grete: He got annoyed. Because I put my foot down and I didn't want to take his threats anymore. Then he got crazy and threatened to kill himself and said he had nothing to live for. I coped with it in a different way when I was clear, I couldn't help him.

Grete described how, as a mother, she managed to reposition herself in relation to Gustav by treating him like an adult (with the associated rights and duties) instead of a small child. This led her to reject the approaches she had taken previously. For example, she stopped lending him money, which he never paid back. As indicated in the above quotation, Grete coped with Gustav's harsh reaction because she was aware of her positioning. In this way, Grete was pursuing her pathway to recovery while Gustav continued to maintain his intense relationship with drinking. In response to a direct question about her having more involvement in her son's treatment, Grete indicated she would welcome getting involved: "how to get me on the team while not hindering the things I want." Here, she was expressing how an invitation to be involved in her son's treatment could be potentially beneficial.

Hanne (an affected family member and the daughter of Heidi) was in a similar situation to that of Grete. Her mother was choosing not to have contact with treatment services for her substance use. Hanne's expectations regarding support were similar to those of Grete. She emphasized the importance of being repositioned and gaining strength as part of a group dealing with similar situations rather than being alone:

> No, I expected help to put things straight. . . . I think it was good to have contact with people in similar situations, and to be able to understand them. You are not alone in living like this. You are not the only one, as you used to think.

Hanne had no expectations on behalf of anyone other than herself. She sought support in taking care of herself, her husband, and her children, and in drawing boundaries around her relationship with her mother.

Storylines of Connection

In other conversations, families described how, during their initial encounters with treatment, they felt positioned as "two [people] in this [situation]," thereby calling on storylines of connection which recognized that the family system had been harmed and that this needed to be addressed relationally. Eight of the 10 families in the present study had received some kind of joint intervention or consultation, as was the case for Dina (an affected family member who was married to Dag):

Dag: No, it [joint consultation] is natural, and I think we were encouraged to do so.
Dina: You said you wanted me to join, I said that maybe you'd rather go on your own, I think it was maybe once.
[. . .]
Dag: In this period I went to treatment alone once or twice [. . .] It has been very natural for us. I feel that I'm the one who has the problem, but we are two [people] in this [situation].

This couple had found themselves positioned as an affected family and were subsequently offered help and encouraged to engage in treatment. This positioning matched their preferences, which they described as "very natural for us." In this extract, we see the way Dag sought to engage Dina in the

process which put him in the position of deciding whether she could be involved. In his initial reply, he took up the position of responsibility for leading them into this situation, but then, he moved to accepting that they both should naturally be included: "I'm the one who has the problem [positioning himself within a medical storyline] but we are two [people] in this [situation, positioning them both within a storyline of connection]." Frank expressed something similar:

> It wasn't so interesting going alone. [. . .] After I started with that drug [disulfiram] the drinking wasn't an issue, then it was our relationship as a couple that became the problem.

Frank found that using disulfiram removed drinking as an option and enabled him to control his drinking; what he saw he really needed was a strengthened relationship with Frida. This highlighted for him the importance of the medical assistance he was receiving but only as a first step. Treatment in the long run needed to focus on their relationship as a couple.

Christian's description of his drinking further elaborates on the relevance of being positioned as an affected family:

> This is not just about my body and reactions to alcohol, it is as much or in fact more about interaction, conversations, and connections between me and Caroline and our surroundings. [. . .] To perform therapy on me without my wife present could be a total waste of time. It's something in the insights, something in the conversations between us, something about the changes occurring in these meetings; but most of our lives are lived outside these meetings.

Here, Christian, as did Frank and Dag, was following a storyline that extends the medical storyline. Storylines of connection made sense and combined what happened in treatment with their everyday lives outside the meetings. Christian even expressed it as a "waste of time" to be in therapy alone. He argues that therapy should not only focus on processes within the body and its reactions to alcohol but on what happens in relationships. Storylines of connection relate to what Adams (2008, 2016) has identified as "reintegration." He provided a framework for conceptualizing addiction as a social event centered on a person in a relationship with a substance or process. This relationship needs to be seen as fundamentally social in that when the relationship intensifies, other relations in life deteriorate and lose their integrity. Adams introduced the term "reintegration" as an alternative to "recovery" in order to highlight how, when attempting to reduce the strength of an "addictive" relationship, the process of social reorientation and reconnection with affected family members is crucial.

The interviews also contained examples where participants were positioned within storylines of connection, but where such positioning was rejected. Emma reported how her husband, Erik, currently had no contact with treatment services and had sought help elsewhere, while Emma had pursued service appointments either on her own or with her daughter.

A place for open communication. One of the elements highlighted by families participating in joint consultations was the key role played by enhanced communication between couples in their progress. Christian put it in the following way:

> One of the positive changes after we received professional support was that we realized that there was a problem and that we now had a language to talk about it.

For them, the role of alcohol and other drug treatment was to help them find the language with which to describe and consolidate different positionings. Caroline described the intrinsic problems with communication as follows:

> I am not allowed to say anything back home. Our relationship can't take it, or you can't take it, or I can't take that you can't take it. This is very complicated.

The quotation expresses the problems with communication related to substance use. It is highly sensitive and touched upon issues of shame, guilt, and ambivalence. The problems with communication underline the importance of this focus in treatment.

Other couples also highlighted how facilitating a place for open communication played a crucial role in their process of reintegration. Frida put it in the following way: "The point was for us to be able to talk together. We would never accomplish that on our own, the way we were back then." Astrid had a similar experience: "We haven't always been able to talk about the things we should talk about." In this way, they highlighted how open communication enabled them as a couple or as a family to move forward.

Keeping up with each other. In the process of joint treatment, many of the participants described how they were on two quite different "planets". Dina introduced the metaphor of being in a race, with her husband Dag running far ahead of her. She related it to the issue of trust, underlining how the process of rebuilding trust was something that needed to continue a long time after any actual bodily rehabilitation.

Those family members consuming substances sometimes see themselves as recovering well before affected family members. Allan was ready to end relations with treatment services but Astrid, for safety reasons, wanted to continue. In the following extract, Allan reflects on the importance of "keeping up" with each other:

> I had six months of coaching and a lot of other things. It was easy then because my partner was standing on the outside. It was like I was way ahead. And she is still at the same place, maybe a bit further along but not as far ahead as me; she hasn't been through the same process as me. But later it was very important for the family that she caught up with me [. . .] because I had reached a certain point, but she hadn't made it as far. It needs to even up.

The quotation shows how in the process of "evening up" affected family members might need more time than the person using substances. Allan expresses the importance of catching up with each other and that affected family members should be allowed the opportunity to do just that. Working on relationships can serve to bring progress for both parties into alignment (Lee, 2014). Hussaarts, Roozen, Meyers, McCrady, and Van De Wetering (2012) explored ways in which couples interpret addiction issues and found problem areas in family life are often not synchronized. This further underlines the importance of communication and the task of developing a joint understanding of the situation.

Translation. Family members spoke of acquiring an understanding of each other's situation as a key ingredient in achieving a more symmetrical positioning between family members. Allan placed high value on the role treatment played in "translating" for Astrid what he had been through in the process of gaining her trust:

> It [family involvement in treatment] is very important. It felt as though they [family members] never would or could understand you. No matter what I said about never doing it [drinking] again, they wouldn't trust me. But it was necessary to have professional service providers that could explain. At least in the beginning. Astrid was sceptical about everything I said, at least in the beginning. So it was useful to include someone from the outside who she had no reason to doubt.
>
> [. . .]
>
> But the most important thing is for her to trust me again.

This quotation explains how staff—being in a neutral position—can play an important role in educating affected family members, providing an understanding within the family. At the same time, this also illustrates how important the issue of trust is and how it has been jeopardized in the process of substance use. It is interesting to compare this with findings from a study by Kennedy and Horton (2011) who highlighted how family members support clients in many ways during rehabilitation, but also how family members may lack knowledge of clients' experiences and this can hamper progress.

A new man, a new couple. Some of the families had endured long processes spanning several years and had reached a stage where they had reestablished their relationships and were able to look back to describe what went on. Others were still at a stage of ongoing negotiation where outcomes were uncertain. Frank illustrated the former situation:

Frank: First we had to get rid of the old stuff. Forgive each other, understand each other. [. . .] We both walked around being mad at each other in the beginning. I was mad because she left, she was mad because I had been lying. [. . .] So we have to clean those things up.
Frida: One aspect is the talking; another is someone putting you on a rational train of thought. [. . .] Finances, use of time, work, relationships.
Frank: There's nothing we haven't gone through.
Frida: We are like a new couple.
Frank: Yes, I think so. I became a new man afterwards, I think. Or the good old man.
Frida: A lot of the good old man, but also further on the way to a healthy relationship and marriage. It was like that in every aspect of life [laughter].

This quotation shows how a focus on connection can contribute to a process for reintegration. For this couple, working together facilitated the experience of themselves as a new couple—a matured and strengthened unit. The role of the treatment in this repositioning process was to enable a place for communication and the building of trust.

Storylines and Conditions of Possibility

This analysis is not exhaustive of the storylines represented in alcohol and other drug treatment and those relevant for promoting change processes. The main focus is on the experiences of families and their opportunities while engaged in treatment and on how they reposition themselves accordingly in their storylines of access. In general, participant stories highlighted the complexity as well as the ambiguities associated with substance use and the challenges these pose for service provision.

Focusing on storylines and positioning in relation to treatment highlight a range of opportunities for people involved with treatment services (Selbekk & Sagvaag, 2016). This helps reveal the kind of stories treatment institutions favor, and more specifically in our case, it highlights how treatment institutions integrate the needs of affected family members into their storytelling. What follows on from this is the question: Are affected family members even in a position to negotiate their involvement?

The families in this study all participated in treatment, but they also talked of the power of a medical storyline in assigning rights and duties in ways that excluded them or rendered them invisible. This, in turn, narrowed their options in tackling their problems. Their comments echo similar concerns from other studies which question the dominance of individualized perspectives in service provision (e.g., Flynn, 2010; Orford et al., 2013; Selbekk & Sagvaag, 2016). We saw earlier how individualized "medical" storylines tend to position family members as, at best, supernumeraries, and to locate the "real" action as what is going on between patient and therapist/doctor. The findings of this study have highlighted how affected family members are able to negotiate "medical" storylines and reposition themselves as an important part of the process. The results challenge the story of treatment as simply a matter of mending broken bodies or disordered minds.

The storylines of autonomy and connection highlight different ways of involving people both as individual affected family members and relationally as families. Previously, a study by Selbekk, Sagvaag, and Fauske (2015) explored them as two layers of reality faced when dealing with the complexity of substance use. They further suggested that the two storylines of autonomy and connection are useful at different stages of treatment. The present study highlighted how the way services positioned family members did not always align with the way these members positioned themselves. This calls for adopting a sensitive approach toward the needs of both those using substances and affected family members, while, at the same time, keeping a variety of storylines at hand to adjust interventions according to need. The relevance of certain storylines also relates to the current strands of intimacy in family relations (Adams, 2008). When the strands of intimacy remain strong and families are seeking reintegration, an appropriate first choice would be storylines of connection that emphasize direct work on relationships. As Lee (2014) pointed out, working with affected family members separately from the person using substances risks overlooking the opportunity for concurrent growth and healing. Nevertheless, in cases when the strands of intimacy are relatively weak or oppressive, the optimal solution might be to work according to storylines of autonomy by offering individual support to affected family members.

For the participants in this study, the storylines of autonomy and connection were important to them in different ways. Storylines of autonomy can play a vital part in dealing with the powerlessness experienced by affected family members and in restoring the balance of power between family members. This is particularly the case when gender contributes to the dynamics. Storylines of autonomy enable a focus on taking care of oneself, setting boundaries, and holding people responsible for their drinking or drug-taking. They play an important role for affected family members in many challenging contexts. In some circumstances, the substance user can also benefit from alternative positioning (Smith, Meyers, & Austin, 2008). Storylines of autonomy can help affected family members move from feeling abnormal to feeling normal, from seeing themselves as sick to getting better, from being a victim to becoming a fighter, from "being in the waiting room" to "knowing what you are waiting for," and from being alone to identifying with a group of people in similar circumstances. Naylor and Lee (2011) emphasized how sharing a community narrative, in other words sharing your story with others in the same situation, can have positive effects on one's sense of self. This also highlights the extent to which affected family members can feel trapped and deadlocked in their family situations and how difficult it can be to identify useful coping strategies, especially when these involve separation and diminishing contact with loved ones.

Storylines of connection, on the other hand, can play a role in helping people move from the unwanted position of caretaker/care receiver, mother/child, or perpetrator/victim to more symmetrical and balanced relationships where they gain a better understanding of current realities and move on to becoming a new couple. The participants emphasized the need for alcohol and other drug treatment to facilitate a place for open communication and to enable ways of speaking with a shared vocabulary that helps them respond to common difficulties. This could also play a role in promoting mutual and synchronized processes of change.

Conclusion

Affected family members have a critical rather than peripheral role in tackling the challenges associated with substance use (Orford et al., 2013). In many cases, the role of affected family members has been neglected. In our view, alcohol and other drug treatment strategies need to recognize, at an early stage, how responding to problems needs to include both individual and relational processes. The findings in this article challenge views about recovery as an individual process and suggest it, by its very nature, should involve other people. In line with Adams (2016, 2008), by adopting the term "reintegration" instead of "recovery," the focus shifts to a relational perspective on change where the

conversation is about people-in-relationships and about their identity as it is constantly produced and reproduced by social means. Viewing change in terms of reintegration opens up a range of new opportunities for services where relational problems in families are taken into account in the course of treatment and where the needs of families are addressed throughout the different stages.

Storylines offer a way of understanding and responding to problems arising from substance use. Each storyline can help to address important aspects of people's circumstances and to facilitate constructive processes for people with a history of substance use. The article has also highlighted how single storylines can fail to embrace important aspects of complex situations. A variety of storylines, based on the expressed needs of both those who use substances and their families, need to be enabled in order to tailor effective treatment responses.

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Note

1. In the Norwegian treatment system, alcohol and other drug treatment is part of specialist health care, and the people involved in treatment are "patients."

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