Stories from family life: living with problematic substance use and recovery in Norway

Sari Kaarina Lindeman

A thesis submitted for the degree of Professional Doctorate

Departement: Tavistock & Portman NHS Trust

University of Essex

Date of submission for examination March 2022

ACKNOWLEDGEMENTS

This research project would not have been possible without the support of other people. I am grateful for all help, inspiration, and encouragement I have gotten along the way.

First, warm thanks to the participants who shared stories from their lives with me. Without them, this project would not be worth anything.

A large thank to my amazing supervisors. Dr Britt Krause as the main supervisor, has been unique, supported, challenged, and taught and inspired me so much during these years as a doctoral student in Tavistock & Portman clinic. My Norwegian supervisors, Professor Ottar Ness and associate professor Lillian Bruland Selseng have been a tremendous support, with outstanding professionalism and warmth.

Heartfelt thanks to my friends and colleagues Øyvind Kalsås and Lennart Lorås. Without Øyvind, I would never have become a family therapist, and without Lennart, I would never have dreamed of starting the doctoral project. So, you're important to me. Thanks also to my fellow students in Tavistock. Mirjam, Toril, Line, and Heidi - this doctoral group has been the source of support and fun. Former colleagues and leaders from the substance use field have been important, and very special thanks are given to Siv Myking and Hilde Bergesen.

I would also like to thank my colleagues and leaders in my workplace, Western Norway University of Applied Sciences. Thanks to my leaders, Svanaug Fjær and Knut Simonsen, and the entire group in the research project 'The Drug death Related Bereavement and Recovery Study' (in Norwegian, 'The END-project') for support and encouragement. A special thanks to

Kristine Berg Titlestad, who has been a Ph.D. student at the same time as I have worked on my project and has been all the way my support, co-author, and friend.

The doctoral project requires both time and finances. Dear Torstein, Rosa, Iris and Mattias. Thank you so much for enduring and understanding how important this has been to me.

Sari Lindeman

Bergen

March 2022

ABSTRACT

The research project is a small-scale, narrative study aiming to gain insight into problematic substance use (PSU) and PSU recovery processes from a family perspective. Exemplified with ethnographic participant observation and qualitative interviews, the research project shows how family members talk about their lives with PSU at different times and from the perspective of different family positions and roles. Such knowledge is essential for understanding the needs of families and supporting family participation in long-term recovery processes.

The overarching research question is:

How do people living in families with problematic substance use construct their family life through their stories?

The following sub-questions elaborate on the main research question.

1. How do family members talk about their past, present, and future roles while living with problematic substance use?

2. How do family members assemble meaning about the impact of problematic substance use in their roles and relationships in the family?

2. How do family members voice their concerns and fears related to problematic substance use through their stories?

The narrative approach was chosen as the main methodology. The findings, presented as stories, demonstrate how complex and multifaceted family members' stories are. "*A story of love*" and" *A story of family ties*" are about the importance of family life and relations. In contrast, "*A story of fear and preparedness*", and "*A story of protecting other family members from PSU*" are about experienced dangers and efforts to protect the family members. "*A story about the unforgivable*", "*A story of doubt*", and "*A story about tough choices*" provide insight into intolerable dilemmas related to life in families. "*Stories difficult to tell*", "*Directing the stories*", and "*Stories with chaos*" show how stories are told.

This research project suggests that researchers and professionals need more awareness of acute tensions and paradoxes in families.

Contents

1 INTRODUCTION TO THE STUDY

The history of this research project began with a story about Tom's grandmother. I worked on a project where we closely followed people with problematic substance use (PSU). One of them – I'll call him Tom – lived with his 78-year-old grandmother. I have never forgotten all the telephone conversations with her. I saved her number on my phone as "Grandma" to be prepared for her calls. She phoned around ten times every day. Usually, she wanted to know if I had seen Tom or to tell me how worried she was about him. In addition, she often wanted to discuss the inadequacy of treatment options. She thought it was reprehensible that I could not force Tom to treatment. "But Sari, he's a danger to himself", she said repeatedly.

PSU is a complex problem associated with significant health risks and a serious risk of premature death (WHO, 2019). As the story about Tom's grandmother shows, it impacts close others. PSU has overwhelming consequences for both persons using substances and for family members (Orford et al., 2013). Recovery from PSU is often a long-term social process unfolding over time and involving others (Veseth et al., 2019). My experience as a clinician and supervisor is that professionals often find it challenging to meet the needs of these families, and research shows that help services for families with PSU in Norway are scarce (Selbekk & Sagvaag, 2016). I often meet families with PSU in my therapy practice, which has aroused interest in understanding how families live with PSU and recovery. My main wish is to develop more insight into how, in Norway, these themes can be covered in therapeutic conversations with families based on research-based knowledge.

1.1 Aims and research questions

This qualitative research project aims to gain insight into PSU and PSU recovery processes from a family perspective. With ethnographic participants ' observation and qualitative interviews, I exemplify how family members talk about their lives with PSU at different times

and from the perspective of different family positions and roles. By doing so, the research project aims to provide insight into some of the complex experiences of family members and how their experiences are related to their social and cultural context. Such knowledge is essential for better understanding the needs of families living with PSU and supporting family participation in long-term recovery processes. Such knowledge is also important to develop a greater understanding of the implications for the family therapy profession.

Based on the aim of this study, I address the following overarching research question:
How do people living in families with problematic substance use construct their family life through their stories?

The following sub-questions elaborate on the overarching research question:

1. How do family members talk about their past, present, and future roles while living with problematic substance use?
2. How do family members assemble meaning about the impact of problematic substance use in their roles and relationships in the family?
3. How do family members voice their concerns and fears related to problematic substance use through their stories?

1.2 My choice of narrative research approach

My research project is a small-scale, narrative study. The choice of the narrative research approach is often made because the researcher believes that it allows her to see "different and sometimes contradictory layers of meaning, to bring them into useful dialogue which each other and to understand more about individual and social change" (Squire, 2008, p. 5). This quote explains the purpose of my research project to acquire an extensive understanding of how stories of families' life with PSU and recovery are told and how they are linked to local and cultural resources, affecting family members' possibilities to action.

The framework of the research project impacts the language used, and expressions like "assemble meaning", "talking about", and "voice" are used to emphasize that this research is about peoples' stories. The central idea in narrative research is that people create meaning in life by organizing their own experiences as stories (White et al., 1990). These stories impact how people experience themselves, their relations, and their possibilities for action. I describe the narrative approach used in chapter four, but I present central terms for this study already here to guide the reader.

I use the term *story* when I refer to personal stories. I also refer to the themes presented in the analysis as stories, but these stories are my interpretations from themes in participants' interviews. The term *plot* describes the sequence of events that make up a story. Polkinghorne defines a plot as "an organizing theme that signifies the importance of every event as it is related to a larger storyline" (Polkinghorne, 1988, p. 160). A plot can be understood as a way for the storyteller to bring elements in the story together (Ahmed & Rogers, 2017). From a narrative perspective, people's personal stories will always be linked to local resources that culture and social relationships make available for people and that people use to help construct their personal stories (Gubrium & Holstein, 1998; Smith, 2016). In this study, such local and cultural resources will be called *narrative resources*.

1.3 Other clarifications of terms

PSU is usually understood as the harmful use of psychoactive substances (WHO, 2019). In this study, both legal substances, such as alcohol and illegal drugs, are included. *Recovery* in this study is understood as a long-term social process unfolding over time. This process

involves both control of substance use and the processes of building a meaningful daily life and relationships.

The term *family* is understood to include different kinds of family relations, such as parents, children, siblings, partners, and ex-partners. *Family life* is understood as a social process unfolding over time, including the everyday life of the family and everyday experiences of relations in the family, and dimensions like roles, obligations, practices, emotional bonds, and communication.

1.4 Structure of the thesis

This thesis is organized into eight chapters. This chapter is the introduction, which describes the aim of this research and the research questions. In chapter two, I present the Norwegian context for my research. In chapter three, I critically review the relevant literature concerning PSU and family relations. Chapter four consists of methodological considerations for this research project. Chapter five presents the reflections from my fieldwork. Chapter six presents the findings from the narrative analysis of the qualitative interviews. Chapter seven presents the discussion and my implications for practice and future research. Chapter eight consists of the concluding remarks.

2 THE NORWEGIAN CONTEXT

Introduction

In this chapter, I present the context for my research, the Norwegian context for family life and PSU. Both participants and I look at the family life, parenting, and PSU from a Norwegian perspective, and insight into the Norwegian context is therefore important for this research. This chapter is divided into two parts. Part one provides an overview of the context

of Norwegian family life. Part two presents an overview of how challenges related to PSU are understood in the Norwegian context.

2.1. Insight into a Norwegian family

In Norway, the most important relationships are often described as family relationships (Lorås & Ness, 2019). Norwegian families are manifold, and different cultures and orientations are part of the picture. The form and organization of the family are constantly changing, and duties which in the past rested on family members are today taken over by social institutions (Lorås & Ness, 2019). The Norwegian and Nordic contexts are characterized by developed welfare schemes, relatively small class differences, and more democratic relations between women and men and between parents and children, compared to other countries (Gullestad, 1996). The family is essential in caring for people's basic needs for love, security, belonging, care, and social development (Lorås & Ness, 2019; Vedeler, 2011). However, the importance of the family does not imply that family life always is a good thing. The closeness and necessity of family relationships may involve resources, protection, and a safe base for individual development (Vedeler, 2011). On the other hand, the intimacy and importance make family an arena for particular vulnerability to violations and negative experiences (Vedeler, 2011).

Gullestad (1991, p. 85) has formulated hypotheses about central themes in Norwegian culture according to family and everyday life; for example, equality defined as sameness, home-centeredness, desire for peace and quiet, independence, and autonomy. She described Norwegian culture as profound individualism, in which individuals are independent and self-sufficient. At the same time, the idea of equality as sameness is strong in Norway, highly depending on whose point of view one takes. As Gullestad (1986a, p. 46) wrote: “equality as sameness may provide protection and solidarity for the majority, but also isolation and

alienation for the one too different in terms of social class or way of life". Problems with others perceived to be 'too different' is, according to (Gullestad, 2002), often solved with avoidance because open confrontations are seen as a threat to Norwegian values about peace and quiet. Gullestad (1991) paints a picture of Norwegian family life as home centred. The Norwegian home is a framework for values and activities and objectives for an investment of money, time, energy, care, and love. Gullestad (1991, p. 495) explained:

> Each individual or family can carve out a space in which to create wholeness and freedom. From the insiders' point of view, the gap between everyday life and the system is considerable, and in Norway at least, this ideological gap relies heavily on the sharp division between inside and outside.

Gullestad (1986b) argues that in Norwegian society, in which the state increasingly interfered in family matters, people may increasingly need boundaries for their private lives at home.

2.1.1. Norwegian views on parenting

In most countries, the responsibility for children is mainly attributed to the family (Herlofson & Daatland, 2016), but how parenting and a child's position in a family are understood is highly cultural. Gullestad (1996) points out that in modern society, instead of individuals being resources for families, families are becoming resources out of which individuals construct their selves. Parents' task is to support children's ability to find themselves and develop themselves, but only within certain limits. According to Gullestad (1996), parents both think it is wrong if children make choices just to please them, but at the same time, children are not supposed to do something entirely different from what their parents want. Parents' duty of care for their children is anchored in Norwegian law (The Children Act). Legally, adult family generations are not accountable to each other in Norway. Still, the parents' task is to support their children in transitioning to adulthood long after they reach the

age of majority. The limit for what is a child has increased in line with a more specialized working life and a longer education (NOU 2019:20). The roles of parents and children tend to be stable over time; for example, parents usually help their children most of their lives, and the direction of help tends to remain stable until the parents reach the age of 70–75 (Herlofson & Daatland, 2016). In Scandinavia in general, compared to other European countries, more people agree that "parents must do their best for their children even if it comes at the expense of their own well-being" than believed that "children must always love and respect their parents" (Herlofson et al., 2019, p. 37).

In 2017 about 20 000 underage children experienced that their parents divorced (Bufdir, 2019), and the number has remained relatively stable since 2007 (Dommermuth et al., 2015). In Norway, shared care after a break-up is the preferred solution, both ideologically and empirically (Blaasvær et al., 2017). Divorce parents often share custody for their children (Kitterød et al., 2016). Fathers spend more time with their children they do not live with both monthly and during holidays. Nevertheless, a child rarely lives permanently with the father after a break-up (Kitterød, 2005; Kitterød & Lyngstad, 2014). Women still bear the most significant responsibility for care tasks in families (Breimo, 2014; Lotherington et al., 2018).

2.2 Insight into PSU in Norway

Alcohol is Norway's most prevalent addictive substance (Kvaavik & Rossow, 2018). Alcohol use is legal, and alcohol is an important part of many festive occasions and socializing (Bye & Rossow, 2021). However, the use of alcohol also causes health and social problems, both for people with PSU and others (Bye & Rossow, 2021). In Norway, about eight percent of men and three percent of women are registered to have an alcohol use disorder over 12 months. Even though alcohol is the most used and most damaging addictive substance in Norway, it is more tolerated than other substances. Because alcohol is the only legal substance, the other

substances are often organized under the collective term illicit substances. Compared to alcohol, illicit substances are still rarely used. A Norwegian population survey showed that during the past 12 months, circa six per cent of the population had used illegal drugs (Sandøy, 2018), but these are uncertain figures. Although the use of illicit substances in Norway is rare from a European perspective, the rate of fatal drug overdoses has remained high in Norway for several years. In 2018, 286 drug-triggered deaths and 335 alcohol-triggered deaths were registered (Gjersing, 2019).

In discussions about the best way to treat PSU, the dominant understanding has been that PSU occurred because something was wrong with the individual. The use was seen as a symptom of poor morale, social problems, or mental health problems (Fekjær, 2004). In recent years, there has been a clear shift towards a medical perspective (Mørland & Waal, 2019). In Norway, the PSU treatment is based on the patient's rights centered around the individual patient. The national political-professional guidelines are clear about the importance of the involvement of the next of kin in treatment (The Norwegian Directorate of Health, 2017). Nevertheless, family and next of kin involvement rarely occurs as a systematic aspect of treatment (Kalsas et al., 2020).

2.3. Summary

The family plays a central role in the lives of individuals in Norway, and the parents' responsibility for children is statutory. When an individual develops problems such as PSU, it is nevertheless a rarity that the family is included in recovery and treatment processes.

3 LITERATURE REVIEW

Introduction

This chapter is divided into three parts. Part one provides an overview of the literature concerning PSU and family relations and different family positions (parent, sibling, partner, children) and the impact of PSU. Part two provides insight into systemic psychotherapy literature concerning families and PSU. Finally, part three shows the literature concerning central ideas of help and support for families with PSU.

3.1 Presentation of the relevant research literature: substance use and family relations

In this part, I present literature about the impact of PSU on family members. I have carried out a systematic literature search (introduced in 3.1.2.). This systematic literature search, together with the systematic review I am co-author of about drug-related bereavement (Titlestad et al., 2019), has provided me, as I consider it, a good overview of the literature in this field. The literature reviewed in this chapter is not exhaustive but provides an overview of diversity. Presented studies are quality assessed using The CASP Checklists for research (CASP, 2019) (example of the procedure, see Appendix 1).

3.1.1. Impact of PSU on family members

For nearly three decades, Orford and colleagues have conducted several quantitative and qualitative studies of the consequences of PSU for family members (Orford et al., 1992; see also Orford, 2017). Their research activity spans from more extensive quantitative, cross-cultural studies to smaller qualitative studies with specific groups of family members in several countries (Orford et al., 2013; Velleman et al., 2008). Living with a relative's PSU is described as highly stressful (Orford et al., 2010b). Orford (2017, p. 9) claims that although there is a common core to the harm experienced by family members living with PSU, the family harm is also variable. For example, the hardship for family members seems to be most

significant in close family relations, and when a family position is characterized by structural dependence and the number of experienced burdens (Orford, 2017, p.14).

Weisner et al. (2010) show that family members of substance-using patients had significantly more somatic and mental health problems and significantly higher use of health services than other groups. This study had the final sample consisting of 1983 family members of PSU patients and 7336 control family members. The experience that PSU affect both the physical and psychological wellbeing of all family members is documented in several other qualitative and quantitative studies (see f.e. (Barnard, 2005; Casswell et al., 2011; Ferris et al., 2011; Orr et al., 2013; Rodriguez et al., 2014). A recent Islandic doctoral study (Ólafsdóttir et al., 2018; Ólafsdóttir, 2020) reports from a quantitative study that 36% or more of spouses, parents, and adult children had average, serious, or very serious depression, anxiety, and/or stress. This study indicates that it made little difference to the family's wellbeing, which family member had PSU (Ólafsdóttir et al., 2018).

The reviewed literature shows that how an individual's PSU affects family members is well-documented in several quantitative and qualitative studies. I consider that the main focus in this research is how family members experience the impact of PSU and not how they live with these impacts in their everyday family life and relations. The substance-using family member's perspective is rarely included.

3.1.2. PSU and impact on family relations

I and co-authors Kristine Berg-Titlestad, Lennart Lorås, and Terese Bondas have carried out a systematic literature search of published qualitative research focusing on how family members' PSU affects family life (Lindeman et al., 2021). We used a meta-ethnography methodology to analyse search results. Regarding the limitations, readers should be mindful

of the aim and the search strategy of this meta-ethnography, which were adopted to get a broad understanding of the phenomena. The method choice ensured rich descriptions of family life and family relationships but misses and partly ignores different traditions, cultures, socioeconomic differences, etc.

A systematic search identified over 24.000 studies, which varied in sample size, represented different countries and described different roles in the families in various stages of life.
We adopted inclusion/exclusion criteria according to the aim to synthesize knowledge of studies with detailed descriptions of family life and family relationships with PSU. We included all family members, also the substance-using family member. The inclusion criteria were: family, next of kin, parent, child, sibling, and spouse (population); substance use (the phenomena of interest); family life (the purpose of the study or evaluation); and qualitative research (type of research). The studies primarily focusing on the impact of PSU on individual family members' lives and coping without descriptions of family life were excluded (for details of the search, see Appendix 2).

In the following, I summarise the results from the meta-ethnography.

An unknown invisible intrusion

The final sample comprised 15 articles (Arcidiacono et al., 2009; Church et al., 2018; Fereidouni et al., 2015; Fotopoulou & Parkes, 2017; Hodges & Copello, 2015; McCann et al., 2019; Moriarty et al., 2011; Näsman & Alexanderson, 2017; Ólafsdóttir et al., 2020; Reis et al., 2017; Tamutiene & Laslett, 2017; Tamutienė & Jogaitė, 2019; Tinnfält et al., 2018; Weimand et al., 2020; Werner & Malterud, 2016). Appendix 3 shows that most themes are presented in all included articles.

In this study, we chose the overarching metaphor, *An unknown invisible intrusion*, because we wanted to express the range and severity of the consequences PSU had for family dynamics and relations (for more descriptions, see Lindeman et al., 2021). The study described how families tried to adapt to life with PSU. PSU seemed to have been a longstanding problem before family members understood it, and the initial thought for families often was that the problem could be solved without outside help (Arcidiacono et al., 2009; Church et al., 2018; Werner & Malterud, 2016). However, the escalation of the crisis forced families to relate to it, and the time following was described as a long-lasting 'rollercoaster' between hope and mistrust. As we understood the results, the families' understanding of the problem changes with time, often involving re-evaluating their resources for helping their family members. Yet, family members tried to maintain a family life that was as normal as possible (Lindeman et al., 2021). Our understanding is that the family members applied what appeared to them to be the best strategy accessible at any actual moment.

One of the findings in this meta-ethnography was that families experiencing PSU often were invisible to their social environment and felt lonely. There was limited access to help, partially because PSU was difficult for professionals to discover and partly because PSU was perceived as a family matter to a certain extent. Across the different countries represented in the articles, many family members felt shame and blame for being closely related to a person with PSU and isolated themselves from social relationships outside the family. Family members sought help late in the process and primarily for those who had PSU and not for themselves (Lindeman et al., 2021).

3.1.3 Family roles and positions and impact of PSU

In this part, I present research that describes the impact of a family member's PSU on different family roles and positions. I refer both to the literature included in earlier presented meta-ethnography (Lindeman et al., 2021) and to other literature I consider as relevant.

Parents

Keeping in mind parents' legal responsibility for their children and that PSU often starts in adolescence or young adulthood (Cadigan et al., 2019), it involves parents deeply. The studies about parents of children with PSU of all ages more often present mothers' perspectives than fathers (Barnard, 2006; Choate, 2015; Ervik et al., 2019; Lindeman et al., 2021; Usher et al., 2007). Parents often feel shame and guilt when they experience their children's wrongdoings (Scarnier et al., 2009). Norwegian studies of bereaved parents after drug death (Titlestad et al., 2019; Titlestad et al., 2020; Titlestad et al., 2021) described how shame and guilt for failing as a parent characterized the self-inflicted stigma which parents felt: "In the process of self-examination, several of the parents felt that they had failed because they had not been able to protect their child or prevent their death" (Titlestad et al., 2020, p.160). While other parents experienced their child becoming independent, these parents reported that their child's need for support intensified.

Siblings

The siblings' situation when brother or sister has illness or problems is often forgotten, both in research and social and health care practices (Schmid et al., 2009; Smith-Genthôs et al., 2017). However, research, including siblings' perspectives, describes that siblings experience personal and relational impact (Frrokaj & Tsamparli, 2016; Gabriel, 2017; Incerti et al., 2015; McAlpine, 2013; Schultz & Alpaslan, 2016). An important point may be that severe mental illness usually emerges in adolescence, and siblings experience changes in family relationships as part of their family life (Sin et al., 2014). It is reasonable to believe that this

also applies to PSU (Løberg et al., 2022). The needs of siblings with illness or problems often take parents' focus, time, and resources, sometimes across the adult lifespan (Barnard, 2005). Siblings may experience complex emotions like anger, guilt, and fear (Lukens et al., 2004). In addition, mourning of lost relation to sibling and a loss of normal childhood often is part of siblings' experience (Howard et al., 2010). Studies report siblings' efforts to support their brother or sister (Incerti et al., 2015; Løberg et al., 2022; McAlpine, 2013; Schultz & Alpaslan, 2020). A sibling story is often a story of family life (Howard et al., 2010) because siblings witness the negative impacts on other family members, as parents (McAlpine, 2013).

Children

The children are most vulnerable in families with PSU (Lindeman et al., 2021), exposed to the consequences of unstable life situation without being able to escape from the situation on their own (Tamutiene & Laslett, 2017; Tamutienė & Jogaitė, 2019; Werner & Malterud, 2016). A recent Norwegian literature review (Selbekk et al., 2021) reports that children with PSU in families describe chaos and fear in everyday life. They are subjected to violence, abuse, and neglect. Children in included studies were despairing and angry, experiencing shame and stigma, performing care tasks for siblings and parents, and often having poor finances (Selbekk et al., 2021). Selbekk et al. (2021) have included studies with children's retrospective look to childhood as adults. These adults told how parental PSU had affected them in adulthood. They struggled emotionally and had problems with relationships (Selbekk et al., 2021).

Partner

The PSU interrupts the balance of romantic relationships (Birkeland et al., 2018; Weimand et al., 2020). The entire life situation for a partner to a person with PSU can be affected (Birkeland et al., 2018; Dawson et al., 2007; Tamutiene & Laslett, 2017; Weimand et al.,

2020). Selbekk et al. (2018) described that partner coping strategies often were trivializing or thinking that things would pass or improve. Selbekk et al. (2018) report that partners, primarily females, describe a family climate characterized by conflicts and stress. Some of the included studies show a correlation between domestic violence and PSU (Selbekk et al., 2018). Partners' PSU had an impact on parenting (Selbekk et al., 2018). Some mothers stated that they experienced motherhood as a strength, which helped them. These mothers wanted to spare the children and try to maintain an everyday family life. Some manage it and try to keep routines and rituals in the family. Others expressed that they cannot protect their children but become more irritable and tolerate less as parents.

3.1.4. Families with multiple problems

I consider it important to give a short insight into literature of families with multiple problems because, for many families, PSU is a multi-generation theme (Choate, 2015; Jackson et al., 2007; Kalam & Mthembu, 2018; Smith et al., 2018; Takahara et al., 2019; Usher et al., 2007; Wegner et al., 2014). Some family members have a family history of difficult childhood or childhood maltreatment (Zarse et al., 2019). The Adverse Childhood Experience Questionnaire (ACE-Q) has shown the link between adverse childhood experiences and adult mental and physical illnesses (Felitti et al., 1998; Zarse et al., 2019). According to the ACE study, the possibility of PSU increases with childhood abuse and other adverse childhood experiences (ACEs) (Dube et al., 2003; Zarse et al., 2019). Several studies have shown a connection with exposure to multiple forms of childhood adversity with the PSU in adolescence (Cheng & Lo, 2015; Greger et al., 2017; Shin et al., 2010; Wright et al., 2013) and in adulthood (Dube et al., 2003; Dube et al., 2006).

It is important to remember that the pathway from initiation to PSU is complex, influenced by several factors (World Drug Report, 2018). World Drug Report (2018, p. 6) points to the

factors at the personal level (as behavioural and mental health, neurological developments, and gene variations), the micro-level (parental and family functioning, schools, and peer influences), and the macro-level (socioeconomic and physical environment). All these factors are out of individual control and can make people vulnerable to PSU.

The Norwegian scoping review (Hyggen et al., 2018) summarized knowledge of the consequences of growing up in low-income households. It has a particular focus on research relevant to the Norwegian context. On an individual level, the family played a crucial role in defining the lives of individuals in Norway despite the ambitions of the welfare state (Hyggen et al., 2018). Parents' financial situation impacts whether children will later need social assistance, drop out of school, or be unemployed (Hyggen et al., 2018). As Hyggen et al. (2018) summarize the included studies, violence, abuse, and neglect are not poverty problems, but children growing up in lower-income families are more at risk of adverse childhood experiences. An interesting point made by authors of the literature review (Hyggen et al., 2018) is that there seems to be less correlation between growing up low-income families and adverse outcomes for the children in Norway than identified in the international research literature. Authors point out that this probably means that much of the overall tax and income policy, together with policies in other fields, such as child and family policy, works relatively well in Norway (Hyggen et al., 2018).

3.1.5 Anticipatory grief

Anticipatory grief (AG) is described in the literature as a natural response to an expected loss (Holley & Mast, 2009). AG is described to affect the life of the person with a terminal illness and the relationships within the family system (Overton & Cottone, 2016). Templeton et al. (2016) and Dyregrov et al. (2020) have connected AG with PSU, and I consider it relevant for my research. Also, Titlestad et al. (2021) explained how parents described an emotional

conflict because they hoped for a drug-free life for their child, but, at the same time, they experienced AG. Lindemann (1994) initially described AG during World War II, then the wives of soldiers rejected their returning husbands after the war. Lindemann's description of AG was based on the assumption that the wives had begun their grief work before the loss as the threat of losing their husbands had made them detach their bonds to their husbands (Lindemann, 1994). In families with PSU, the substance-using family member lives risky life and behaves very differently from the person the family knew earlier. Family members could feel loss, grief, and need for distance (Dyregrov et al., 2020).

3.1.6 Summary reflections on the reviewed literature: PSU and family relations

Based on the reviewed literature, my understanding is that several characteristics associated with PSU make it especially demanding for families. The change which starts in youth continues as a development that may change family life and last for a long time (Lindeman et al., 2021; Orford et al., 2010b). It is a process with an unknown course that can result in recovery or a life-threatening and long-lasting struggle (Nesvåg, 2012). That a family members' PSU affects other family members has been documented persuasively by several researchers, especially from Orford and his research group (1998; 2010b; 2013; 2017). The research method used is most commonly quantitative or qualitative med semi structured interviews analysed with different forms of thematic analysis. The family life with PSU is characterized as a process of changing understanding and continual adaptation which means that family members may have different experiences in different periods of PSU (Lindeman et al., 2021; Maltman et al., 2020). In addition, different family positions (as children, parent, sibling, partner) influence how PSU in the family is experienced (Løberg et al., 2022; Selbekk et al., 2018).

3.2. Presentation of the relevant research literature: Systemic perspectives on PSU and family

From a systemic perspective, families are understood as a systemic whole (Bateson, 1972; Boscolo et al., 1987). That is, a system of circular communication where there is reciprocity in all relationships, where "everything affects everything", and no single component can be understood except in relation to other components and their interaction (Bateson, 1972). Central in a systemic perspective is recognizing living life as so complex that it cannot be understood as individual parts (Bateson, 1972). Instead, it is more useful to see phenomena in the context of other phenomena occurring simultaneously and affecting and mutually amplifying each other (Bateson, 1972). It is called a circular understanding of relationships (Bateson, 1972).

Carr (2012, p. 52) describes families as:

> …unique social systems insofar as membership is based on combinations of biological, legal, affectional, geographic and historical ties. In contrast to other social systems, entry into family systems is through birth, adoption, fostering or marriage and members can leave only by death.

As this quote shows, many systemic psychotherapy perspectives could be included in this thesis, and the following review is not exhaustive. Systemic psychotherapy has offered both understanding and concrete therapy interventions for families with PSU.

3.2.1. Systemic family perspective on PSU and families

Earlier contributions from systemic psychotherapy have focused on understanding and describing family dynamics in families with PSU (Wegscheider, 1981). PSU is presented to become part of the family dynamic in that the substance-using family member's behaviours have consequences for the other family members (Reiter, 2014; Stanton & Todd, 1982; Wegscheider, 1981). The concept “the addicted family” described how families create unhelpful dynamics, characterised as dysfunctional (Stanton & Todd, 1982). The family addiction cycle was used to explain how the family system was searching for equilibrium and maintaining familiar patterns, which in the short term allowed the family unconsciously to

feel balanced (Stanton & Todd, 1982). Stanton and Todd (1982) claimed that “addicted families” had characteristics distinguished from other dysfunctional family dynamics. These peculiar characteristics included a higher frequency of multigenerational chemical dependency, developing into a family tradition. In the literature, addicted families were associated with pseudo-individuation, in which the substance-using adolescent may be viewed as never having fully achieved separation and individuation from parents (Reiter, 2014; Todd & Selekman, 1990; Weidman, 1983). Families were characterised by a particular focus on death themes and the high presence of premature and unexpected deaths (Coleman & Stanton, 1978). Reiter (2015) described PSU as a family disease. He defined patterns, rules, and characteristics that described these families, like parental inconsistency or denial. Similar contributions were suggested by Steinglass (1987) with the idea of “the alcoholic family”, which described how families in phases developed an alcoholic identity where the whole family was organized around the PSU. Steinglass (1987) claimed that alcoholic families could often engage in short-term problem strategies and were more together in times of ongoing PSU.

The ideas of addicted families can be linked to early, first-order family therapy thinking in which family dynamics could be observed and described from an outside perspective. More recent second-order and post-modern perspective to family therapy includes the therapist's own personal or theoretical bias as part of the observation (Boston, 2000). It avoids language with static descriptions of living people (Andersen, 1991). The more recent literature describes how systemic psychotherapy is used as a therapeutic method for families in which PSU is present. A systematic review from Austin and co-authors (2005) pointed out that while family therapeutic work with these families was initially based on systemic psychotherapy, the term family-based has evolved and expanded with time. Many family-based approaches are influenced by systemic psychotherapy, but also principles from numerous other sources,

including cognitive behavior theory, attachment theory, developmental theory, and socioecological theory (Ozechowski & Liddle, 2002).

3.2.2 Family life cycle theory

PSU in families is described as a long-term process, impacting family members in different roles and positions (Lindeman et al., 2021). Therefore, I consider family life cycle theory as a useful perspective to describe and understand common changes in family life (Carter & McGoldrick, 1989). The "family life cycle" describes stages in family life (Carter & McGoldrick, 1989), from young adults leaving home to families with parents nearing the end of life (see McGoldrick et al., 2015). Each stage is described to include emotional transition processes and tasks essential for developmental progression (Carr, 2012). For example, Leaving Home as the first stage involves a young adult person leaving the family home as a single adult and establishing an adult existence (Carter & McGoldrick, 1989). For this stage, the emotional transition process is accepting emotional and financial responsibility for the self (Carter & McGoldrick, 1989). Carr (2012) stated that problems in developing emotional autonomy from the family of origin may occur at this stage and may find expression in many ways, including depression, substance use, eating disorders such as anorexia and bulimia.

3.2.3 Systemic family perspective on family stress and resilience

This section gives a brief insight into some considerations about families in stress and resilience. I consider it a potentially useful perspective because, as described in the literature reviewed earlier in this chapter, PSU in families is often experienced as stressful, and families have different ways to cope (Orford et al., 2013).

How families experience hardships has engaged many researchers (see Boss, 1987). Family stress can be understood as a process of family change rather than an event or situation that happens in or to a family (Boss et al., 2016; Malia, 2006). Malia (2006, p. 143) pointed out that the family stress process often includes a complex balancing through which the family

system attempts to maintain equilibrium in its family life. This process consists of individual and relational processes, spinning in different time schedules (Malia, 2006). Patterson and co-workers have conducted several longitudinal quantitative studies of families living with chronic illness and disability (see Patterson & Garwick, 1994). Patterson and Garwick (1994) claimed that families' adjustment to chronic stress includes processes for meaning-making on several levels. Level one processes were about the family's definition of chronic illness. For example, it could involve scepticism or denial and search for a cause in others or themselves. The second level of meaning was about the family's identity. Routines for managing the illness tasks, role rearrangements, and the family's old structural organization were no longer enough to meet the new challenges (Patterson, 1988). At the third level of family meaning, the focus was on the family members' orientation toward the family's purpose in life. Patterson and Garwick (1994) pointed out that some families experienced stigmatization and isolation within their communities. Community attitudes and beliefs about chronic illness influenced families' meanings of their situation (Patterson & Garwick, 1994).

Walker (1985) reminded us that there is no "no-stress" baseline family pattern. She claimed that the resources and coping repertoires of individuals, families, and communities would predict more about the family process than will knowledge on the contours of a particular event (Walker, 1985, p. 829). Concept resilience is used to describe dynamic processes in hardship fostering positive adaptation as coping, recovery, and growth (Walsh, 2016). Family resilience can be defined as “the family's capacity to withstand and recover from stressful life challenges, strengthened and resourceful” (Walsh, 2016, p. 315). Walsh (2016, p. 315) notes that “resilience entails more than managing stressful conditions, shouldering a burden, or surviving an ordeal”. It also includes the possibility for personal and relational change and positive growth (Walsh, 2016). Even families who have experienced severe trauma or very troubled relationships have the potential for healing and growth over the life course and

across the generations (Walsh, 2016). An essential part of supporting family resilience is acknowledging that no single model of healthy functioning fits all families or their situations (see Walsh, 2012; Walsh, 2016 for greater detail).

3.2.4 Summary of the literature: Systemic perspectives on PSU and families

In summary, a systemic psychotherapy perspective and an awareness of families as a systemic whole can be helpful perspectives for both understanding and supporting families experiencing PSU and recovery. The descriptions of the addictive family appear outdated, at least in a Norwegian context, and this impression is enhanced using language that appears both defining and conclusive. However, I recognize the descriptions about the family dynamics which these studies contain from my clinical work.

In different ways, the reviewed literature comments on processes that occur over time in families. The primary purpose of family life cycle theory is to describe common changes in family life across the life span and at different stages (Carter & McGoldrick, 1989). Steinglass (1987) described the phases in which families develop an alcoholic identity and how the interaction in the family is organized around PSU. Patterson and Garwick (1994) explained how the family restructures itself to adjust to demanding and stressful situations and how it impacts the family's identity and a sense of purpose in life. Walsh (2016) highlighted how the processes for optimal functioning and the well-being of members might vary over time as challenges emerge and families evolve.

3.3. Presentation of the relevant research literature: central ideas of support for families

Here I provide an overview of the relevant literature concerning central ideas of help and support for families with PSU. As stated in chapter one, one of the aims of this research is to

develop more insight into how to help and support families with PSU and recovery in Norway. I consider that understanding present central ideas about help is therefore important.

3.3.1 Codependency

Codependency is a concept that has been used within the field of PSU since the 1940s to describe dynamics in families with PSU (Bacon et al., 2020; Nordgren et al., 2020). The development of the concept is associated with self-help groups and recovery movements such as Al-Anon, Codependents Anonymous and Adult Children of Alcoholics based on the 12-step and Minnesota models for treatment (Nordgren et al., 2020). There is a strong notion of self-diagnosis or self-identification surrounding codependency, and there is a lot of self-help literature on the topic (Nordgren et al., 2020). The core of the idea is that a codependent person is described as dependent on a substance-using person to feel happiness in a way that causes problems. It is claimed that a codependent person denies these dynamics (Bacon et al., 2020) and is an “enabler” to PSU (Nordgren et al., 2020). An enabler is a person who reinforces a relative's PSU instead of setting clear boundaries. Therefore, the codependency perspective suggests that the family members should use “though love”, meaning strength in setting limits to a substance-using family member.

3.3.2 The Stress-Strain-Coping-Support Model

Orford et al. (2010a) were concerned that families with PSU have been overlooked in health and social services because of the lack of a good support model. Orford’s group developed a model to focus on and care for family members affected by addiction problems (Orford et al., 2010a). The first component in the model is an assumption that when one person has a serious PSU, this can be highly stressful for close family members and the person with PSU. The second component is the strain experienced by family members as a direct consequence of the stress associated with a close relative's PSU. The third component is family members' responses to their relatives' PSU. Authors highlight that the expression ‘coping’ is not limited

to well-thought strategies but includes all kinds of responses (Orford et al., 2010a). A central assumption in the SSCS model is that people in such situations have resources to deal with the situation and can also help the substance-using family member. Orford et al. (2010a) believe that affected family members need good quality social support that can help them manage their stressful life situations. Therefore, the fourth element of the model is social support that may come from a number of different directions, both informal and formal, and is not limited to support from the closest members of social network (Orford et al., 2010a, p. 41).

3.3.3 The social-ecological (SE) model

Adams (2007) writes that the SSCS model has a shortcoming as it does not provide tools for working with the relationships in the family. His alternative social-ecological (SE) model is based on a social paradigm, which emphasises working with relationships and systems (Selbekk et al., 2015). The strength of the social-ecological (SE) model is that it develops practices for conducting joint sessions and family therapy (Selbekk et al., 2015). Adams (2007) introduces the concept of fragmented intimacy and describes how the intense relation to PSU changes character in other relations. As a starting point for his theory, he describes a social system in a person's life as composed of various attachment points, such as connections to family. Then PSU becomes the most important attachment point, the relations with family members become fragmented aspects of this intimacy (Adams, 2007).

The social-ecological (SE) model acknowledges that only the individual can decide to stop PSU. Still, the process of recovery has little chance of success if the outside world is not engaged in the process (Selbekk et al., 2018). Adams (2007) argues for the importance of reintegration of relations through which the substance-using person moves back to a normal social world with connections and relations (Adams, 2007). The professionals have an essential role in preventing fragmentation and strengthening social inclusion (Adams, 2007; Kalsas et al., 2020; Selbekk et al., 2018).

3.3.4 Family recovery from substance use as a long-term process

The idea of long-term recovery has a short history in the field of PSU, and many of the concepts have been adopted from the fields of mental health (Galvani et al., 2022). An important discussion has been whether recovery from PSU should be understood as a total absence of substances or could it be a self-defined process of rehabilitation and social reintegration (Galvani et al., 2022; Monaghan & Wincup, 2013; Roy & Buchanan, 2016). The prevailing understanding is recognizing recovery as a journey and not an event (Dekkers et al., 2020; Kougiali et al., 2017; Laudet, 2007) and as a personal process but within a social context (Best et al., 2016; Mudry et al., 2019; Price-Robertson et al., 2017). UK Drug Policy Commission (UKDPC, 2008) identified some of the key features of recovery from PSU. These included the increase of positive benefits and not just reducing or removing harms caused by PSU. The Commissions' understanding of recovery emphasized the building of a satisfying and meaningful life, as the person defines it. It involves, for instance, being able to participate fully in family life (UKDPC, 2008, pp. 5-6).

Both in Norway and worldwide, there is almost no research about the experiences of the recovery journey of PSU from a family perspective (Lindeman & Selseng, 2022). In the field of mental health, the literature points out that the family members often go through a process of change (Price-Robertson et al., 2017; Topor et al., 2011). Wyder and Bland (2014) described distinctions between the user's recovery journey, the recovery-oriented support role, and the family's recovery journey. However, it may be impossible to separate these processes, and the individual processes for all family members affect each other mutually (O'Grady & Skinner, 2012; Wyder & Bland, 2014).

Two British survey studies (Andersson et al., 2018; Edwards et al., 2018) focused on family recovery processes at different stages of treatment and recovery from PSU. Studies highlighted that current ongoing use and new, repetitive periods of use affected family

members' wellbeing (Andersson et al., 2018; Edwards et al., 2018). These studies explained that family members benefit from the recovery, but some long-lasting harm may remain (Edwards et al., 2018; Andersson et al., 2018). As survey studies, however, these studies have limited descriptions of long-term family recovery, and themes are predetermined by researchers. The focus is mainly on confirming how PSU impacts families.

3.3.5 Summary of literature concerning central ideas of help and support for families

Compellingly, the literature points out how different ideas of help impact how services for families are formed. Codependency-oriented treatments and self-help groups are committed to breaking down denial and helping the family set limits on the substance-using family member. The SSCS- model is built to support and help family members but excludes the substance-using family member. The central idea of the model is that when family members have received quality support, they are more able to support the member who is using substances. Adams (2007) argued for more social perspectives on PSU to reduce the pain felt by all family members. In these studies, a long-term family recovery perspective on PSU is lacking, but studies from the mental health field call attention to the importance of long-term perspective also on families with PSU.

3.4. Summary reflections on the literature review

This chapter has presented the research literature concerning PSU and family relations, different family positions and impact of PSU, systemic psychotherapy literature relating to families and PSU, and literature concerning central ideas of help and support for families with PSU.

That a family members' PSU impacts the whole family has been documented convincing, especially from Orford and his research group (2010a; 2013; 2017). I agree with Orford (2017)’s thoughts that while it is important to acknowledge cross-cultural similarities in family members' situations, it is also essential to look at the variations and nuances of family

members' experiences. I consider it a shortage that the substance-using family member is rarely included as participants in studies and is often seen through the family members' experiences. The characteristics of PSU push attention to the problem; PSU (Lindeman et al., 2021). The substance-using persons and the other family members are concerned about PSU, and services have directed their attention to the problem. When families did seek help, they often mainly sought help for a substance-using family member and not for themselves. Available knowledge shows that many treatment units in a Norwegian context lack a clear structure for the work with families (Kalsas et al., 2020).

Several perspectives (stress, resilience, systemic psychotherapy) presented in this literature review emphasize how managing family challenges is a process over time. Nevertheless, a prevailing understanding of recovery processes in Norway is often individual-oriented and short-term (Kalsas et al., 2020; Selbekk & Sagvaag, 2016; Selseng, 2017). Moreover, both in Norway and worldwide, there is almost no research about the families' own experiences of the long-term recovery journey (Lindeman & Selseng, 2022).

PSU is mainly understood and treated as an individual problem, and family dynamics tend to be seen through the lenses of PSU. This may be a reason why some parts of family experiences are richly researched, both qualitatively and quantitatively, while other areas have still received too little attention. I consider that research mainly describes what impacts families experience and less of how they live with these impacts and what variations there are. Qualitative research describing recovery processes from PSU from a family perspective and from different family positions and roles is lacking. In search to understand family life, some ideas can be observed as dominant discourses, like "the addicted family", " tough love", or "enabler". I believe that how PSU and family relations are understood and talked about impacts how people experience their possibilities for action and how services are formed and made available to families.

4 METHODOLOGY

A methodology is the "general research strategy that outlines the way in which research is to be undertaken" (Howell, 2013). A methodology is not a recipe or a precise series of steps but a general orientation. This chapter presents the methodology and explains my research design in detail.

4.1 Philosophical stance

The researcher's way of seeing relates to her philosophical stance. Sutrisna (2009, p. 6) claimed that the philosophical stance is portraying a bigger picture: "that is how the researcher perceives reality in his/her life that will certainly influence the way he/she is doing the research rather than how reality is perceived in one particular research". The philosophical stance of my research is multifaceted and may appear contradictory, but it reflects how I perceive life and my research theme.

4.1.1 Ontological and epistemological stance

Guba and Lincoln (1994, p. 108) clarify that ontology demands answers to the questions: What is the form of reality? What is there that can be known about it? The epistemological questions are: What is the relationship between the knower or would-be knower, and what can be known? (Guba & Lincoln, 1994, p. 108). Ontology and epistemology are tightly connected. Ontology logically precedes epistemology, while epistemology precedes methodology (Sutrisna, 2009).

In the postmodernist age, it is usual to think that things can be viewed and experienced in several ways (Kvale & Brinkmann, 2015). My project concerns how families live with PSU. So, it will be possible for me, and it may be the obvious choice as a narrative researcher to position myself in a social constructionist tradition. This tradition emphasizes the subjective experience communicated through language. But the ability to talk in narratives and the function of narratives is something humans share through different languages and is very

concrete and measurable. In addition, there is something very tangible and measurable in PSU, but at the same time, PSU also is understood and constructed in different ways by the individuals involved.

Selbekk et al. (2015, p. 197) wrote that a phenomenon like addiction is:

> …a necessarily layered or laminated system, involving mechanisms at a biological, psychological, social and cultural level, where powers at the more basic level of reality (physical, biological and psychological) are emerging into more complex strata of reality (social and cultural).

I agree, and I have chosen a critical realist scientific position for this research project because I want to research how people address and live with something that exists independent of themselves, but which is nevertheless understood and constructed in different ways by the individuals involved. The chosen scientific position may nevertheless not be visible in my research questions or design choice. My interest in human beings' diverse narratives about actions and choices in their lives can be characterized as a typical study of situated practices at the micro-level. Nevertheless, my understanding of the importance of macrolevels as our biology and societal structures outside of humans' awareness of it is an important part of this study. The choice of the scientific position in this study is present as an acknowledgment of reality as Bråten (2016, p. 125) describes it: "Reality is real beyond people's "grip" on it, and this "grip" varies in time and space and may never be faultless".

Critical realism is connected to Bhaskar, who argues that reality exists independent of the human mind (Bhaskar, 1997). Patomäki and Wight (2000, p. 223) explained:

> According to critical realism the world is composed not only of events, states of affairs, experiences, impressions, and discourses, but also of underlying structures, powers, and tendencies that exist, whether detected or known through experience and/or discourse.

This underlying reality provides the conditions of possibility for actual events and perceived or experienced phenomena (Patomäki & Wight, 2000). Critical realism adapts “the insights of other meta-theoretical positions such as empiricism, realism, and social constructionism” (Bhaskar & Danermark, 2006, p. 280). Bhaskar et al. (1998, p. 38) wrote that “social structures, unlike natural structures, do not exist independently of the agents' conceptions of what they are doing in their activities", and acknowledge the subjective in people's life experiences.

4.1.2. My ways of seeing: three conceptual tools

Three conceptual tools are essential aspects of my philosophical stance; my ways of seeing. As a systemic family therapist and teacher in systemic family therapy education, I am deeply influenced by the systemic perspective. Bateson (1972) introduced a circular epistemology as a framework for understanding human interaction. Bateson was concerned that our understanding of something depends on the context in which we see it: “Without context, words and actions have no meaning at all” (Bateson, 1972, p. 15). I tell my students that once you start to see interaction as a relational and circular phenomenon and become concerned with the formation of meaning in context, it is difficult not to become concerned about the meaning-making in context. So, the systemic metaphors are an important part of my philosophical stance. In my study, the systemic perspective is present at each stage, from the development of research questions to my positions in interview situations where I often turn to inquire about the individual's relational rather than the internal processes. At the same time, the participants in this study and I are part of a culture, which often is characterized as a Western individualistic culture (Giddens, 2013). According to Hofstede (2010), Western individualism stands for a society in which the ties between individuals are loose. Everyone has a strong sense of self and needs to look after him/herself. It has been challenging to be in

the relational perspective as both the participants and I are used to thinking and talking from the I perspective.

The other analytical tool I am concerned with is a narrative. My study is a narrative study. As mentioned in chapter one, storytelling is an important part of this study, both as a research interview and as a method of analysis. The narrative is often used as a collective term for all types of stories and histories, from human history to accounts of minor episodes in a person's life. A term used in a broad sense easily creates confusion. Hydén (1995) describes four different ways to use the term narrative. According to him, narratives can be seen as a symbolic expression of real events. The narrative is then a way of describing and rendering human actions and is used in the same way as, for example, the metaphor system (Hydén, 1995; Hydén, 1997). Secondly, narratives can be seen as a way to transform events into part of our individual experiences by sharing them. The third way refers to the pragmatic side of a story. People use narratives to convey the past and the future (Hydén, 1995; Hydén, 1997). Frank (2018, p. 554) describes storytelling as meaning-making: "A life becomes understandable through the stories that the self and others tell about it and how those stories are told—what counts in any given telling—constantly shifts".

Hydén (1995) describes the fourth aspect of the narrative as the social aspect. Stories are related to the social and cultural context in which people live. In all cultures, certain narratives become more dominant than others. These cultural narratives influence, for example, how people emphasize certain life events and give others less weight (White et al., 1990). The “narrative terrain comprises both culturally dominant plots and alternative plots which have been neglected but to which attention can be directed” (Frank, 2018, p. 554). In this study, all four ways to use the term narrative are relevant. In my analysis, I understand storytelling as a meaning-making process made by the participants and myself, influenced by the cultural

narratives. I use a story as a conceptual tool and a symbolic expression of real events in the analysis. I have explained my use of central narrative terms in chapter one.

The third conceptual tool I choose to introduce is a rhizome, as presented by Guattari and Deleuze (1987). A rhizome is an underground root system, a living and open network that branches out to all sides unpredictably and horizontally (Sermijn et al., 2008). "A rhizome has no beginning or end; it is always in the middle, between things, interbeing, intermezzo" (Guattari & Deleuze, 1987, p. 25). A rhizome can take different forms, and it can split and spread in all directions on the surface. The essential characteristic is that it has multiple entryways (Sermijn et al., 2008). As Guattari and Deleuze (1987, p. 7-9) wrote: "any point of a rhizome can be connected to anything other and must be" and "'a rhizome may be broken, shattered at a given spot, but it will start up again on one of its old lines, or on new lines'. Sermijn and Loots (2015), inspired by the metaphor of 'rhizome', connected it to the narrative research approach. According to them, which entryways stories take, and which connections are made during the speaking depends on the context in which the telling occurs. Stories are told to the other, which may be a concrete another person, and "the societal language and discourse that an individual uses during speaking" (Sermijn & Loots, 2015, p. 112). There are many possible stories, depending on the entry that is taken, which can lead to different and new constructions (Sermijn et al., 2008). As Sermijn and Loots (2015), I think that conversations between participants and myself could have taken other forms and ways if we had met on another day or in a different context. Both participants and I come into the interview situation from "something", and this "something" characterizes the discussion that develops between us. I consider the conceptual tool of the rhizome an essential image for my understanding of human interaction, with myriads of possible entryways that are hard to understand or consider. For me it is also a way to bring different theoretical and philosophical stances together in this metaphorical image of the multiverse.

How can these three conceptual tools go along together and with my chosen critical realist scientific position? First, critical realism recognizes that social phenomena are meaningful for people, and therefore meaning cannot be measured and counted but must be understood (Andersen, 2007). Andersen (2007) stated that there will always be an interpretive dimension in the social sciences. At the same time, it is central for a critical realistic stance to acknowledge that social structures both enable and limit people's actions. As Bhaskar has said:

> Humans do not marry to reproduce the nuclear family and do not work to reproduce the capitalist economy. However, it is nevertheless the unintended consequence (and the inevitable result), but it is also a necessary condition for their activity. (Bhaskar, cited in Sayer, 1992, p. 96).

I see these three conceptual tools as lenses and loops. I think that it is possible to use narrative as a metaphor for life and as a framework for meaning-making, and at the same time see the system as a valuable metaphor for the interaction between family members without losing the complex and multifaceted which the concept of the rhizome so well illustrates. Finally, a critical realist scientific position allowed me to explore and include all complexities and acknowledge that not all these levels of reality are accessible for either researcher or research participants. Social constructionism, as a scientific position, might not have allowed that. Social, and human phenomena, such as problematic substance use and family relations, involve biological, physical, psychological, social, and cultural levels of reality. I believe it is important to strive to accommodate this complexity and acknowledge that not all levels of reality are accessible to people.

4.2 Quantitative and qualitative research

Guba and Lincoln (1994, p. 108) write that “the methodological question is: How can the inquirer (would-be knower) go about finding out whatever he or she believes can be known?“. Quantitative and qualitative research traditions have different strengths in the research process. Quantitative research often concerns measuring a phenomenon and applies structured questionnaires including many participants. The qualitative researcher is most concerned with meanings and qualities that characterize a phenomenon (Langdridge, 2006).

As described in chapter three, despite the well-documented fact from qualitative and quantitative research that family members' PSU affects family life, more nuanced knowledge is needed. This project searches for the nuanced understanding with a research question, “How do people living in families with problematic substance use construct their family life through their stories?” I am interested in hearing descriptions of what it is like to live in such a life situation and studying these stories in-depth, looking both at how the stories were told and how I listened and understood the stories. Therefore, a qualitative research methodology was most suitable for my project.

4.3 Research design

I now present the design of my research project. First, I explain the narrative research approach generally. Then follows the background and context for the ethnographic element and how I completed my fieldwork. Then follows chosen narrative research approach, the sampling strategies and criteria, the description of narrative interviews and a data collection process, and the data recording and transcription process.

4.3.1 Narrative research

Narrative research is the study of stories, and it is undertaken by multiple academic disciplines and involves a variety of narrative methods of analysis (Frank, 2012; Riessman, 2008). Within the framework of narrative research, researchers use several research approaches, strategies, and methods (Pinnegar & Daynes, 2007). Narrative research offers no

automatic starting or finishing point (Squire, 2008). It can increase the researcher's opportunities for flexibility but also make the research process overwhelming and methodically unclear. But as Pinnegar and Daynes (2007, p. 17) stated, it allows researchers to become interested "in the noises, the other fits, and the blurred areas". Narrative research allows wondering, tentativeness, and alternative views to exist as part of the research (Pinnegar & Daynes, 2007). This is important for my project seeking to reflect the research theme from different angles. My research theme – family life and relations - invites to look at phenomena such as meaning, identity, change and development, uniqueness, context, and language – all phenomena central to narrative research perspective (Spector-Mersel & Knaifel, 2018). Stories help make sense of life and enable personal practice (Frank, 2010). I have chosen the narrative research approach because I am interested in how family members make sense of their experiences through their stories.

4.4 Data generation

4.4.1 Ethnographic element: fieldwork

The research project started with a period of fieldwork. I have met many people with PSU and their families in my clinical practice as a family therapist. I wanted to start my research with the possibility to attune myself to my research topic in the contexts of the research participants, without being in the role of professional helper. Participant observation is the method for data collection through participating in the participants' lives to observe their situations and how they behave in them (Fangen, 2010).

I was a participant-observer in four group meetings for relatives within the PSU field, led by professional group leaders. The group was an open group, in which new participants were welcome every week. Each time two group leaders were present, and these were not always the same persons. A total of 6-7 professionals and co-workers with their own experiences of PSU constituted the group leadership. Group meetings lasted two hours each time. The

attendance varied from 10 to 20 persons. Most of the participants were mothers. Occasionally, fathers and siblings were present.

I contributed sporadically, listening and discussing with the participants before and after the group meeting. I tried to understand why the participants came to these groups, what they possibly wanted to reach, how they interacted with other group participants and group leaders, what they chose to share about their own experiences and how they talked about them. The purpose was to take inward impressions and get to know my reactions and thoughts about the participants' different topics. Malterud (2002) writes that participating observers must learn to live with the ambivalence in the ambiguous role. Because of my clinical experience, I could easily have been in the role of leader of this group, and it was not easy to participate in a familiar arena but in a new position. As a result, especially at the beginning, I used a lot of energy not to be too participatory and not take too much responsibility for the participants' issues. Eventually, I found my role, which can probably be described as more observant than participatory, because I mostly listened.

4.4.2 My narrative approach

The narrative research model was applied from the beginning to the end of the project. Riessman (2008) proposed several levels of representation in the narrative research process: attending to experience, telling about the experience, transcribing the experience, analyzing the experience, and reading the experience. In this study, the experiences family members shared were systemized and interpreted in several phases, from interview setting to analysis. The implemented model was inspired mainly by Frank (2012) and Riessman (2008), but also by authors such as Hydén (2008), Hollway and Jefferson (2008), and Gubrium and Holstein (1998).

Frank’s (2010; 2012) dialogical narrative approach presents people as inherently relational rather than bounded individuals and storytelling as part of a dialogue between two or more

voices. For Frank, then, storytelling is a relational act, where meanings are created through stories together with real or imagined others (Smith & Sparkes, 2009). According to Frank (2010), the aim is to understand what the story does, rather than to understand the story as a portal into the inner thoughts of the storyteller. As Frank (2010, p. 3) stated, stories "work with people, for people, and always stories work on people, affecting what people can see as real, as possible, and as worth doing or best avoided".

The important part of Frank's (2010, 2012) dialogical narrative approach is the research participants' engagement in their struggles of becoming. Moreover, the dialogical narrative approach requires hearing participants' stories, not as a substitute for their lives outside the interview but as acts of engagement with the researcher (Mishler, 1986). Example from this engagement from Veronica's interview:

> I talk to a friend who works in substance use services, and also has a child with someone who is like that (has PSU). Just not as much. We were in a bit of that kind of meetings and stuff. We've been thinking that really we have to do something about it, because if everyone just sits and experiences it, no one really does anything about it (elevates the ex-partners' perspective). But now you're doing something about it, so that's good.

Participants in this study were engaged in talking with me, and some of their stories were directly addressed to me as a possible salesperson for their case.

4.4.3 Research context and details of the participants

My participants live in different parts of Norway and are ethnic Norwegians. A total of sixteen family members participated in my study. The participants were assured confidentiality. Because people's family stories contain names, places, and other information that can be used for identification, the stories were edited to protect the anonymity of the storytellers and others appearing in the stories. Therefore, the participants' details are given with approximate information, presented in Table 1 (Appendix).

4.4.4 Sampling strategies and Sampling criteria

I used purposive sampling to recruit participants for this study from different parts of Norway. The recruitment was done through relevant organizations in Norway. I also contacted professionals working in services where they meet potential participants and asked them to disseminate the information to persons with whom they were working. I planned to interview people in five positions in the family: parents, siblings, adult children, partners, and substance-using family member. One of the professionals misunderstood and recruited ex-partners. This was a fortunate misunderstanding because this turned out to be an important family position which I had not thought enough about.

It has been important for me to get perspectives from both substance-using family members and family members affected by other family member's PSU. This choice concerns my positioning in the field. In my recently published meta-ethnography (Lindeman et al., 2021) (presented in chapter three), only two studies represented experiences from both substance-using family members and not using family members (Fotopoulou & Parkes, 2017) (Näsman & Alexanderson, 2017). Many services differentiate between the substance-using family member and close others. The family perspective in the PSU field is often focused on the family minus one – the substance-using family member. Even the language we use invites this: the relative and the user. But as I see this, family life with PSU challenges consists in frequencies of interaction between all family members. Interviews from different family positions make it more possible for me to see phenomena and events in families from different perspectives. It enables me to use a systemic perspective in this study more actively. Even though participants are not from the same families, they still represent different family roles and positions, making it possible to try to understand family interaction patterns.

My sample consisted of persons who had lived or lived close to PSU and recovery in their families. All interested persons over 18 years who had these experiences could be included in the project if they consider themselves qualified. Children under 18 year and persons who could not be interviewed in Norwegian were excluded. There were no other exclusion criteria, and I accepted all participants who were interested and contacted me. The plan was to get two or three interviews in every family position, but because I was contacted by one parent who wished to participate after I already had enough parent interviews and I did not want to reject the participant, I ended with four parent interviews. I used this sampling strategy, because I wanted to meet participants who wanted to talk to me. I assumed that those who contacted me, wanted to participate.

I chose to interview substance-using family members in recovery, both because persons using substances ongoing are more difficult to recruit and possible more unstable to interview. This was a choice also made for ethical reasons, and I address this later. Other family members lived in different life situations. Some of them lived with ongoing PSU, some with their family member in long-term recovery, and some were bereaved after PSU-related death. My study recruitment ended with overwhelming female participation. Only two participants were male, and both were family members in recovery. This was not my intention but a result of not wanting to reject participants interested in participating. This undoubtedly affects this study and maybe is a limitation, but it also illustrates the common perspective on studies of families and PSU. As described in earlier chapters, the family perspective often means the parents' perspective, and even more often, the perspective of mothers. It is the theme I come back to in analysis and discussion.

4.4.5 Narrative interview

Interview data in this study were collected with an in-depth qualitative interview, loosely inspired by the Free Association Narrative Interview (FANI) (Hollway & Jefferson, 2008).

Hollway and Jefferson (2008) developed this holistic analysis method to achieve an analysis that focuses on people's circumstances and positioning in socially available discourses and on people's investments in those positions. Holloway and Jefferson are influenced by Kleinian psychoanalysis and the ideas of a defended subject, a fundamental proposition in psychoanalytic theory (Hollway & Jefferson, 2008). They consider that the traditional question and answer method of interviewing tends to suppress the respondent's agenda in favour of the interviewer and invite discursive rationalisations (Hollway & Jefferson, 2000). Original FANI consists of two interviews. The first is the interview, in which the researcher tries to provide as much space as possible for the participant's story and uses a few open-ending questions. Then, the researcher listens to interviews and pays particular attention to incoherencies and contradictions in the interview (Hollway & Jefferson, 2000, p. 137). Out of this generates the questions for the second interview in the original version of FANI. I have only interviewed my participants once because I wanted to have several participants and family roles represented in this study. I, therefore, could not allow participants to reflect on the interview with me.

I have adapted parts of the FANI method, such as the interview with open-ended questions and not using the theme guide. I have not adapted FANIs fundamental psychoanalytic assumptions, i.e., my hearing, seeing, and analysis are not based on the 'defended subject' concept. Instead, I have replaced the assumption of the defended subject with the assumption of the relational subject, which is a fundamental assumption in a systemic perspective. As described earlier, my project has its anchor point in systemic and narrative understandings, with an executive philosophical stance in critical realism. I listened out participants talk about their close family relations, placing emphasis on the idea of the 'relational subject'.

I can follow Hollway and Jefferson (2000) in their thoughts that participants can intentionally or not knowingly defend parts of their stories. Some parts may be challenging to talk about. I am inspired and influenced by Norwegian family therapist and psychiatrist Tom Anderson's thoughts on dialogue. He advised therapists to follow the feelings in the conversations. Andersen collaborated with physiotherapist Bülow–Hansen, which led to his attention to how people's breathing changed when unpleasant topics were talked about (Andersen, 1991). Just like when a physiotherapist touches a pain point in the body, so changes the breathing. Andersen moved these thoughts to therapeutic conversations and showed how the moments of pain in people's stories and lives affected breathing and speech (Andersen, 1991). I have tried to follow participants and my breath and feelings and gently encourage the participant to talk more. Hollway and Jefferson (2008) highlight four principles of a narrative interview. Interviewers should use open-ended questions, encourage telling stories, avoid why questions, and use follow-up questions. All these principles are familiar from family therapeutic work and, for example, Andersen's thinking, and I have used them in this research project. In family therapeutic work and systemic interactions, the reality is understood as co-constructed between the therapist and the people with whom they meet (Carr, 2012). The professional strives for a conscious position in a conversation, where he or she does not believe that he or she knows what people's experiences have meant to them (Anderson & Goolishian, 1992). In working systemically, the central focus is also on the system rather than the individual. Then, for example, systemic skills, such as circular and reflexive question types are useful (Tomm, 1989). The circular questions focus on relationships and important people, even when the person is not present in the conversation. These questions lend themselves to providing new ideas for interaction or new awareness of the importance of relationships (Hedges, 2005). Such a question may for example be: What do you think your partner may have said about your relationship? How was your way of dealing with this situation different from your

mother's way? Reflexive questions can help both the client and the professional to be more curious and wondering. For example: Have there been times when you have not been affected by the concerns related to substance use? Both reflexive and circular questions open up many opportunities for follow-up questions. The goal of such questions is often to bring out different understandings of the same phenomenon, eliciting possible solutions from themselves or creating a common understanding (Tomm, 1989).

4.4.6 Narrating sensitive topics

PSU and its impact on families can be defined or experienced as a sensitive topic. Studies about PSU in families and bereavement after drug-related death point out how shameful, silenced, and stigmatized people can feel (Lindeman et al., 2021; Titlestad et al., 2021). To raise my awareness in the face of potentially sensitive topics, I have sought the support of ideas Margareta Hydén (2008) has about narrating sensitive topics. First, Hydén (2008) points out that what is perceived as a sensitive topic varies. Researchers may assume that some topics are more sensitive than others, but the participant may experience other topics more sensitively. At the same time, both the researcher and the participant may find it difficult to talk about some topics in the conversation. Hydén (2008) claims that what is a sensitive topic and what is not is due mainly to relational circumstances and is about the relationships between the teller and the listener. Research interviews can include issues that participants are ashamed of, issues that might be rated culturally low, or events that have left them vulnerable (Hydén, 2008). She points out that a researcher may risk meeting resistance from an interviewee manifested in various ways of avoidance (Hydén, 2008). It may be about the researcher's position of power and the imaginable audience, which they do not want to gain insight into their situation. Hydén recommends seeing the interview situation as a collaboration, in which the researcher helps and supports the participant's storytelling. She

warns researchers not to be too preoccupied with sensitive and painful topics because it can make the researcher too occupied with the suffering (Hydén, 2008).

The last important point from Hydén is her thoughts about the differences between an event that involves sensitive, even traumatic, experiences and a sensitive topic. An event is something the participant has experienced, and a topic is something that appears in a discussion. Hydén (2008) explained that an event that involves a traumatic experience has the potential to form a sensitive topic without necessarily doing so: “Talk about a traumatic experience, for example, has the potential to pose a threat and even has the potential to re-traumatize the traumatized, but such talk can just as well have the potential to heal” (Hydén, 2008, p. 4). In my interviews, I met both stories about traumatic events and sensitive topics, as described in the next section and in the analysis.

4.4.7 My narrative interviews

I met participants in different locations in different parts of Norway. Most interviews were conducted in hotel rooms, and some in my office. Interview length varied from 1,5 hours to 2,5 hours. All interviews were emotional, in a sense, that the participants showed feelings and cried, and all participants said the experience had been significant to them. In some interviews, the participants cried almost all the time in the conversation, while in other conversations came tears when we talked about given topics. As Andersen recommended (Jensen, 2006), I addressed the feelings when it felt natural to interrupt the participant, and sometimes the participant herself explained why the tears came. At other times, I did not want to disturb the participants’ storytelling and let the story go on, as in the interview with Celia:

> Celia: so I think that I have acted in the best sense and I can't take it inwards more than, but at the same time you feel that it will… She distances herself from us and doesn't want to and doesn't like us. We ruin her life and everything like that, but it turns out that you don't like your own kid anymore.

Celia seemed to be upset, so I chose to wait and say as little as possible:

> Sari: silent hm
>
> Celia: At least not who she is now, she's going to give me a hug
>
> Sari: silent hm
>
> Celia: I don't really want to hug her
>
> Sari: silent hm
>
> Celia: At the same time, I know that if I'm not in it, she knows this and that's not what I want her to do.
>
> Sari: silent hm
>
> Celia: I don't want to push her away, but at the same time, there's something going on inside of me...

Silence. I sense that she has more to tell, so I chose to ask more about her feelings:

> Sari: How long ago did you feel sincere that you liked her?
>
> Celia: Eh... hm good question. Actually, I don't know. That is, because what I think when you ask is that I have to differentiate in a way between really liking her and the feeling that I feel sorry for her.

The alternation between waiting silently and asking questions is what I did in most of the interviews, and it probably also characterizes me as a therapist. I'm not usually afraid of silence, and it was a valuable skill in these interviews.

As Hydén (2008) pointed out, researchers may assume that some topics are more sensitive than others, but the participant may experience different topics more sensitively. I wasn't prepared for ex-partner interviews to be so full of pain. I have tried to understand why this came as a surprise, but it may be because I have imagined that it is easier to keep a distance and choose not to have contact as an ex-partner. I was wrong, and it made me strangely passive in my interview with Veronica, who had many difficult experiences and had not talked about them with anyone before. I felt shame because I had not foreseen that this family

position could be so demanding. Veronica surprised me because she expressed that the most challenging and most sensitive thing for her was the certainty of everything her son had lost. I was prepared that her obsession with the violence she was subjected to be the most challenging part to talk about in interviews.

The participants approached the topics very differently. Some of them expressed that the topics needed to be raised to the public and said their anonymity was unimportant. Others expressed concerns about their anonymity, explaining it with a desire to protect the other family members. Some topics may have felt too intimate or emotionally overwhelming. Especially in an interview (Lars), the participant did not want to go ahead with two of the topics. I responded to these two situations differently. In the first situation, my compassion for what I perceived as the participant's shame stopped me from moving on. In addition, I can notice from my responses that I am trying to comfort the participant:

> S: You said earlier that your mother lost her apartment because of you. Was it like when you were young, or when was it?
>
> L: Yes, it was early.
>
> S: Hmm.
>
> L: Won't go into more about it.
>
> S: Don't need
>
> L: No, it is... Yes, there was a lot of disappointment, but they have not had it especially easy.
>
> S: Not for either of you
>
> L: No.

My all too soon “Don’t need” attempted to make the situation easier for Lars. If I had followed my role models, Andersen and Hydèn, I might have received a fuller answer from Lars. At the second stop, I tried to encourage him to talk more about the topic, but the story of Lars' role as a father remained as little detailed:

S: What time did you become a partner and a dad?

L: Uh, I was 21 when he was born

S: A young dad.

L: Yes, far too young

S: Hm, was substance use present then or equally intense present then all the way? How long did you live in this couple's relation?

L: Hm... Hm… no eh yes, I will not go into that very much.

S: No (long pause)

L: Not very long, not so good to say

S: yes

L: It was...

S: It may be difficult to remember any of these…

L: Yes, I remembered… I did not know how many years I was even myself, true.

S: Hm

S: Eh.. that is what I wondered… It is ok if you do not want to talk about this, but in that time, when life was a struggle, becoming a dad, being a dad, how much did it occupy you or did it go inwards you or how was it?

L: Uh. It was....eh, it was eh... I should have been able to hold myself, but I certainly do not know what to blame, but I can tell you there was no peace in the house. I mean, it was just yelling there for things that had happened earlier.

S: Hm

L: But I should have absolutely made it

The meetings with the participants and my emotional reactions and topics that the participants did not want to talk about or avoided talking about have become part of my analysis described in chapter six.

4.4.8 Data recording and transcription

All 16 interviews were recorded using a digital recorder. I chose not to transcribe interviews myself for practical reasons and my busy life. Instead, I paid for a family therapist who

routinely carries out this work for researchers. Participants were informed that I used a transcriber, and the material was anonymised before she received it. All identifying information was left out of the transcripts. The transcripts were then analysed by using narrative analysis.

4.5 Data analysis

4.5.1 Data from the fieldwork

I wrote my field notes after each group gathering. These notes are about my observations, reactions, thoughts, and feelings (Appendix 4), and I have used them to write a reflection of fieldwork. My reflections of themes that caught my attention are presented in chapter five.

4.5.2 Narrative analysis

I have chosen the narrative analysis because it, as Blix et al. (2015) described it, does not seek a generalization, but has a purpose of embracing the contextual, diverse, and nuanced. I have tried to understand participants' family context and the diversity and nuances in their family stories, roles, and relation to theme PSU. I have wanted to do this using several steps in the analysis process. I have focused on the interview content and both the participants and my reactions and feelings. Riessman (2008) suggests the typology of narrative analysis distinguishing between four ways of handling and analysing narratives: thematic, structural, dialogic/performative, and visual. In this study, I have been interested in several parts of participants' stories, both “hows” (dialog/performative) and the “whats” (thematic) of storytelling. Gubrium and Holstein (1998, p. 165) use the term “analytic bracketing” to allow us “to focus on one aspect of narrative practice while temporarily suspending analytic interest in the others, and then later to return to these issues”. The analytic bracketing is used in this research project.

4.5.3 My narrative analysis

Focusing on individual interviews

In the face of 16 interviews, nearly 40 hours of speech, and over 100 pages of text, I started my analytical bracketing with the individual interviews. Both Riessman (2008) and Frank (2010) recommend starting analysis focusing on the individual narrative before looking across the narratives. I wrote a narrative resume in Norwegian (a short story or concentrate) of every interview and oriented towards the stories told about family relations and the roles of each participant (Appendix 5). I made notes of themes, structures, and my reflections. Interviews were full of entrances to different storylines, and it was hard to stick to the planned length of resumes. It felt like I was losing those dimensions of the narratives both Hollway and Jefferson (2008) and Andersen (1991) had inspired me to hold on to. I didn't see the emotions in the text, and it was harder for me to sense how the content was told. The pain, cold, heat - all the nuances felt to be gone. The analysis was becoming more of an intellectual exercise, and emotions had disappeared. Therefore, I decided to put the writing aside for a while and returned to the spoken.

Listening to interviews

In this phase, I listened to interviews two times each. I had my earphones on several days, and I noted places in interviews where participants stopped, breathed differently, and I tried to move back to the interview situation. I let the participants' and my feelings lead the way. I focused on the relationship between participants and myself. Riessman (2008, p. 105)'s question: "What was the response of the listener/audience, and how did it influence the development of the narrative and interpretation of it," and the dialogical in Frank (2012)'s narrative analysis were important inspirations in this phase. This phase resulted in the start of several of the stories presented in findings, such as "*Stories difficult to tell*", "*Directing stories*", "*A story of doubt*", and "*Stories with chaos*". I also noted topics that appeared in the various interviews.

Reading interviews

In the third round, I re-read all transcriptions, and I oriented my analysis towards the content of the interviews trying to find themes participants were mentioning. I asked questions Riessman (2008, p. 105) suggested: “Why was the narrative developed that way and told in that order, how does he/she locate herself in relation to the audience, how does he/she locate characters in relation to one another and relation to herself”. I was particularly concerned about the ‘relational subject’, such as participants' stories about their family life and relations. I listed topics (for example, fear, preparedness, family connection) and noticed that some topics were present in several interviews and compared them with the notes from the previous phases. Based on these topics, I used Frank (2012)’s dialogical narrative analysis to explore how the impact of PSU was represented in the stories of family relations (Appendix 10). Frank defines narratives as the social stock of available discourses that function as narrative resources that people draw on to produce local stories (Frank, 2010; Frank, 2012) . This phase resulted in the content-based stories “A story of family ties”, “A story of love”, “A story about the unforgivable”, “A story of fear and preparedness”, “A story about tough choices”, and the “A story of protecting other family members from PSU”.

Creating stories

In this phase, I wrote the presented stories. They are co-constructed by me, the interviewer, and the participants. The different storylines I found connected to the stories are presented with quotes from the different participants. It is important to keep in mind the “in-process nature of interpretations” (Frank, 2004) and not understand these stories as the final word on people's lives.

4.6 Reflexivity

Finlay (2002) defines reflexivity as “a thoughtful and critical self-awareness of personal and relational dynamics in the research and how that affects the research” (p. 318). From my critical realist scientific position and with my chosen design, I believe that the analysis will always be subjective to a certain extent. Krause (2012, p. 3) writes: “no one can be sure because the way anyone explains any bit of culture depends on their point of view.” I believe that the stories presented in this study are about how the participants tell them, but just as much how I hear them. My experience as a therapist in the field helped me ask, see, and

understand but could lead me to see some parts of the stories more distinctly. I am passionate about relational perspectives and family therapy. Does this mean that I will emphasize the importance of relationships in this study more than the participants would have wanted? Clifford (1986, p. 121) says that "we struggle to confront and take responsibility for our systematic constructions of others and of ourselves through others". It is a struggle I intended to take seriously in this study. In the qualitative research tradition, the terms trustworthiness, confirmability, and transferability are connected to the quality of the study (Kvale et al., 2015). These concepts mean that I aim to make all the phases of the research, my choices, and my interpretations as transparent for the reader as possible.

Holloway and Biley (2011, p. 970) wrote that "being a qualitative researcher means being accountable—for the choice of data and their interpretations—to the participants and the story's readers. It entails recognizing emotions and some of the motives of the researcher. So, what are my emotions and motives for this study? Part of it is to see if family therapy practices could give some new possibilities to the field of PSU and families. As a family therapist in the field of PSU, I am used to elevating and arguing perspectives that are not included in the prioritized tasks of the services. Such a position both as an outsider and an insider is part of my life as well because as an outsider from Finland in Norway, I often have the outsider position while also having strong roots in Norway. I consider it as an enrichment to be both an insider and an outsider. Also, in the family therapy field, I have often felt like an outsider because I have been interested in both the early development of family therapy and the latest ideas, and also including interest in narrative therapy. It has been important for me to integrate different areas of knowledge and competencies into my work. However, the most important part of my systemic position is understanding peoples' difficulties in the context of social relationships and culture. While working on this thesis, I have found inspiration from

systemic family perspectives on family stress and resilience, which I didn't know well before. This area of knowledge has become a new inspiration for my family therapeutic work.

Another motive for this study is my curiosity to understand what makes family members stand in these demanding processes year after year. I have moved from my homeland to another country and have an emotional distance from my own family at times. When my sister, in adulthood, experienced challenges to her mental health, nothing changed my daily life despite feeling that it was both sad and inconceivable. I haven't started visiting my parents more often, despite them getting older. But the mere thought that something should happen to my children, who are now all young adults, is too painful to conceive. It was clear to me in the interviews that I could identify with the participant parents' feelings about fear and the need for control. I started working in the PSU field by chance, but I've always liked my work. I have often thought that perhaps I rarely become morally upset by people's choices different from mine. Since I now work primarily with families with PSU, I have felt more annoyance about substance-using family members than in my earlier work with substance-using individuals. It may be so because I now meet the whole family, and for example, the parents' perspectives are closer to my life than the substance-using individuals.

Finlay (2002) makes a distinction between being reflective and reflexive. She pointed out that reflectivity means that researchers take a critical stance to their work when they have completed it, and I consider that this includes adding a cultural perspective. Even though I have moved from my home country, I have not moved further than to another Nordic country. Davies (2012, p. 91) writes that “the main difficulty and the source of most criticisms of generalization is the necessity to specify its boundaries, that is, the extent to which it may be judged valid”. I do not think that Norwegian findings can be easily transferred to other contexts. Norway is a wealthy Nordic country with well-established public services. Such conditions are not prevalent in all societies. All my interviews were conducted in Norwegian

and were translated into English. In that process, I have noticed how difficult it is to transfer the meaning from one cultural context to another. To reach more reflectivity, I have used my supervisors and colleagues as discussion partners in all phases of this research.

4.7 Research Ethics

Ethical reflexivity is an essential part of the research project. In addition, the participants in this study are likely to be a weary and possibly stigmatised group of people, which makes it crucial to have a gentle approach and awareness of how I talked. Previous research on vulnerable populations' research participation has shown that although it is painful to be contacted about difficult life situations, the informants are often very concerned about possibilities to learn from their situation (Dyregrov et al., 2000; Dyregrov, 2004; Halek et al., 2005; Hydén, 2008; Kassam-Adams & Newman, 2005). These studies highlight that the research should be carried out with sound ethical research principles and by researchers with expertise to meet people in vulnerable life situations. All phases of my research project were compiled in line with the Helsinki Declaration (World Medical Association, 2013).

Because this study was conducted in Norway, appropriate approvals were obtained for the study from the regional committee for ethics in medical research (REK) and the Tavistock and Portman Trust Research Ethics Committee (TREC). Information letters, consent forms, and approvals from ethical committees are attached to Appendix (6-9). I have not used the theme guide, as recommended in FANI.

I chose to interview the family members individually. It was a challenging choice because, as a family therapist, I am concerned with the dynamics in the family and the relational aspects. My choice was based on ethical reflections. It was possible that the impact of PSU on family relations was thematised only to a small extent in the family. It could have become too challenging to thematise this topic for the first time in the research conversations. Participants might also feel freer to talk about their family relations in individual interviews. I chose to

recruit family members with PSU only while they were in long-term recovery. Again, this was a choice based on the ethical reflections because some interview topics may have caused a risk of increased PSU.

4.8 Strengths and limitations of the research method

This study with sixteen family members has its strengths in the participants' detailed stories. The narrative analysis invites and makes possible the close reading of interviews. The participants' and my interest and dedication contributed to the rich interviews. The quality of research is about the relationship between the researcher and research project and participants. From my critical realist scientific position and with my chosen design, I believe that the analysis will always be subjective to a certain extent, and I have tried to make my choices in this research transparent for the reader.

I have followed The CASP Checklists for qualitative research (CASP, 2019) to improve the transparency and wholeness of the research process. I have given a clear statement of the aim of this study, data collection. As I consider it, the study design and analysis are appropriate to address the research aims. A possible limitation is my recruitment strategy, which appealed especially to women. The research project may also be qualitative better if I had interviewed participants twice as FANI suggested, allowing participants to reflect on the first interview.

5. FIELDWORK REFLECTIONS

In this part, I give a brief insight into my fieldwork in the next-to-kin-group. My reflections of themes that caught my attention are based on my fieldwork notes, as described in chapter four. The following is a quote from my first visit:

> The meeting place for the next of kin - group is central but outside the core center of the city. It wasn't easy to find, so I had to google and ask people passing by. When I found the front door, I also found the sign and a large handwritten sheet that informed me that this was the place where the relatives met. The sign also stated that the door

> was closed after office hours, and therefore one had to call a specific mobile number, and that one was then picked up.

The temporality of the premises and handwritten signs made me think about how the services for families are often organized as an extra offer alongside the core tasks of different clinics and treatment centers. The second variant is usually a group offer organized by volunteers and enthusiasts in borrowed locations during afternoon-evening hours. It takes effort to figure out these offers, and it gives me the impression that this is not the main task of the services. All four times, the group consisted of people who had been there before and newcomers. Some of them seemed to come to get information, while others remained permanent group members. From my notes:

> A family member tells a lot of positive things about the offer the substance-using family member has received and recommends the offer for the others as well. Another person said that the family member had not received any treatment options yet, but it still seemed that the family member was interested in treatment.

This quote is an example of the most typical content in most meetings. The family members shared stories about the offers that have been given the substance-using individual, what services their family members had tried and services that are lacking. They compared the different offers, criticized and praised others, and asked questions about possible offers directed to the other family members and group leaders. It could have been a a group of people exchanging consumer information because they needed somebody to carry out work, but the intensity that was present in dialogs told about the desperation. Instead, the family members searched for solutions to a challenging life situation. I thought that advice from others might give them a feeling of being closer to something redeeming.

In the rounds that are carried out, the group participants talked about frightening events, situations of violence, conflicts within the family, and madness, as they call it. Nevertheless, the mood in the group was often merry and light. As the group members said, there was a lot

of laughter because of all the madness. I thought about this a lot afterward and wondered both about the safety of some of the family members and the meaning of the laughter. I asked if it was relieving and significant for survival or whether it could contribute to the displacement of seriousness. At least it seemed that the opportunity to talk was significant in the group. Feedback or comments were not always given, but they did not appear to be missed or wanted.

6. FINDINGS

This study is about how people living in families with PSU construct their family life through their stories. In this chapter, I present my findings presented as ten stories. The stories are intertwined but analytically separated. Each story concentrates on and highlights a particular topic, and such a presentation, as Frank (2012, p.16) wrote, may overlook or marginalise other potential angles and interpretations. This chapter presents how I understand and interpret the stories.

The quoted excerpts are slightly edited, translated into English, and speakers have been given pseudonyms. After each story, I present my subsequent reflections, discussing each story individually. As described in the methods chapter, I have been interested in both the “what” (thematic) of participants' storytelling and "how” (dialog/performative). All stories have both “how” and “what” elements, but inspired by analytic bracketing (Holstein & Gubrium, 2003), I have separated “how” and “what” stories analytically asking different questions. I present stories in this chapter separately and return to the end of the chapter to reflect on how “what” and “how” stories may be intertwined. The stories in this chapter represented some of the aspects of the complexity for families dealing with PSU, which is why I wanted to deepen each topic with subsequent reflection. The overall discussion follows in the next chapter.

6.1. Stories of what

This part presents the content-based “what” stories. These stories are based on topics participants talked about in their interviews. Stories are labelled: “*A story of love*», «*A story of family ties*”, “*A story about the unforgivable*”, “*A story about tough choices*”, “*A story of fear and preparedness*”, and the “*A story of protecting other family members from PSU*”.

6.1.1 A story of love

This story is about love participants expressed to their family members. In interviews, I noticed statements that show how the relationship with a family member is told with loving and intimate understanding. It can be told as a love story, with a strong emotional attachment as Anna, female partner to a man with PSU, said:

> Because it was that little boy – the fact that he could be the vulnerably honest, completely vulnerable, raw, that we could actually be in the room – the pair of us – and look at each other up close. He saw that vulnerability in me too, of course. That was what made me fall for him. The fact that he pretty quickly saw through my entire facade.

I have analysed parts of Anna's story elsewhere (Lindeman & Selseng, 2022). Here I have included some overlapping parts from the earlier analysis. In Anna`s story, her partner gradually developed growing PSU. She fought for years for her partner and her couple's relationship:

> In my desperate quest to try and find a way to have it all by ensuring his survival and getting him healthy. So it was very like, it was very selfish too, because it was about that point of time, it was about everything, it was about my life too, it was so intertwined. It oscillates between extremely vulnerable closeness and shared despair in the common enemy of someone who is possessed and is going to destroy it.

Hanna, a woman in her forties, has a younger brother with PSU. Hanna told the story about her brother with tenderness. She used words like "funny", "talented," "my little brother". Hanna said that these sides were rarely present today, but suddenly she could see glimpses of

her brother as he was earlier. She talked about how sad she felt because her brother had not received the good in life that she had received:

> …I can't bear the idea of someone getting the wrong idea about my brother, and that they won't understand that this is about a struggle and grief. I need to protect him because he's my little brother. He's important. I feel a great sorrow for what I've lost. We had something really beautiful, something particularly beautiful. I kind of lost my four-leaf clover.

As Hanna and Anna talked about from their different family positions, people around had little understanding of the emotional bond they had with their family members. Lindeman and Selseng (2022) render a story of Anna, where she talked about a situation in which her partner had an episode of intense PSU. She was told by the psychiatrist who came: "'Just leave him lying here. You need to get home and just forget him.' That's what I was told to do, but of course, there was no way I could do that," Anna explained.

Frida, an adult daughter of parents with PSU, made several statements where she takes a distance from her parents, but it ends every time that she returns. She explained how her parents always have wanted her in their lives. She stated that it is about strong love:

> One time when we were going to resume contact, I set a condition that they had to go to family therapy with me. They did it – it was bloody great. I remember distinctly how we'd got an appointment at the family office, and I guess I had my doubts about whether they'd come. But they showed up and came through for me. In order for us to restore contact, we needed to sit down and talk and be prepared to listen. There must have been some very powerful love somewhere at the bottom of that. I think I have parents who had a very strong love for each other. I also feel that I'm on the receiving end of very powerful love from both my parents.

Lise, a woman in her fifties who stopped PSU several years ago, told how she had an important couple relationship while using substances. However, after she decided to try to cut PSU, the relationship became more complex:

> We first tried it out together and we lived together for a year while he was kind of into that on and off. And then I realised that if I was going to make it. I had to move while he was drowning. I was hoping he'd drown in custard. That was the picture I had. He had fallen face first into a bowl of chocolate pudding and custard and I was hoping he'd drown, so I thought to myself, ok then... perhaps it's time to move.

Lise's partner died in drug-related death, and she explained that she thought how her life would have been if he did not die. He was in her thoughts often:

> Then I lost him. We'd always had our plan that if he managed it then we would get back together again, I mean it was like... that was how it was all the time and I stayed with him for periods after I'd moved out and then I'd be with him for a weekend or a week or whatever. We never fell out or anything like that. So yeah. But then I lost him... So I don't know for sure, but in my head I still think that it would have all been great again. But then I was thinking about this one day and... I was thinking to myself that it's easy to think like that when you just don't know. Right? So it's not certain... maybe he would have manage to stop using and we wouldn't have worked well together without drugs. It's possible, and we just don't know. But it's good to have those kinds of thoughts in your head. That everything could have been good.

Reflections on "A story of love"

It is not surprising that family members express love. Love is often connected to close important relations such as family or couple relations. "*A story of love"* in the Norwegian context is a well-known social resource and legitimates, especially a couple relationship. In a couple relationship, emotional arguments are considered more legitimate than reason-based arguments (Thagaard, 2005). Love appears as the lifeblood of modern close and personal relationships (Beck & Beck-Gernsheim, 2018). Also, in relationships between parents and children, love appears as something fundamental (Hennum, 2004).

At the same time, it is a common understanding that life with PSU is difficult to combine with important and meaningful relationships (Birkeland et al., 2018; Blais et al., 2012; Neale & Brown, 2016). Descriptions of groups of people with PSU are often characterized by brutality, cynical behaviour, and manipulation (Blais et al., 2012). Few published studies about PSU and intimate relations describe how people with PSU distinguish between the core relation - their real relation - and life applied by the PSU (Crowley & Miller, 2020; Rhodes et al., 2017). At the same time, the relational and PSU are also intertwined.

Although the story of love can be part of how participants assemble meaning about their family relations, it seems to be a story that may come in the shadow of the PSU. It may be easier to be listened to in a problem story than in a love story. As I concluded in an earlier analysis of participant Anna's story, understanding partners – and families - means understanding both the subject and the relationship as existing in multiple stories of what PSU is and what love is (Lindeman & Selseng, in 2021).

6.1.2 A story of family ties

"A story of family ties" is about how participants told in interviews that family ties for the whole family or some family members are essential to them. They have many statements describing their efforts to keep family relationships and experience family life. Lars is describing the family as a place where it is possible to him to relax:

> I would visit her [the sister] often, and especially because I was able to find peace there. When I was there I could relax and didn't have to think about all the bad things I had done. It was safe there and I could take a break from my substance abuse. When I was there, I kinda saw what it was all about. My nieces were there and there were lots of games and fun and all round family life. My brother-in-law is like a brother to me. And there was also the fact that I could get away from the constant reminder about

> what an ‘asshole’ I was. I was able to talk about problems with her and hear what she had to say.

This quote from Lars shows several themes which, according to Gullestad, are central in Norwegian culture for families’ everyday lives, as equality defined as sameness, home-centeredness, and desire for peace and quiet (Gullestad, 1991, p. 85). In her sister’s home, Lars is uncle and not an “asshole,” and there is peace and quiet, home-centred play and fun, the family life.

Rose, a mother to a substance-using daughter and foster mother to her daughter’s son, told how she tried to give her daughter a touch of the joy of family relations. She said that this could be difficult for both her and her daughter:

> But I’ve promised her that I’ll take care of her son right until she is ready to take care of him herself. It’s my duty to supervise them when my daughter and grandchild are having contact. My daughter fights hard to stay away from drugs when she has contact. But I see whenever she is granted an extra overnight stay that she very quickly becomes irritable. It’s tough both for her and me, but I also see her joy at coming with us on trips to the cabin and having a relationship with the family.

As Rose said, being a family that travels together to a cabin, as Norwegian families do, and experiences joy with it is so important that they can endure what is tough for them. Maintenance of family routines and rituals is important to participants. Hanna talked about how she chose to spend an hour with her brother in her parents' house each Christmas after she could no longer invite her brother to her home. As Hanna said:

> Because now we’re going through this hell that we can’t celebrate Christmas together. It’s just as problematic every time – it’s just as painful every time. We have to part ways and we have to... it’s just crap. So I decided that instead we would go to church and participate in what was going on there, and I figured that okay, this year my time at church is together with the four-leaf clover. So I did that because I knew that he was

> going to my parents' house. That's how it turned out. A brief hour with the four-leaf clover.

As Hanna explained, participants made efforts to find a way to adapt family ties to the challenges PSU could entail.

Philip, a man in his late thirties, explained how grateful he was to his father because he always allowed him to live home. He explained how he appreciated that his father let him be part of the family, but he did not see how his PSU could also be a family matter. As Philip said:

> It went so far that I was in the process of destroying the relationship between him and his new wife at the time. Not because I was doing much wrong, but because I was actively getting high, living at home with my dad and his wife and my little brother who should really have been shielded from my behaviour. Things went so far that he came to me and said that if he had to choose he would choose me, but... and he put this in a really elegant way... it was something like I really like this woman and I don't want to lose her, but if you don't move out and stop being high around the neighbourhood then she'll be gone. That made me realise that my substance use... you see, I've always believed that I'm getting high for my own sake rather than to bother someone else or my family. I don't do it to be mean to them – I do it to be kind to myself. But there and then the penny dropped that my substance use was affecting people other than myself.

I find in Philip's story the plot of how family ties create commitments both ways. Father allows Philip to live home while risking consequences, and Philip moves out from the family home to protect his father from these consequences.

Lars, a young man in his twenties, talked about choosing family ties and caring for his father. He explained how he, while using substances problematically, experienced that his father suffered a stroke. Lars told how he visited his father daily to train him and how he managed to limit his PSU while visiting his father.

> He was pretty helpless when his whole right-hand side went to shit. So that needed stair climbing training, and I knew that he was sitting there all on his own, for sure... and I knew that when I made it up there to be with him it wasn't like he was yelling and screaming at me. He appreciated that I was coming to train him. So it ended up that I wasn't using too much when I was up with him. Because he was dependent on me being ready in case he fell. He was completely helpless. I really did a lot for him. Because before he had his stroke, my father would – no matter what time it was provided he wasn't in Thailand – always come through for me. Time after time after time. He never failed...

I was surprised that Lars stuck to this commitment despite ongoing PSU, probably revealing some of my prejudices. I asked further:

> L: He never failed…
>
> S. So that made it natural for you to take care of him?
>
> L: Yes
>
> S: But still, I have worked many years with problematic substance use, and I believed that it may not always be easy, no matter how much you want, to choose something else than substances?
>
> L: No yes
>
> S: But you did it. Have you thought about it afterwards that what made it possible for you?
>
> L: hm.. No, he was completely helpless. He couldn't do anything himself. He's got nurses and stuff like that, but... I don't know. I feel it now also, because I can't so easily visit him because of the Covid situation.
>
> S: Hm
>
> A: He has such an electric chair now and he does not give a shit. He just drives out.
>
> S: (laughs)
>
> L: (laughs). Driving around the water on that chair. I visited him last weekend, so. No, we have good contact.

Reflections on "A story of family ties"

How does "*a story of family ties*" differ from "*a story of love*"? I think that family life with structures, rituals, scripts, memories, values, and so forth has a multifaceted impact on individual lives. Family ties may be an ideal, a sense of the family. It may give a real feeling or illusion of belonging. Either way, it seems to mean a lot to participants. They make great efforts to achieve a version of what family means to them. If Christmas cannot be celebrated as it was before, they create a variant that everyone can agree on. Family ties can be maintained within demanding consequences, and they can be prioritized over PSU.

Aarseth (2018, p. 85) writes that the family in Norway is, to a lesser extent than before, something one just has, people that just are there and on which one can always fall back:

> The glue in our close relationships is based on emotional bonds. These ties are something that must be done and created continuously. It causes a deep tension in our close relationships, between on the one hand the longing and the dream of belonging and cohesion that we can always be confident in, and on the other hand the knowledge that we can never be completely safe.

If so, why do families in which PSU creates relational trouble put in so much effort to maintain family ties? It seems that participants, through their stories, construct their family relations in spaces between the problematic and the significant. The significant can be memories about family as it were, storylines about actions that showed family affiliation, ideals about the importance of family, and feelings about belonging. What is significant for participants differs, but the common theme is that participants give significance to some family ties in their stories.

6.1.3 A story of fear and preparedness

"*A story of fear and preparedness*" is about how participants talk about how having PSU in a family means stress and upsetting situations. Fear causes an unpredictable existence, which

participants describe as a constant preparedness for something frightening and dangerous to happen. Preparedness is being described as “a radar”, “hypersensitive antenna”, or “continuous tension”. For me as a listener, these parts of the interviews were special because the participants talked about their fear and preparedness expressively and in detail. I could often imagine the situation visually and feel their fear and worry in the room. I recognize many plots about how PSU and being together with persons affected by substances is potentially dangerous.

Marion, the mother of two adult children with PSU, has a harrowing story about preparedness for dangers with PSU. Her son died because of PSU, and her daughter has ongoing PSU. I find in Marion’s story a plot about how the PSU is not only potentially dangerous but also potentially deadly. Marion made statements about herself as a strong person, with a self-preservation drive and an acknowledgment that nothing can break her. Nevertheless, she told me about days when she must call at work and say that she could not make it today.

> I don’t know how to explain it, I just feel so insanely empty, so I do all the things that I’ve learned will help. I go out, I have candles on the table and flowers and I cook and eat. But then the evening comes, and I sit there with dread in my stomach. What’s happening, where are they, what are they doing? I can’t even bring myself to scream.

The quote shows which effect a plot of PSU as potentially dangerous and deadly seems to have, giving little room for maneuver. Marion talked about how her fear created conflicts between daughter and mother. The mother was worried about the daughter, and the daughter did not want the mother to be concerned.

> She feels controlled and I feel left out. I know that things happen that give me a good reason to be worried. She doesn’t contact me because she doesn’t want me to see her like that. She waits and sleeps in so I don’t see how bad it is. I know that she’s been assaulted, raped, I know that she’s overdosed, but she doesn’t say much. I think that with her, it’s how it is with me. There are two levels. I don’t need to know everything,

> but I need to know that she's alive and that she has plans and that she's safe, which she isn't as long as she's taking drugs.

The plot of PSU as dangerous and potentially deadly makes constant preparedness necessary. Marion told how she tried to handle her fear and preparedness by searching for more information and control. As she said, she does not experience that her fear is recognized either by her daughter or by the services. Marion explained that she was very conscious that her daughter could die. She had even checked that it was possible to put an urn with her ashes in the same grave as brothers. In the interview, Marion described how exhausting it was to live with the fear of all dangers of PSU and the risk of death all the time, although she thinks that she is very good at putting the fear aside. Marion explained that when she does not get in contact and is scared, she tries very hard not to call anyone. Marion has statements that describe the tension she feels:

> I walk round by myself, I take the dog out for walks. If I had the right sort of carpet, I would have worn a path into it like Donald Duck does, because I just walk back and forth, around and around. Then I think that maybe I should take a trip to visit my mother, so I drive to see her. After half an hour I start to feel like I can't stay there. I get restless.

Marion described in interviews how hectic she could get in her fear, making her do many actions she knew did not help. As she said:

> So I sent her loads of messages on all channels. Please let me know you're okay, I'm getting worried, I know you don't want me to bother you, but can you just let me know that you're okay. I ask if there's anything she needs help with. Should I pick her up from somewhere. It's a lot of that, and I understand that she gets annoyed. If she'd not had drug problems, and I was controlling her life that way, it would have been abuse, to harass someone like that. But she doesn't see the messages, she doesn't care and she doesn't bother to read them. So sending all these messages doesn't help. I just have a bad conscience and I know she's annoyed with me. And what's more, not getting an answer just confirms to me that something's happened, so I get even more afraid. So it would be better for me if I could refrain from sending these messages. At

> one point or another, you cross a line and start invading another person's life. I'm very aware that my worrying is something I have to deal with, it's not her problem that I'm worried. I can't do anything for her, but I have to do something for myself.

Marion talked about a demanding dilemma. She explained how she both thinks that a mother who worries so much about an adult daughter is unnatural, but at the same time and because of the dangers of PSU, she can allow herself to do it. But she also had statements about the ambivalence, questioning her right to be afraid and prepared: "I have to do something about me". Marion's story about fear and preparedness is detailed, real, physical. I am holding my breath with her. It appeared to me as a story about a person trying to control overshadowing, all-encompassing fear.

The same feeling I got while listening to Veronica's story. It is a story of a person who has been terrified many times but survived. Veronica's ex-partner and father for her child has in periods had PSU. She explained how she had seen him at his worst while substances impacted him, and everything had blacked out for him, and he had been violent. She explained how she often had been prepared for difficulties because she prepared herself for him being again affected by substances. In Veronica's story, I find a plot about how the PSU is potentially dangerous for herself and her child, even deadly dangerous. As Veronica said:

> I often have a gut feeling that something bad is about to happen. A radar. Once we were arguing on the phone, and I just had this gut feeling that something was going to happen soon. I was just waiting for him to come. Then his car shows up, and I, like a fool, just ran outside. All I was thinking was that he couldn't come inside, because my son and my stepson were in there. So I ran out and jumped into the car, but I didn't think we were actually going to drive away, but we did. He was frothing at the mouth, and I just sat there shaking and then I threw up. Then I had a panic attack, and I thought he was going to drive me into the woods and everything else. Then everything changed, and he said, my god, you're scared of me. I love you, and you're the mother to my son.

Veronica told how her fear and preparedness in periods affected her mental health. She has several statements about how she is always prepared that her ex-partner can be affected. Therefore, as she talked about it, it is potentially dangerous to meet him. She explained how difficult it is for her not to have control of his condition.

> I had a long period where I had panic attacks, only I heard a message sound. I thought afterwards that it must be harmful to our son, no matter how I tried to hide it. I was completely worn out, mentally. Because it was so...it was so completely...it gets very engrossing, in a way, and then you're supposed to be the healthy one. But you're actually in a situation where you have no control over what happens. You can't choose, because it's not you doing it and there's a lot of emotions involved at the same time. It's like being poisoned, slowly but surely.

Because of the plot about PSU and substance-using persons as potentially dangerous, it becomes essential to be prepared for this possibility. Veronica told how important it was for her to know if her ex-partner had taken substances and to be prepared for the potentiality her ex-partners had used.

Nina grew up with her father's PSU. She told me how fear and preparedness were a big part of her childhood. Nina's story is rich with descriptions of the potentially dangerous, even deadly dangerous PSU and the potentially dangerous substance user. She told about the long list of fears she had as a child:

> I was scared that I wouldn't be allowed to see him anymore because I realise that he wasn't able to take care of us in the same way as my mother. I'm afraid that if he moves out, I won't see him anymore because I feel that I'm taking care of him. I do, and I do it to a large extent, I do take care of him, and I think that he could die, he could harm himself or others. But driving drunk, running into someone, breaking into places, getting caught by the police. There's so many episodes where he's been more or less dead drunk where I have to wake him up, and I think that if I hadn't been there, he would have died or been very seriously injured. I'm scared that he's going to start being violent towards my mother, so I have a lot of fear about that obviously, that she

> could get injured. That she could be killed. I've probably been afraid of him hitting me, but I think the fear that he would do something was much greater than the fear for my own safety. The fear that he'd burn the house down, either on purpose, or because he smokes in the house and falls asleep with a cigarette in his hand, or he puts things on in the middle of the night, he'll turn the stove on and forget to turn it off. I remember being afraid that he'd eat my rabbits. He once said that rabbit tastes really good, and I know now that it was completely illogical but for me at the time, it was real. I was scared for my sister. In a way, she was like my own child and I took great care of her, so I was very worried that she'd be as scared as me and that she'd experience the same things as me, and that she'd be hurt or frightened. Then I was scared of financial things because I eventually realised that my mother would get angry because my father spent money on things that he wasn't supposed to, and bills weren't getting paid. Lots of adult things like that, afraid of infidelity – because I eventually realised that he was unfaithful – so I remember writing on his cigarette packets because I thought the other women would see he had children.

"*A story of fear and preparedness*" can appear in everyday life. Family life turns out in interaction which does not feel natural. Hanna had descriptions of situations where everyone in the family becomes strange. She found it painful to handle this stress and worry about sending her daughter to her parent's house because she was unsure that they would have managed to care for her daughter if her brother had come to visit. She told how exhausting fear and preparedness could be for the whole family. As Hanna told:

> I can see that my parents can't stand much more. Mum's started having some sort of anxiety attack. Everything goes black for her and it reaches a boiling point for her. The difference between my mother and father is that my father is more able to open and close things. He manages to shift focus and do other things and get some of his life back, while mum just goes on hold between crises. She walks around feeling afraid and worrying about death. She's scared that my brother will die. My brother is in a chronic crisis. One crisis is worse than the other.

Participants' stories of fear and preparedness are told in strong, physical words. The consequences are felt in the body; they shake, vomit, head spins, panic anxiety takes over, and

death anxiety comes. The body is under an intense load. The plot about PSU and a substance user as potentially dangerous, even deadly dangerous, either to a substance-using family member, themselves, or other family members, seem to make the struggling preparedness feel necessary.

Reflections on "The story of fear and preparedness"

Research about ongoing PSU reports on terrifying situations, from episodes of violence and experienced horror to conflicts and an atmosphere of mistrust and tension (Lindeman et al., 2021). PSU is a process with an unknown course, and it is sometimes dangerous, potentially deadly, for substance-using people and others. Focus on my analysis is nevertheless not on the real dangers, but on how PSU in participants' stories is presented and interpreted as dangerous and which effect such stories had on their lives.

There is a lot of fear and preparedness associated with PSU in participants' stories. It can be situational triggers or false alarms that remind participants of previously frightening events. It may be situations in which everyone feels awkward and tries to find the best available solutions in the situation. The fear is also perceived as little recognized, leading to participants trying to hold back and hide their fears.

Adult children's problems and successes influence the relationship and impact their parents' well-being and worry for the other are typical in a parent-adult child relationship (Crow & Myers-Bowman, 2011). Both Hanna's parents and Marion do what parents often do – worry for their adult children. Likewise, Marion's daughter does what young adult daughters often do; she is irritated with her worrying mother. In Norway, parents are expected to make efforts to have shared parental responsibility after a break-up. The plot about dangerous PSU seems to conflict with ideals of family connections and relationships, as they are presented to should be in Norway. Hanna's parents and Marion prepare themselves for their substance-using child's death, maybe experiencing anticipatory grief (Dyregrov et al., 2020). Marion has

already lost one child to substance use-related death, so she has thought the thought and imagined the abyss. Marion and her daughter present two family communication levels about the dangerous PSU. They choose not to talk about this topic, but at the same time, they are aware that they both know that it is there.

I wonder why these efforts to silence the fear of death and dangers of PSU are necessary. In Norway, people take challenging hiking tours and are often reminded about The Norwegian Mountain Code in the media. One of the codes is that the hiker should inform others about the route they have selected, and if the others have not heard from the hiker, it is important to alert rescuers. My perception is that in Norway, it is acceptable to be afraid for a hiker in dangerous terrain, mountaineers, skydivers, family members who are seriously ill or have unsafe tasks or demanding life situations. It is okay to speak up if a family member takes big risks, does not wear a seat belt or life jacket, or takes shortcuts through dangerous areas at night. So why do the study participants seem to be making efforts to mute, hide and stop the fear? I am wondering if the central idea of the addictive family who is too involved and should not be so involved could be part of it. There is a great deal of stigma associated with PSU, which perhaps makes different feelings around PSU harder to talk about. A death from PSU is more shameful than death from falling off a mountain for the bereaved (Dyregrov & Selseng, 2021).

6.1.4 Story of protecting other family members from PSU

The story of protecting other family members from PSU is strongly evident in participants' interviews. PSU is presented to transform the person using substances into a dangerous and irresponsible person. Protection from PSU is described as a solid motivation for actions. The desire to protect children from substance-using adults is significant for many participants.

Rose took over the care of her grandchild immediately after she became aware of her daughter's PSU. Her statement shows how obvious this choice was for her:

> So when there's a child in the picture...I've been very concerned about children...I think that I could have gone overboard when it comes to children. That's what I think. Even with my own.

Fiona has a sister with serious PSU and four children. Fiona has tried to protect her sister's children for nearly thirty years and is a foster mother to some of them:

> The reason I'm crying now is because I remember all these parties where I...it just came to me in a flash...I picked up kids there, I was woken up in the middle of the night to pick kids up at a party, and one time my sister had cut up her whole hand. I thought that I don't give a shit about what's happening with you, I'm taking the kids first. So I took the kids home and got them safe.

Fiona told a story of protection as it was the obvious choice to make. The plot of a substance-using person as dangerous and irresponsible makes them unsuitable as parents. Fiona is still overwhelmed with emotions and struggles to tell the story, but she managed to "pick up the kids". In the stories of protection, participants put aside their own needs to protect children from PSU. For example, Philip had fought for his daughter's care because the daughter's mother had mental health challenges. Life was good for a while, but gradually his PSU took over:

> Once I had a taste of being high again, it took a few days, and I was sat in the bathroom with syringes in the morning. Eventually I realised, I really realised that this wasn't working, I couldn't stop, I couldn't take care of her needs.

The plot of a substance-using person as dangerous and irresponsible makes them unsuitable as parents. The impact of PSU in this plot is that the person is no longer able to meet the needs of others, especially children. Philip shares this point of view. He sought help from his sister and was met positively:

> She said, my God, yes. And so I started to cry, and then she said I didn't need to explain, just come with her. I said thank you, and I called the child welfare services afterwards. So I asked if you could come, that my name is Philip and the address is...can you come over. Then two nice ladies from child welfare came to visit.

Philip talked elaborately about protection; all the details were to be included. He folded his arms and showed the syringe marks to me, as he said, see, here was a child not supposed to be. He told a story about the choice he and other persons in the story are pleased with. This child was supposed to be protected. The dominating story in Norway is that it is impossible to be a good parent and protect the child with PSU.

Nina, a woman in her forties, grew up with her father's PSU. As a child Nina experienced many frightening episodes caused by her father. As an adult, Nina also has other stories about his father:

> He could listen to me, and he met me on emotions. He was understanding and very un-judgmental. I felt like I could tell him a lot more than I could tell my mom about my stuff both because she didn't have room for it and because he was genuinely interested. Han engaged in things I did. I think he knew a lot more about how I felt at school, what I studied, and we did things together. We built exhibition boats, miniature boats, we watched movies, so we did a lot more. In a way, we had a closer relationship actually or maybe not closer, but deeper emotionally than me and my mother had.

Protection stories are primarily about children, but they can include adults as well. For example, Lars, who has had many years with PSU, tried to protect his family by distancing himself. He was afraid that his family would be affected because of his problems.

> …you live in a shithole, where people are so sleazy and cunning and they steal from you. They're doing everything they can to destroy you. Almost everyone was against each other. But some are worse than others, so you get sort of psychotic and you're afraid that something will happen to your family. So I kept away because of that. When I went to see my sister, I turned off my phone and the GPS and took out the sim

> card, so that no one could know where I was. I was scared that someone or that bastard would come after me.

Sometimes, distance taking may be the only protection left to give to a family, as shown in Lars`s story.

Reflections on "A story of protecting other family members from PSU"

In Norway, the most important relationships are often described as family relationships. From that perspective, it is not surprising that "*a story of protecting other family members from PSU*" seems to be so central to participants. How families can protect growing children and youth from PSU has been a topic for research projects (Kumpfer et al., 2003). Family-based protection on PSU in youth is seen as an important part of preventing PSU.

Participants in this study had experienced that PSU already had found a way to the inside of families, and the task of protection from PSU is different. Protecting children from PSU is a crucial professional point of view in Norway. Leading teaching literature for professional practitioners in health and social education programs conveys that it will always be unfortunate for children to grow up with parents with PSU (Bunkholdt & Kvaran, 2015; Kvello, 2015). In Norway, it is a solid narrative resource that children and adolescents should be protected from substance-using parents. Counter-stories of parents being more than their PSU or having several sides as a parent are not as common as narrative resources in Norwegian society. Internationally, too, there has been little room for more nuanced presentations than the cultural trope of 'junkie parent', and the simple binary rationality of good (clean) and bad (addict) parenting», as Rhodes et al. (2010, p. 1497) wrote. Although these thin counterstories about parents being more than just bad parents may be part of how participants assemble meaning about their family relations, they may be more difficult to tell than the stories of problematic parenting. As Rhodes states from the UK: «There is little public space – including within helping services – encouraging of open talk and reflection

about what constitutes good parenting in the face of problem drug use» (Rhodes et al., 2010, p. 1496). Rhodes and co-authors claimed that this could make it demanding to substance-using parents to seek help.

6.1.5 A story about tough choices

This story is about making decisions which participants talked about as tough choices. The participants were in a situation where choices must be made, but none of the options were optimal or straightforward. There is a plotline of "'the consequence of the choice is a burden the participant must bear". They must choose between the devil and the deep blue sea. The devil in stories is often the dangers of PSU in the face of family ties, love, and the need to protect several family members simultaneously. This plot is referred to in statements that describe how difficult these decisions are to take and how demanding life with the consequences can be.

Hanna had a history of strong family ties in the face of her younger brother's PSU. She called her family a four-leaf clover—mother, father, rebel brother, and the regular-type sister. For a four-leaf clover, it was important to maintain family contacts despite her brother's growing PSU. The change came when Hanna experienced episodes that crossed her line as a mother to her children. She had to decide what kind of contact she could have because she experienced her brother as unpredictable. Thus, a four-leaf clover, her picture for longstanding family solidarity, was forced to change:

> It's brutal, because it's always been the four of us, and then I was excluding him and saying he couldn't be with us, and that we couldn't be together. But then it was Christmas and a misjudgement. I knew it when he came through the door. He wasn't where he was supposed to be.

Hanna talked about this Christmas with immersion, which allowed me to be aware of the tension they felt that night:

> I just got strange, and my parents got strange. Everyone got really hectic. I realised that we were in the middle of something we had no control over, and it was supposed to be Christmas, we were supposed to have two little kids with us, and Christmas is so important to my family, maybe one of our most important traditions. But then he was so hectic and high, and I saw how my children reacted and withdrew. It was such a challenging atmosphere, to say the least, we just walked around trembling. Then it dawned on me clear as day that we just had to eat our dinner, open the bloody presents and then get the hell out, because I couldn't handle it, I couldn't bear it. Everything was ruined because it was starting to get completely out of joint. I can bear this, Mum can bear this, Dad can bear this, but I can't bear the consequences it has for my children. I saw how Mum and Dad mobilised their whole body language. It was very unsafe. I saw that they were trying to calm down, and the whole mood was just everyone trying to fix it. I felt that my parents weren't themselves at all. My youngest child tried to have a little extra contact with their grandfather, and my father couldn't quite take it in.

It was the first time Hanna felt her brother's problems went beyond her needs for family life. It provoked a decision of a change. In Hanna's story, this seems to be an important plot. The original four-leaf clover had to give place for the new four-leaf clover. Mother Hanna protects her children, but daughter Hanna, family-loving Hanna, does not do it with an easy heart.

> Now this is going beyond my kids. Their grandparents will be inaccessible, and we adults will be weird and the children will get scared. It won't work, I don't want it, it can't continue. I've really pushed the envelope and didn't expect anything in return, but this is my limit.

Rose described in the interview that she had chosen her grandchild's interests instead of her daughter's needs. Rose had made a choice, but the consequence of the choice is a tough burden for her to bear. She told how difficult it had been for her to realize that if her grandchild had been in another home, her relationship with her daughter would have been different. The strong narrative resource in Norwegian society is that a mother does not leave

her child. Mother is the archetype of protection and care. Rose described how she could have been this Mother:

> I'd held her in my arms. I hadn't left her alone. I'd been the worst nightmare she could ever have imagined, because I wanted her back at any cost. That's how my daughter sees me. That's how my whole family sees me. So the dejectedness which says that you can't do anything is terrible. I've also talked to my daughter about that. She's also asked that I never give up on her, and I don't want to.

But Rose had a dilemma. She has a grandchild, innocent, more in need of care than her daughter, who she felt she had lost to PSU. The following statement describes why Rose had to distance herself from her daughter to protect her grandchild and protect herself:

> There's nothing like all those bad feelings, all these bad trips. I've had calls where I've been told that there's no certainty she'll survive, or that they'll be able to find her. So I hang up, and go and play with her son, not knowing if his mother is dead or alive. It was just as painful as someone tearing down absolutely everything I had and stood for and was. I felt that it was so painful that I couldn't process it. I can't allow myself to feel like that, because I don't know how many times I could handle it.

Not being able to protect both her daughter and her grandchild from the dangers of PSU is a plot of suffering in Rose's story. She can't choose them both, and she is no doubt who to choose, but the choice is painful.

For Fiona, her choice to become a foster mother to her sister's children costs many relationships. She told how she has a poor relationship with her father and siblings because she has taken such a solid stand for the children's side:

> I've spent a lot of money on everything they needed, lost a lot of relationships. My first boyfriend said I had to choose between the kids or him, and of course, I decided to be on the kids' side. My choices have also impacted my marriage that ended in a breakup.

The hardest part for Fiona is that she has protected her children less by choosing to protect her sister's children. She explained how she must bear the burden that her choice has had consequences for her children:

> The most difficult things to think about are my own children. The worst thing is thinking that because of the choices I've made, they've seen me as a mother who has been very scared and on standby all the time. I've been so exhausted; I wish I could have enjoyed my own children more.

Some choices are so complex that they will never be fully taken. Frida explained how choosing to distance herself from her parents had been a continuous movement. Her mother has had severe PSU for as long as she can remember, and her father can have periods with hefty alcohol use. Frida had taken distance from her parents in periods, but these decisions have been full of ambivalence and doubt:

> I'm very divided. Even today I feel a lot of pain towards my father, but then I know that it isn't my responsibility. It's not so easy to just leave a person in it, but it's such a heavy matter than you can hardly stand it. Seeing someone just lying there like that, and another person going and serving the other person until one slowly but surely dies. I love them and have lots of good feelings for them. It's been a process, I've gone in and out of it. I've been closed off for long periods to try and live my life. It's clear to me now how difficult it is to bring out the whole story and describe emotions. You become so disconnected that you just have to keep going.

Using Celia's words, her 19-year-old daughter is "a complicated compound creature" who has struggled with an involuntary eating disorder since she was a newborn. Celia explained how her daughter resisted all the help and how her life has gotten worse by the service she has received. Daughters' PSU began at the age of fifteen years. After staying in institutions, Celia explained how her daughter now lives in her parents' home with her boyfriend, who also has PSU. Celia explained how the choice they both wanted to make and were forced to make made the lives of her husband and herself terrible. She made statements that describe how

their own life stopped entirely, and her relationship with her daughter had become emotionally cold:

> We can't do what we want ourselves, so we're locked in. We cannot leave them alone at home, so we are pretty much home all the time. She says that we destroy her life and all that, but it gets to a point where you don't like your own kid anymore. At least not who she is now. When she comes to give me a hug, I don't really want to hug her. At the same time, I know that I'm certainly not into it, so she knows it, but I don't want to push her away. Something has happened inside me. I feel sorry for her, but that isn't the same as liking her. I feel like I've become cold and cynical, but I think it's a survival strategy that I've made for myself, simply because I don't think it would have worked without it.

The plot of the Mother, who is supposed to love and like her child whatever, is in conflict with the plot of PSU, transforming a person into a dangerous, immoral, and not likable person who she needs to protect herself from.

Reflections on "A story about tough choices"

The story about choices participants labelled as tough appears as a story full of ambivalence, doubt, conflictual positioning, and paradoxes. This ambivalence is between protecting the family from PSU and being the family member participants wished to be, and in idealized descriptions of family life ought to be. Conflictual positioning between protecting own children and protecting parents, siblings, and siblings' children creates doubts for participants if they have made the right choices. Even if they are sure of the choice, it can be painful. Paradoxically, longstanding family solidarity may lock family members in demanding situations, but giving up the family traditions or well-anchored family ideals is also demanding. Seeing family dynamics affected by PSU draws a different picture than seeing family members' PSU affected by family dynamics. For instance: is Celia's daughter using drugs because her mother does not like her, or does Celia struggle to like her daughter because her daughter's PSU has transformed her into a person who is hard to like? Or have

her longstanding somatic and psychological challenges formed her into someone who needs substances to like herself, but who may, because of PSU, become a person from whom family members protect themselves from? Is Fiona rescuing her sister's children with hard costs for her own family because the consequences of PSU in a family require it from her, or are her actions a way to survive demanding childhood, just like her sister's PSU? My answer as a systemic researcher is that I believe that living life is so complex that it cannot be understood as a single causal explanation. Living life is complicated and complex and cannot be met with one-dimensional understandings or simple explanations (McLeod & Sundet, 2020). As a narrative researcher, I believe that the narrative analysis can help gain insight into this complexity by showing up some of the processes that create dilemmas, paradoxes, and complexities.

Expectations, participants' own and others, about the different family positions and roles seem conflictual and demanding. Hanna as a daughter, mother, and sister, Rose as mother and grandmother, and Fiona as a mother, daughter, and foster mother, struggle to accept that they cannot live up to their own and others' expectations. These participants talked about complicated motherhood. The story of the archetypical mother is about the Mother who does not leave her children and does not stop loving them no matter what. It is hard for a mother in Norway to say that she does not like her child. However, in Celie's statement, I can sense the use of another narrative resource. It is a story about PSU that changes a human being and can be met with tough love. A mother can leave a child with PSU, but it is not straightforward. Celia is suffering. The Mother may choose grandchildren before a substance-using daughter, but it is not straightforward. Rose is suffering, her daughter is suffering, and maybe her husband and grandchild also are suffering. Fiona, the Mother, rescues her sister's children, but even the rescuer is suffering and doubting the choice she made.

6.1.6. A story about the unforgivable

The following story I found in the material I have labelled as "*a story about the unforgivable*". Several participants told me about experiences that have wounded them so that it felt impossible to forgive. The plot of the story is that some choices you just cannot make as a family member without making wounds that do not heal. These wounds impacted how participants assemble meaning about their family life and relations.

Philip talked about how his parents contacted child welfare immediately when they understood that he had PSU because they were unsure what to do. They had barely heard about drugs. As a result, the Child Welfare Service recommended sending Philp to an institution for substance-using children:

> It was overwhelming and strange. I stayed at home with my parents, and my sister and the cat, and then suddenly I was thrown into one of those child welfares regiments, which I've seen only on film and television.

In Philip's story, it was the start of the escalation of PSU, and he also experienced abuse in this center:

> I've been very angry with my parents. I still am a lot, really a lot. My mother has tried to apologise for things, but as soon as she starts talking about it I can't bear to talk to her. I have a very strained relationship with my mother and I think it's in a very large part down to this. I just can't let go of it – it just ends up to a total lock down. I'd prefer to just forget about her, but I have to relate to her. I have a close relationship with the rest of my family, and she's still my mother, even if the woman feels more like a stranger to me sometimes.

Philip has wondered why it has been so hard to forgive his mother. He has been thinking about this a lot. In the Norwegian narrative resources about parental love, the parents should endure, stand in the struggles, and show unconditional care. In Philip's story, the adolescent's

PSU is not legitimation enough for the choice of sending him away and is interpreted as rejection and betrayal:

> I think it's very strange. For example, I can feel closer to an older lady working in substance use services who cared for me. It feels as if the way they care for me is how she ought to have cared for me. That's particularly the case with my mother, more so than with my father. Maybe I have unknowingly blamed her and thought she should have done more, she should have thought it over another ten times and not accepted the idea of sending me away from home. So I think a lot of it is about the rejection associated with being thrown out of the home where I was supposed to be safe and where I was supposed to be able to bring any issues. There's something or other wrong which means I don't trust my mother.

Philip is telling a plot about tough love from an adolescents' point of view. It may be accepted and recommended that parents set limits on PSU, but it can still feel like rejection for the child. The mother should have "thought it through ten times", says a child.

Also, Celia described in the interview how her daughter was angry with her parents because of the treatment choices that had been made.

> She's distanced herself from us and believes that we inflicted her with the traumas that have caused her to engage in substance abuse now because we forced her to eat, and nagged her about food constantly, controlled her life in terms of food and so on. I don't know. I've decided that I have to accept that I acted in her best interests and did what I could. There are probably other things I could have done, but I didn't know about them.

The plot of an adolescent's expectation of unconditional care inside the family conflicts with the mother's plot about how some struggles are too big for parents to handle and need expertise outside the family. Celia explained how their decision and their daughter's reactions aroused different reactions between her and her husband:

> Her father is very deeply remorseful, and dwells on the choices that we made. He thinks that we shouldn't have forced her to be admitted or sent her to any institutions, but as far as I'm concerned we were given all this advice by professionals and it

> wasn’t us who said she should be forcibly admitted – it was the professionals. We didn’t have the expertise to make those decisions. But our daughter thinks we could have said that we didn’t want that for her as her parents. So I think I’ve acted in good conscience and I shouldn’t worry about it, but at the same time I feel that it’ll be enough. She distances herself from us and doesn’t want to engage and doesn’t like us.

The Norwegian narrative resources of the parents' task of caring for their children and helping them to adulthood stands strong as an ideal. The statement describes how difficult it is for Celia and her husband to negotiate a story about their decisions as parents in the face of their daughter's challenges.

For Fiona, her relationship with her father is a big wound. Fiona's parents divorced early, and Fiona and her sisters lived with their father. At the age of five, Fiona decided to be a good daughter. Fiona felt that she had to because her father had enough with her other two sisters. So, she started looking after her dad and stayed home, so her father did not have to be alone. As an adult has Fiona understood her father in a whole new way:

> I always felt sorry for my father, but as an adult I realised that it was him who had let me down. It was us kids who deserved pity. I understand much better why my sister ended up with substance use problems, and I’m frankly a little surprised that I don’t have more issues than I do. He didn’t have any control over us, he didn’t set boundaries for us, he didn’t check up on us. I thought I was stupid because I didn’t do well in school. I’ve blamed myself for not doing well at school, but I didn’t get followed up on at all.

Fiona could have forgiven her childhood, but not that her father has not supported her in her demanding role as a foster mother for her sisters' children. Instead, her father has expressed disappointment because Fiona was setting boundaries:

> He had never been so disappointed because he thought it was unnecessary, and that was when something happened to me. In a way, it was the repercussion for all those years since I was a young girl. I suddenly felt that I saw my father in a completely new

> way. I saw him as having let me down. He hasn't seen how I've been stuck in this all these years, he hasn't seen me, he's just taken it for granted.

Fiona talked about a childhood that has been challenging and in which she has taken a reversed role as a child taking care of her father, understanding his needs. But the reward is missing; the father is unable to see his daughter's needs and disappoints the adult Fiona.

Reflections on "The story about the unforgivable"

"A story about the unforgivable" is about expectations the children had to their parents, and how these expectations came into a collision course with the interpretation of PSU as a problem that must be handled by professional expertise outside the family home. When expectations of a parent staying on your side, without a doubt and with understanding and love, are not being met, it creates relational wounds that the participants carried with them for a long time and could not forgive. The effect of stories like the unforgivable may be important to keep in mind when understanding families' long-term recovery processes.

It may be challenging for participants to live with the unforgivable in a family. Forgiveness is central to the Norwegian cultural emphasis as part of Protestantism. Even though many Norwegians do not define themselves as Christians, the following quote from the Protestant prayer is included in daily speech: "and forgive us our sins, for we ourselves forgive everyone indebted to us.". In Norway, forgiveness is defined as a fundamental value in schools and kindergartens. It seems important to participants to justify the reason for the unforgivable with rich stories, and it may be necessary when you are meant to forgive, but you cannot.

6.2 Part 2: Stories of "how"

Part two presents "how" stories which are stories based on the ways stories were told and performed to me as a listener and on the emotional expressions shown both by participants and by me. I have labelled stories as "*Stories difficult to tell*", "*Directing the stories*", "*Stories with chaos*", and "*A story of doubt*".

6.2.1 Stories difficult to tell

Telling stories about events from our lives is often seen as an essential part of making sense and giving meaning to our experiences (Hydén & Brockmeier, 2008). Still, how stories are told and how the meaning of them is assembled can be a part of the painful, unfinished, and absurd in life. I have labelled these 'how' stories as "Stories difficult to tell". It seemed to me, or maybe even more *felt* to me, that either the whole story or parts of it sometimes were complicated for some participants to tell, while sometimes dialog was fluid, and participants seemed to relaxed talk about the topic. The impression that these stories were difficult to tell emerged in different ways. It could be how the words were used to explain why the story may never have been told before or why it was hard to tell. As demonstrated with quotes from Hanna (sister), Anna (partner), and Veronica (ex-partner):

> I really do feel like I'm selling everyone out...that's how I feel (Hanna)
>
> Do I have enough courage and, uh, what's it called. I don't know... I can also stand for it. And so I kind of asked myself whether I could deal with other people having opinions about my story. I don't know. Am I strong enough to cope with being bombarded by other people's opinion? (Anna)
>
> I have hardly ever told anyone about the violence either, but I guess it's because it's anonymous… [the interviews] (Veronica)

It could also be how my questions were received and how it made me unsure whether it was acceptable to continue with this topic. Lars is a young man in his twenties who is in recovery after several years of use of illegal substances. Lars stopped his story twice when the theme of fatherhood seemed to be too difficult to talk about. In dialog with Lars, I started to hesitate, as I have explained in chapter four. "How" Lars responded to my questions made me immediately think that the topic "what" was too difficult to talk about. This response contrasts with another dialogue (how) about a comparable topic (what) from interviews with Lise and

Philip. Lise, a mother of three children, explained how she took drugs after she had got her children in bed. She told how she looked forward to get the freedom to take heroin and be on drugs. The closest family was aware of her situation:

> Both of my sisters were always offering to babysit because I guess they knew what was going on and thought they'd be helping the kids. But in the end it just wasn't working. It was the kids' holidays and I was bracing myself and thinking how I couldn't let things for them go back to how it had been because then it would all fall apart. That was when I contacted child welfare and the kids moved to a foster home where they lived until they were adults.

Lise's way (how) of talking about the topic allowed me to ask further. It turned out that Lise had discussed this topic with her family earlier, and the family had found a way to handle disagreements about the issue:

> My sisters think they were kind and stepping up to the plate. And obviously at the time I thought they were kind too. But now when we talk about it with hindsight, I've said that I would have preferred them to say no. By looking after my kids every time I asked them to and coming through for me like that, I had greater chances to get high. They did it because of the kids, because they thought I'd get high either way. They thought that it'd be better for the children to be safe with their family at the weekends. It was well meant, so I guess we'll be discussing it to the bitter end. Even if they had said something, there's no guarantee it would have hit home at the time. So all in all, I think they probably did the right thing.

Lise emphasized that the conclusion of the discussion was not the most important thing. Instead, the critical part was the dialogue between the sisters: "But at least we've talked about it. We're able to talk about it."

In the interview with Philp, a young man in recovery as Lars, the "how" in the dialogue felt effortless and fluid. Philip told me a story about how he could not take care of his daughter without hesitation, and he allowed me to ask about different sides of the story:

> The taking substances was what I needed – it was a powerful point of focus. It was constantly inside me, and it stole a lot of time and energy and attention and needs. It took priority over everything else. Like today, my daughter is naturally one of my greatest motivations, but there was a period when I had her and that should have been enough, but where I still managed to push her away by getting high. I haven't managed to put her needs ahead of my own. That seems kind of weird to me given how much she means to me now. I mean, I've always loved her just as much, but there was a time when heroin and all that stuff was such a strong presence that even if I understood it up here, it wasn't enough for me to lay off it. Somehow, I had to lose what I had to realise what I had, I think.

Philip explained that the topic (what), not managing the role of parent, has been hard for him to accept, but he had been and was in an interview situation able to reflect on it and talk about it (how).

Reflections on "Stories difficult to tell"

The theme in Philip, Lise, and Lars' stories is their role as parents and how their PSU has caused them to fail in this role. Not being able to take care of their own children and having to give their care over to others, either voluntarily or because of the intervention of the child welfare service, is often difficult for parents (Syrstad & Slettebø, 2020). The participants imply that it is a significant failure and disappointment not to be able to take care of their own children. So, the topic of the conversation itself could explain why these stories can be difficult to tell, but that may not explain the contrast that I find in the stories. Lars will not tell his story, while Lise and Philip tell it without hesitation, not with ease, but coherent, and with thoughts and wonders.

The apparent factor may be the time. Lars tells about the new, unresolved situation, and his story is unfinished. It is likely that Lise and Philip's stories have been told already before because they appear better developed. Both have probably been in different contexts and situations, in which there has been a demand for a legitimate story about why the children are not with their mother or father. Both Lise and Philip link their story to their individual

recovery processes. Lise wondered if her way would have been different if her siblings hadn't helped her so much, and Philip wondered how the love for his daughter, which is now so important to him, was not sufficient in the past as a motivation for recovery. Stories take place in a specific cultural context, in which accessible shared narratives are resources people use to construct their stories. What narrative resources people have access to depends on where they live and what kind of stories are told there. The narratives of how the power of PSU is stronger than, for example, close relationships that I recognize from Philip's story and the narrative of how help and facilitation from close others can enable the use of drugs are known to be shared narratives in the substance use field. They are ideas rooted in thinking from Anonymous Alcoholics and Anonymous Narcotics and widely used and accepted narratives of the power of PSU. From that perspective, it is a sign of responsible parenting to transfer the care of their children to others.

I became concerned about the loneliness of Lars' story as a contrast to Philip’s and Lise's. Both Lise and Philip have talked about topics with their children and their siblings, who have been foster parents. They have been a long time in their long-term recovery process. Lars has not spoken to anyone, and he doesn't want to talk about it. He has recently started his recovery process. As a result, Lars may have less access to narrative resources and recognition from others. Keeping in mind that there may be several reasons why these stories are told so differently, I nevertheless became concerned with the importance of listeners to stories people tell. The meaning of telling stories to other people, getting responses, recognition, correction, help in processing the emotions related to the story and can make the stories less difficult to tell. I wonder if it might be especially meaningful that Philip and Lise have discussed their story with their family members who also were involved in these life events. Perhaps recognition and acceptance from their children and siblings who were foster parents matter a great deal to how these stories can be told.

6.2.2 Directing the stories

I asked all participants to tell me how PSU became a part of their family life. This invitation gave some participants a starting point for a story that appeared as a clear direction and a plot for me. With a narrative direction, I refer to the storyteller as an agent who chooses how the story is told and tells a story with coherence. The clearest example of that was Linda's story. She is a woman in her sixties who lost her only son to drug-related death some years ago. Her story started:

> He was a much-longed-for child. We were trying for ten years before I finally fell pregnant. I was over thirty years old by the time I became a mother. And that was the greatest experience of my life. We only had him. He was an only child.

The story continued with Linda talking about struggles when her husband drank too much, resulting in divorce and moving, which became difficult for Linda's son. She described:

> When we lived in the old place, my son was an excellent pupil at school. But at his new school, he ended up in a class in his final year where there was always trouble brewing. Always skipping school, and I didn't know a thing about it. And it was awful. Both for my son and me. He was quite strong for his age. That he was. He was thickset and powerful. And he maybe had a few issues. He started smoking, among other things. He was totally against smoking.

Then Linda continued her story about her first meeting with PSU:

> L: No, and his lower secondary schooling passed by but he was mixed up in a bad crowd.
>
> S: Yes
>
> L: it was a sorrow without equal. He had real opportunities.
>
> S: Yes
>
> L: Yes. And when he graduated from lower secondary school, he applied to the drawing, design and painting track at upper secondary because he was so creative. And he was really good at drawing, and, well... He was like that. And, of course, he didn't get in.

S: Yes

L: He was at the top of the waiting list to get in.

S: Yes

I: But there were so many people he hung out with who applied to culinary college. And so did he.

S: Yes

L: And wouldn't you know it, he got in. Right away. There were a lot of people he knew starting there. And you know, they were smoking hash there.

S: Yes

L: I found out afterwards.

S: Yes

L: But not to begin with, as I'm sure you can understand.

S: Yes

L: And obviously he got into that.

Linda has now introduced PSU and her understanding of the reasons for this. She explained that the reason for her son's problems was moving, which resulted in dissatisfaction at school in a school class with a lot of problems and overweight that created poor self-esteem for her son. She went on to talk about all the periods of despair caused by her son's PSU and about periods of hope and family happiness. Finally, Linda ended her story by telling about life after her son's death:

> It's as if I've changed a great deal following the death. I really have. Life became different. It's very different. It's become so empty and it's quiet. And I feel so deprived. Because I lost the biggest thing I was ever given. It was him – my son.

Linda's story is coherent from start to the last word. It is the story of the long-awaited son that Linda lost to PSU due to unfortunate circumstances. Son and mother together battled drugs for many years, but at the end of the story, her son lost the battle, and Linda lost the biggest

thing she had ever had in her life. The interview lasted two hours, and Linda didn't lose the direction in her story once.

Hanna has a story, which is structured in phases. Each phase presents her parents' new understanding of her brother's PSU. Hanna told the story of her brother's PSU in an interview situation directed to the same structure she presented as the phases of the family's history of her brother's problems. The first phase was the story of a talented, rebellious artist for whom substance use was understood as a part of this alternative lifestyle:

> He should just quit being such a rebel. He should just quit. Well, he can keep doing his art, but he needs to somehow return to life or get back into work for example, or he needs to be able to provide for himself or... over the course of many, many years it was always the case that it would all work out one way or another.

The next phase was about acknowledging that the son and brother had a problem. Her brother was hospitalized in a psychiatric institution. Hanna told me how this forced a new understanding of a problem that was not disappearing by itself but needed professional help:

> The brutal story about what happened with Mum and Dad when they basically had to check up on him there and how he got separated from them and they had to just stand there watching them taking him away and leaving. I think that was probably what gave us a different language for it. I think that's probably what triggered us to start talking about it differently. My brother is my brother and he's having a tough time is often how I put it, but I can now say that he's a substance abuser struggling with addiction. And he's struggling with his mental health.

This phase is richly described in the interview and involves the family's attempt to help Hanna's brother. The next phase is about how the family opens the possibility that the brother's challenges are chronic:

> It's like we have updates on which crises are current, and how we're going to handle it. How should we handle it as a family, now he's there, now he's got no money, now

> he’s not got this and he’s not got that. So, we try to talk about how we shouldn’t get involved in the crises, but we still do anyway.

Hanna talked about how respect for her parents was why she followed their way of talking about it. She told me how she often had been ready to realize and talk about the seriousness of her brother's problems before her parents were ready for it:

> I just had to stick to that story, even if it didn’t fit. It was a sort of loyalty, like this is what they’re saying and this is what we’ve agreed we can say. It was like an informal agreement, or a silent agreement, that it was the way it was, or the way I understood it was.

Hanna explained why the approval had to come from her parents:

> I understood that they needed to talk about him in their own way in order to survive and to think that there is always hope. So it was important to have hope and even to this day, we may still have a trace of hope although it is constantly diminishing. But I think the way we’ve talked about this has often largely hinged on that hope – that it would all work out and things would get better, that things would improve for him. Dad is perhaps the foremost advocate for hope alive, so I very much perceived it to be a necessary survival strategy for us to keep up hope and if we began instead to talk about our brother or our son as a substance abuser who is right there having a hard time, that hope would basically have vanished.

Towards the end of the interview, Hanna directed her story to a new phase when she explained that she had begun to doubt her family's ability to help. She started her sentences with “I” instead of «we»:

> At any rate, I’ve started to talk about how this is beyond our control. We can’t pretend that we’re reaching him or hitting home. [...] For my part, I feel that I need to let go of the helper – I’ll never give up on that little hope, but my bigger dream is that he’ll find peace. That’s just what I’m doing, I always will do and all that...miracles happen, but I have to stop trying to control it. It’s completely impossible. There’s no chance.

At the end of the interview, I sensed another new phase and direction for the story:

> So it [the support] probably won't be in a position to do anything either. It's just too bloody awful, it'll just stand on the sidelines and wait for him to...What are we waiting for, we're waiting for an overdose, we're waiting for his body to...I'm waiting for his body to give up, unfortunately. I think, if I'm completely honest, I believe that's what's happening, in a way. I don't think he'll overdose, I think his body will collapse.

Hanna explained that she believes that her brother won't live long and prepares herself for his death.

Reflections on "Directing the stories"

"*Directing the stories*" concerns how participants talk about the family's history of PSU in ways that are appropriate for them. They choose the direction, the plot, and as Frank (2010) wrote, the direction of the stories affect possibilities for actions. PSU is often a longstanding problem before family members become aware of the extent and seriousness of the problem (Lindeman et al., 2021). The family process every so often involves a long-lasting 'rollercoaster' between hope and mistrust and painful resignations (Lindeman et al., 2021). As a listener to Linda and Hanna`s stories, I was told the plots about how a close and beloved family member developed PSU and how the storyteller chooses to understand the challenges and own possibilities to influence the direction in the story.

There is no hope left in Linda's story because she has lost her son, "the biggest thing she has got". In Hanna's story, the hope is also about to disappear, but the story shows how Hanna and her family are storying agents who have been able to choose the direction to their stories that have maintained hope. The family members take ownership of the meaning-making of the brother's challenges. Hanna's story tells how she has chosen to be loyal to her family's history, but eventually also with ways that exempt her from control. She can choose the direction 'or her story, and she can choose to tell it in other ways. New directions give new possibilities to actions.

It seems that Hanna is moving her brothers' story from the restitution story to the chaos narrative. The basic plot of the restitution story is that “yesterday I was healthy, today I am sick, but tomorrow I will be better” (Frank, 2013, p. 75). In the chaos narrative, the plot is that “life will never get better; no one is in control” (Frank, 2013, p. 97). In the chaos narrative, as Frank described them, the individual tries to reassert predictability, but these attempts generally fail, and efforts have a cost for the individual. But Hanna’s plot is also about restoring predictability in her own and family’s life. Hanna is crying while telling me how she had understood that the family lacks opportunities to help his brother.

To me, the theme of accepting chaos and lacking control feels like a catharsis in Hanna’s plot. This plotline seems familiar, like the narrative of codependency and recovery in families. It is about how solid emotional ties between especially parents and children often mean that the parents go to great lengths to help their children when they are in trouble, which can negatively impact their health and social situation (Jackson & Mannix, 2003; Nordgren et al., 2020). Stories occur in a specific cultural context, in which accessible shared narratives are resources people use to construct their stories. What narrative resources people have access to differs according to where they live and what kind of stories are told there. Both Hanna and I live in Norway, where AA and Al-Anon co-dependency narratives about PSU and family ties are common, like in most Western cultures (Vederhus et al., 2019). These ideas often suggest that the family members set up boundaries and stop helping the substance-using family member because family members are powerless against the forces of the PSU. Their help is useless and can, at its worst, enable the substance-using family member to continue to engage in PSU (Nordgren et al., 2020). Hanna has begun to ask critical questions about whether the help the family offers has any purpose: “I’m at least starting to talk about this being out of our control. We must not pretend that we are reaching in or having influence.” I also understand this as a possible process of anticipatory grief, defined as grief that occurs before death

(Lindemann, 1994). Hanna's story may talk about preparation for the loss of her brother and grieving the brother she already has lost.

6.2.3 Stories with chaos

"Stories with chaos" are about how some of the stories participants told in my interviews appeared chaotic and with a structure that was hard to follow. Narrative authors, as Frank (2005, p. 97), have noted that some stories reveal vulnerability, pointlessness, and powerlessness and can be challenging to listen to. Similar thoughts have Hydén and Brockmeier (2008), who wrote that stories might not be that developed, especially in the context of real life and actual illness. They are undecided, fragmented, broken, narrated by voices struggling to find words toward meaning and communication (Hydén & Brockmeier, 2008, p. 2).

An example from my interviews is how Frida struggled to start her story:

> F. I'd never really thought that, in a way that's what I can remember. I think there's just a few years I can't remember. I can say, for example, between or really everything from, I can't see myself from...hm yeah. Hm, what. Tell me where to begin.
>
> S: Hmm, but you aren't able to see yourself as a little girl...
>
> F: No, I can... I basically don't remember what I was like. No, I'm hitting a complete block here.
>
> S: You began by saying that some of the very earliest memories you have are from your adolescence, or...
>
> F: I want to say that it's sort of divided, because I have memories, lots of memories both from home and from a summer house where I've been a lot, but now it's just like my brain is completely disconnected. There's probably going to be a sort of explosion when I answer.

I felt the need to help Frida and I tried to comfort her too. My intention was to reassure her that it was perfectly okay to tell the story exactly as it came out:

S: yes, we take it easy

F: yes yes yes

S: and if an explosion comes, it is okei.

F: I probably don't have to go into all that, but what I remember is

S: hm

I: that there were problems at home I can think back to so that I may have been 10 -11 years old when I remember…

S: yes

F: in a way the arguing and drinking at home

S: The drinking - was it like both parents or?

F: yes, it was both

S hm

F: and then in a way it is my father who is most prominent

S: yes

F: because it wasn't such a secret. All the stuff was there.

S: yes

F: so, he could come home and I was watching how much goods (alcohol) were taken out of the car

Based on the transcript, it looks like I'm interrupting Frida continuously. That wasn't the case. All my little "yes" are there to encourage her to keep talking because she paused after each sentence. In time, Frida's interview was as long as the other interviews, but as a transcribed text, it is shorter because we had so many breaks in the conversation. Nevertheless, my feeling about “how” was that Frida was more comfortable that the conversation went on as it did.

Veronica's partly untold story about fear for her son and troubles in her relationship with her substance-using ex-partner was told with intensity and pain that made me keep quiet. She spoke of events and episodes in a chaotic order. Sometimes it was a difficult story for me to follow:

S: And when you say, “he was nuts”, what was it?

V: yes, then he was almost psychotic

S: Yes

V: it was sometimes at least and suicidal and, yes, I called the doctor, I remember. I had to move him out of that house and put him in another house because there were kids there and not, true… I should have done it in a completely different way had I known what I'm doing now. in a way.

S: Yes

V: But I didn't know. So, I had not done it before, I had (laughs)

S: Hm

V: so, it was kind of, eh, hm, ah. no, it's so hard to explain it, what, it's so long story, it's so many years, you know

S: we have plenty of time

I am here also trying to comfort her that it was okay to tell the story the way it comes out. I am not especially worried that I don’t always follow or understand because it may make sense later. As a systemic therapist, I am used to trying not to understand and conclude too soon and listening to what is said. The most important for me in this situation is that Veronica could feel that it was alright to tell the story as it came out. But it seemed that Veronica might not be comfortable with her story being chaotic. She wondered if I could follow her story several times during the interview:

V: Now, I may be talking very incoherently.

S: That doesn’t matter.

I mean it; it does not disturb me. But I sense that I need to say it to Veronica:
And later:

V: No. No, I realise I’ve been very incoherent.

> S: You’re describing some very extreme incidents that you personally experienced. It’s demanding, difficult and relates to fear...
>
> V: Yes

I am trying to justify and legitimize the lack of coherence in her story. It may not be socially acknowledged to tell chaotic stories. A good story has a clear structure and keeps the listener interested. In that sense – lacking the structure and being hard to follow - Veronica may feel that her story is not good, and I want to help and show support with my comments.

My perception that the story or parts of stories was troublesome for the participant to tell also came from the emotional expressions. Fiona is a woman in her early fifties, and she has struggled to help her sister's children. Fiona alternated between crying intensely and telling calmly and coherently. This statement is from a part with tears, told intensely and without breaks, like a tsunami:

> …there’s so much coming up all at once from such traumatic things relating to injuries and violence and loads of stuff, I’ve been threatened when I’ve come to pick up the kids, and I’ve been threatened afterwards so this is weird, I’ve not thought about it, it’s not something that has... it’s as if all the episodes are appearing at once, I’ve been very scared. I’ve been worried about the kids and I’ve been worried about my sister and I’ve been worried for myself because I’ve been threatened in lots of situations. My sister has threatened me psychologically, but people around me have threatened me and said they’ll beat me up and kill me. I’ve had to file reports about my concerns with child welfare services. I was... I took more care of her kids when I was about 21 years old than she did herself, and it was actually so crazy that when I was 23 I told my father I was joining the navy and that I was going away because I couldn’t cope with it any longer. I didn’t know how I would get away, I had no idea and what I learned then was that it’s much worse being away and unable to do anything than it is actually being there and doing something because the distance was so big and all I heard was that things weren’t good and I heard what massive reactions the kids had when I called home, they were 1.5 and 3.5 years old then. The girl had even fainted after a call because I was the one who had protected her and looked after her. My father and the

> others said they couldn't understand what happened, but that when we rang off she just fainted. They had to call an ambulance because they could bring her round. I was 23 years old at the time and far away on a ship because I didn't know how to get away.

Fiona comments herself how some parts felt different for her to tell. This statement is from a later part of the interview:

> I know now that when I talk to you about it, there aren't as many feelings around this part. [...] I feel that as soon as we talked about the other, it's very painful from before, it's very difficult and I feel that I've really repressed a lot of it.

Fiona explained that parts of her story were processed with a therapist, while other parts she hadn't talked about earlier made them troublesome to talk about.

Reflections on "Stories with chaos"

These unstructured, hard-to-follow stories appear to me to be intense, painful, and chaotic, but also significant in a way that was difficult to understand. Hydén and Brockmeier (2008, p. 10) used the concept "broken narratives". They described these stories as "undecided, fragmented, broken, narrated by voices struggling to find words toward meaning and communication" (Hydén & Brockmeier, 2008, p. 2). Frank (2010, p. 118) described how the plot in these chaos narratives is "not much of a plot because the protagonist is stuck within an immovable complex of obstacles". Based on my feelings as a listener, I believe that the stories contained so many nuances, emotions, and painful events the storyteller may have more acted and survived than thought or reflected about these parts of their lives.

Frida, Veronica, and Fiona had not told their stories as a whole story to anyone before. Frida struggled to start talking about her childhood, and it felt like she didn't know how to sort all the "complex of obstacles". Veronica and Fiona told their untold parts of the story, intense, activated, and incoherent. Veronica's story contained several potentially traumatic incidents of violence and threatening situations. She had not told anyone about them and said that the

anonymous context of the interview allowed her to talk. It touched me to hear her talk about the violence she had been subjected to, especially how intensely they were told. At the same time, Veronica herself said that the violence she was subjected to had never been anything to talk about because the worst thing for her was how her ex-partner's PSU had affected their son's life. I wonder if I was too preoccupied with the sensitivity and pain of domestic violence and took it for granted that it was the most challenging experience. As Hydén (2008) writes, while interviewing people about sensitive topics, there is always a risk of the researcher being so preoccupied with the pain that the researcher conceals their interviewees in their suffering. I don't think I influenced Veronica's story that way, but my reactions have probably made her feel the need to clarify that it wasn't the worst part for her. At the same time, it may be essential to be aware that many family members who have lived with PSU may have stories of events that have been traumatizing. These stories may not have been told, processed, or healed, and speaking about these events in a safe environment can be very important.

6.2.4. A story of doubt

The story of doubt was evoked in me from my reactions while I interviewed Madeline. My struggles to believe Madeline's statements about her relation to PSU became so confusing for me in this interview that I got on track to a story that I have labelled as "*a story of doubt*. Madeline is a young woman in her late twenties who has two children. One of her children has a father who has PSU. At the very beginning of the interview, Madeline made the following statement explaining to me why she was registered as a patient with PSU in a health register:

> So I ended it...no...I also became very depressed...I had the baby and I had such a motherly feeling then but it became very difficult when we came home and I was so depressed and went...I left them then...for five days and I just drank alcohol for five days to try and take my own life, but I regretted it on the fifth day because something happened then, but no one had realised that I had post-natal depression. And then I was... no, I actually called a psychologist myself and said I wanted to be admitted because I didn't want to die after all and I was admitted to detox.

I heard dramatic plotlines of a difficult start to parenting and heavy years in destructive relationships. Nevertheless, the way she talked about these experiences, or perhaps all the statements about someone else's suspicion or unfortunate circumstances in which Madeline was using substances, caught my attention. For example, they turned out as follows:

> And the child welfare service wanted me to go and do urine tests three times a week. But I was going through so much that...I went and did the tests, but then it just became too much for me...

Madeline did not make statements in the interview in which she told me that she had used substances beyond those five days of alcohol use. But all the statements about other people's suspicions about her problems aroused doubt in me too. That doubt took a lot of space in me. It was a feeling I had known many times in my previous clinical work. For me, this interview became "*a story of doubt"* because doubt can be a part of how stories from PSU and families are acknowledged both inside and outside the families.

"*A story of doubt*" was also present in other participant interviews:

> When taking substances is so central, as it's been in her life, and she's still chosen to come to family settings where I've felt a little insecure...I could sort of smell alcohol on her. [...] On family visits. Then I feel very stressed. (Rose)

> He's been without substances for two years now. I hope he's turned a corner. But I'll never trust it because now, uh, my son is ten, uh, and it's been about seven years. Or yeah, maybe eight. (Veronica)

Philip told a story in which his sister, who often has shown confidence that he is not using substances anymore, did not want him to be alone at home in their house with his daughter and niece:

> So the two girls say, our aunt says she doesn't want you to come in here, but we can go out with you. Well okay, I say. And, well, why does she say that. And they ask me...I just say I don't know, I haven't talked to her, I've no idea, but I...and then I just have to say it. So I think, I think it's about me doing drugs and doing a lot of stupid things and stealing, so I don't fully trust myself yet because of what I've done in the past.

Doubt is relational. A sister doubts and her brother feels her doubt. The question is what to do with the doubt between them. Philip described:

> I decided to talk with her, before I was going to travel home and when the kids had gone to bed. Then I said that earlier today, so what's the point...I get here and I can't really come in because you aren't home, but what do you think I would have come up with, and she said that she hoped I wouldn't be mad, disappointed, upset and yeah, it was when she said that she feels like she's got me back, but then there were some small occasional whims, very very small things in everyday life which can set you back or remind you how things have been. She can have those feelings and then she stops herself. When it comes to my sister, I just accepted it and let her have them. She's been so much for me...how can I say this...she's allowed a little weakness.

It was possible for Philip and his sister to put the doubt into words, and their relationship was strong enough to endure it.

Reflections on "A story of doubt"

Doubt is a known phenomenon in the PSU field. An atmosphere of mistrust is often the result of earlier experiences of lies and half-truths family members have, and many of them are constantly suspicious (Lindeman et al., 2021). Doubt also characterizes professional relationships in services because the professional's task is often to control the PSU. People using substances are used to be suspected, and they are used to avoid telling too much. My

experience is that the interaction is often played out like a game, as a game that Goffman (2002) described as social life played out as roles on a stage. Both participants may be aware of the game and the unsaid in professional relationships. In the family relationships that the participants are talking about, the doubt seems to be serious and long-reaching.

Stories of family relations and PSU are not only snapshots. The participants talk about a process unfolding over time, with past, present, and future intertwined in the present. For example, when Philip uses the statement “she’s allowed a little weakness”, I get an understanding that he doesn’t quite like his sister’s actions (present). Still, he understands why his sister does that (past), and he can accept her actions (future). As Bateson (1972) considered, every act of communication has an aspect of content, what people are saying, and an aspect of a relationship, consisting of the social relationship between people who are communicating. Some of the participants' relationships seem to find a way of handling the doubt, while it can become a breaking point in other relationships.

Participants make statements that suggest how doubt has been present in the relationship for a long time due to previous experiences. It is not easy to have trust because of past experiences, and it is challenging to manage doubt in present relations. Gambetta (1988, p. 217) defined:

> Trust (or, symmetrically mistrust) as a particular level of subjective probability with which an agent assesses that another agent or group of agents will perform a particular action, both before he can monitor such action (or independently of his capacity ever to be able to monitor it) and in a context in which it affects his own actions.

As I understand participants' stories, they talk about several dimensions and practical consequences of mistrust/doubt/trust. They talk about assessments in which they have concluded that family members cannot be trusted and, consequently, organize everyday life based on this doubt or mistrust. They talk about how trust can change over time based on new experiences. The PSU process is often understood as polarised, either as a problematic

process of ongoing PSU or as a resolved process through which PSU and its associated challenges are over. A central idea circulating in society as narrative resources is the AA story about how once an alcoholic always remains as an alcoholic. Although a significant number of adults recover from the PSU, both through natural recovery without treatment and by the help of treatment, the idea of PSU as a life-long struggle is a strong narrative. It may be important for family members and professionals to understand how long-time doubt could be an issue that affects family relations and everyday life after ongoing PSU not being present anymore.

6.3. Summary of the findings

Through a narrative analysis of the data, ten stories with subsequent reflection were presented. "*A story of love*" and "*A story of family ties*" told me about the meaning and importance of their family life and relations. In contrast, "*A story of fear and preparedness*", and "*A story of protecting other family members from PSU*" are about all dangers, fears, and efforts to protect the family participants talked about. "*A story about the unforgivable*", "*A story of doubt*", and "*A story about tough choices*" highlight how the significance of the family on the one side and the dangers of substance us on the other side often were experienced as conflicting and challenging to manage for family members. "*Stories difficult to tell*", "*Directing the stories*" and "*Stories with chaos*" show how participants told their stories in different ways, and how stories sometimes are impossible to tell, sometimes are told in a chaotic way as broken narratives, and sometimes coherent and told without hesitations.

7. DISCUSSION

Introduction

My research project aims to provide insight into some of the complexity of experiences of family members living with PSU and recovery. This research topic is at the junction of several perspectives and areas of knowledge. A value with the perspective from small-scale

narrative research is that it allows paying attention to interpretations of family life with PSU and recovery, which may be the taken-for-granted. Identifying and naming the types of stories interviewed family members told may help other relatives and professionals recognize and think about what kind of stories they are telling. My findings can also provide a basis for reflecting on what is the potential effect of stories told on people's lives. The stories presented in this research project represented some of the aspects of the complexity and provided insight into the complex picture. In this chapter, I will take up several topics that seem particularly valuable to a systemic researcher/clinician in the substance use field.

Based on my findings, I structure the discussion around the following themes: Division between inside and outside; family roles and positions are not equal; women's voices of living with PSU and recovery; individualistic perspectives, relational needs of support; journeys, and not events of family recovery; talking and listening; and closing reflections. I then turn to the study's implications for practice and present some questions for future research.

7.1 Division between inside and outside

The findings of the study illustrate how cultural narratives are resources from which persons construct their stories. In Norway, there are several narratives pointing out how family relationships are a significant source of safety and love for people. As Gullestad (1991) explained, family is seen as a unit of sameness, where something is defined to be inside and something outside. Inside the family are the relations people consider as their family relations, their ideas, and actions described to be family life. Stories of love and family ties illustrate how people could make significant efforts to keep a substance using family members inside and continue family activities. "He is my brother" is an explanation enough to justify actions.

The stories about family importance come into conflict with the stories of dangers and brutalities of PSU, also richly presented in cultural narratives in Norway and confirmed by other research (Lindeman et al., 2021; Orford et al., 2010b). Family members often meet help and support services that advise them to distance themselves from the substance-using family member or make sure they take enough care of themselves (Ramm, 2022). PSU is presented as something which should be outside the family, for example, in professional services. The effect of the story of PSU as something which should be handled outside the family made it important for the family to continually search for the best available services to find resources outside the family, as I also experienced in my fieldwork observation. In spaces between the dangers of PSU and the significance of family relations, family members use these specific narrative resources to talk about their relationships. For example, strict boundaries can be understood to represent outside-perspective, indulgent actions the inside-perspective. These perspectives are also described from the standpoint of the substance-using family member, and PSU is presented as reason enough to be placed or to place themselves outside the family. Nevertheless, memories of actions based on outside resources (such as sending youth out of the family) are presented in their stories years after as wounds in trust. This is one of the many examples of emotional, cultural, and social insolvable and intolerable dilemmas family members relate in their stories. As Vedeler (2011) pointed out, the family is a powerful factor both as a necessity of life but at the same time as a potential danger. Maybe the substance using relationship uncovers and enlarges an aspect of all family relationships, namely the paradoxical nature of them.

Despite the importance of the family in Norway, the dominant stories of PSU as dangerous remain strong in participants' stories. When participants talk about actions in which they took a lot of responsibility or worried a lot about the substance-using family member, they criticize themselves for doing so. It gives the impression that it is shameful to care too much, which

again seems to be an intolerable dilemma, even a paradox. Both internationally and in Norway, there are few opportunities to present substance-using parents nuancedly as something other than bad parents (Rhodes et al., 2010). Being aware of what kind of narratives circulate in society and what stories we take for granted is essential, as these narratives form the basis of what stories can be told (Sparkes, 2005). Frank (2010) points out that problems arise when existing narratives cannot help people make sense of their stories: "[A] story outside any narrative is a fish out of water: it can't breathe and usually will have a quick end" (Frank, 2010, p. 122). It may not be easy to tell counterstories about the not dangerous PSU in family contexts or good parenting from substance-using parents. So, giving voice to stories like Lars visiting his sick father while he was using substances regularly can be an important counter-story because it challenges the taken-for-the-given understanding of PSU as a dangerous and egocentric individual.

7.2. Family members' roles and positions are not equal

Research with family perspectives on PSU is often presented to be presenting all family members, but it often turns out that certain family roles and positions are more represented than others (Lindeman et al., 2021). The main emphasis is on the parents' experiences, while, for example, siblings are less represented (Løberg et al., 2022). It is common practice that the studies have excluded the substance-using family member, picturing the family only from other family members' points of view. In my research, I have included several family positions and roles. Without thinking that the small narrative study invites comparisons, I believe that the comprehensive and detailed stories the participants told me and the close reading of these give possibilities for particular insight and reflections about the meaning of family roles and positions in families in which PSU is present. Orford (2017) suggests that family members experience greater coping difficulty and higher levels of strain when they at the same time experience other burdens or if they are dependent (e.g., financially) on the

substance-using family member. Although most people find it stressful to be relatives of seriously ill people, the experience will vary with their own life situation and their positions in their families (children, parents, spouse, other relatives) (Lilleaas & Fivel, 2011).

My research project confirms that Norwegian parents' duty of care to their children creates many dilemmas for parents to a substance-using child. As Gullestad (1996) points out, children are given relative autonomy from their parents but also indirect dependence. Children should not be too different from their parents, and families should be resources from which individuals construct themselves (Gullestad, 1996). From this perspective, parents with substance-using children can be suspected to have done a deficient job. Parents in this study do not accuse themselves of their child's PSU, but they talked about doubts about whether they have made the right choices while their children have used substances. Trying to protect adult children from PSU and fear for the death of the children is strongly present in parents' stories. Parents in this study extended parenthood and were prepared for their child never standing on his/hers own two feet. Cultural narratives about parenting emphasize parents' responsibilities, and it is common in Norway that help flows from parents to adult children (Herlofson & Daatland, 2016). When the ideas of though love simultaneously stand strong, the parents again become involved in several paradoxical pulls. Also, preparation for a child's death before that of the parents is a fracture of the usual life course. Stories describe how some parents, over many years, prepare for death while at the same time trying to prevent it from happening. The insolvable and intolerable family dilemma are amplified, with the ideas that they were not supposed to give too much help to substance-using individuals, but also that they should give adult children autonomy to make their own choices (Gullestad, 1996), In many ways, parenting which usually had been understood as good parenting (trying to

contribute to better health, trying to prevent deaths) takes on a different dimension when PSU is involved, making it difficult for parents to maneuver.

Parents in this research project seek to understand why children have started PSU from reasons outside the family, such as illness or school difficulties. The interesting contrast comes from stories from some siblings and especially family members in recovery. They are not blaming their parents and are taking a lot or all of the responsibility on themselves and partly highlighting the dangerous PSU as a reason for their actions. Meanwhile, they describe their family from a multiple problem perspective. As presented in chapter three, this could be understood as a risk to PSU. It is important to raise questions and think through how the topic of scarce parental care could be thematised in family conversations without blaming the parents but at the same time noticing the impact upbringing may have on the development of PSU.

Parenting and PSU as themes are presented in stories in different ways. Stories are told directly from parents, but they are also told from adult children, foster parents, and ex-partners. In chapter six, the most dominant story of parenting is about the need to protect children from PSU. An interesting exception is the stories from adult children who talked about closeness and love towards their substance-using parents. Keeping in mind how stories are templates for our experiences and how different stories give different room for actions, it is important to reflect on these nuances. The possibilities for family members to understand themselves and their family history may be lost if the substance-using parents are understood only as bad parents. Several perspectives (stress, resilience, systemic psychotherapy), presented in chapter three, highlight joint meaning-making as an important part of family recovery. As Rhodes et al. (2010) pointed out, substance-using parents are often presented as “bad” parents, and this may hinder parents from seeking help and caregivers from telling nuanced stories.

On the other hand, it appears to me to be essential that tasks of protection, when needed (as when family members experience violence, threats, worrying care situations for children), cannot only be placed on the shoulders of individuals. Conversely, stories idealising family ties can give family members little opportunity to distance themselves and end their relationships. Ex-partners and foster parents in this research project, in particular, have stories in which the need to protect the child is in conflict with the importance of family ties or Norwegian ideals about joint parental responsibility for divorced parents (Blaasvær et al., 2017). As a result, these family members experience intolerable dilemmas both inside the family and in relation to services.

7.3. Women's voices of living with PSU and recovery

In my research project, the voices of women are the loudest. The two men represent family members in recovery. As explained in chapter four, my recruiting of participants appealed to women, without this being my intention. Also, people I met in my fieldwork were primarily women, amplifying the assumption that men do not use self-help groups for next of kin as much as women (Høie & Sjøberg, 2007). There is every reason to believe that lack of male perspective is important to this research project. Findings in several earlier studies are that women and men experience responsibilities for chronically ill family members differently, and women report, for example, higher levels of stress and depressive and anxiety-like symptoms. (Lilleaas & Fivel, 2011; Pinquart & Sörensen, 2006; Wade et al., 2021). I wonder if the story of fear and preparedness may especially voice risks in the living situation for females. In particular, in this research project, it was the stories about ex-partners in which there was talk about the fear of violence.

My research is not the only research in which a female perspective is dominant. As presented in chapter three, women, and especially mothers, were more often represented in earlier research than fathers (Ervik et al., 2019). A Norwegian survey of women and men with drug problems shows that male clients were closely followed up by their mothers and female girlfriends (Gran & Størksen, 1990). The absence of men in previous studies and in my research may reflect the actual extent of how involved men and women are with the challenges of PSU in their families but also power structures in society. Women are generally more often caregivers (Finnvold et al., 2020). The expectation for mothers is high, and the disappointment is great if the mother fails. At the same time, the studies presenting the male perspective indicate that fathers may experience stresses similar to mothers (Ervik et al., 2019; Orford et al., 2010b). In participants' stories, fathers are moving in the background. They are described as a contrast to the mother's choices or as the one parent with whom the child has had the best relationship. It may be that a different involvement of fathers is expected, but my findings also suggests that fathers are doing something different than mothers. In one participant's interview, the father being the main caregiver was also considered to be the main disappointment.

7.4. Individualistic perspectives, relational needs of support

My findings showed how involved family members are and how PSU and recovery impacted family life. However, as presented in chapter three, the understanding of PSU and recovery and the goals for substance use services is highly individualistic in Norway (Selbekk & Sagvaag, 2016). The western individualistic tradition, which treats people separately from their environments and considers the individual as the focal point around which everything else revolves (Markus & Kitayama, 1991; Saft, 2014), is dominant. Individuals are expected to control themselves, their struggles, and their PSU and recovery. The services are offered directly to the individual person who has problems so that this person can fight the problems.

Participants in my study are telling their stories from their individual positions. As a systemic family researcher and therapist, I see the contours of possible stories from the other involved family members in so many ways in negative remarks or lacking perspectives. There are many stories about how family life unfolds and the tensions between family members in a family. Participants describe many complicated processes involving family dynamics from their positions. Suppose I choose to look, for example, at Philip`s story about how hard it is to forgive his mother together with Celia's story about how hard it is to live with a decision to send her daughter to an institution. In that case, I see another pattern than when just considering individual stories. If I picture that Celia had been Philip's mother and Philip Celia's adult daughter, I can imagine the circular and relational space. Perhaps Celia's daughter as an adult cannot forgive her mother but can excuse her father. Maybe Philip's mother could not see any way out in Philip's youth and struggled to help her son. As an outsider, researcher, and professional, I can imagine the feelings and choices of the family members when I hear the individual stories from substance-using individuals or the persons living close to them. But often, the professionals in PSU services only hear the individual stories largely because of how these services are structured. As a result, other stories and perspectives are lacking.

However, maybe something about these individual stories forces professionals to approach the material lineally? How to challenge Philip with his mother's views when he has felt so much suffering because of it for many years. How to challenge the mother's story with her daughter's perspectives when the mother herself hardly can speak about her feelings? But as Adams (2007) argues, the suffering is not only individual but experienced by both the person with PSU and by their close others. Even if it is only the individual with PSU who can decide to stop using substances, the process of recovery depends on whether the outside world is

engaged in the process (Adams, 2016; Selbekk et al., 2018). I believe that family recovery often is essential for individual recovery.

7.5. Journeys, and not events of family recovery

My findings emphasise that recovery from PSU is a long-term journey and not an event. Several perspectives (stress, resilience, systemic psychotherapy) highlight how managing family challenges are processes unfolding over time. The dominant polarised understanding of the PSU and recovery process is often presented as either a demanding process of PSU in which the family members must protect themselves or as a resolved process in which PSU and its associated challenges are over (Lindeman & Selseng, 2022), inviting to short-term thinking from professionals. The findings in this study are based on the stories told at different time points of PSU, such as ongoing PSU, recovery, drug-related bereavement, etc. This allows me to understand the experiences as highly contextual and fluid and as a social process evolving over time.

Narrative traditions have an idea of storying, which embraces how people continuously make stories about their experiences (Stærk et al., 2021). Any description of oneself or life is the result of myriad narrative interpretations that the person has made (Freedman & Combs, 1996). In the process of storying, existing stories can be maintained, but also, the traces of new stories may appear and sometimes get life through conversations (Stærk et al., 2021). A key point in narrative tradition is that problems never are static (White et al., 1990). They come into people's lives at certain times, and they change over time. How stories from the past are told in the present influences not only the present but also possibilities available for the future. PSU is often understood as a process with an unknown course (Nesvåg, 2012)), while the family processes involved are described as situational images, often based on periods of ongoing PSU. The aim of earlier studies has been to describe the experiences of family members living with ongoing PSU. In contrast, the long-term family recovery

perspective has not been a research focus (Lindeman & Selseng, 2022). Participants' stories in this analysis shed light on how choices made in the past influenced family relations in the present and may challenge possibilities in their relations in the future. How family members assembled meaning of PSU opened to different repertoires of actions. In the PSU field, it is often presented as appropriate to keep in mind at the same time possibilities for different scenarios of both possible recovery and potentially persistent problems, with risk for premature death. The families' choices in their stories seem to be based on coping in emergencies, while the long-term perspectives are not present. When PSU ends, professionals often understand family recovery as a resolved process. As my findings show, families' challenges don't end when PSU ends; for example, doubts and relational troubles can be present for life. But as presented in the family resilience perspective, even families who have experienced severe trauma or very troubled relationships have the potential for healing and growth over their life course and across the generations (Walsh, 2016). Nevertheless, families in long-term recovery from PSU are often left alone to try to make meaning of choices made in families, the doubts they have, the healing they need, and the possibilities for growth and joined meaning-making may be lost.

7.6 Talking and listening

Based on my findings, it seems important to pay attention to how stories are told and received. Strong emotional expressions, chaotic stories, stories that stopped, and topics that the participants did not want to talk about are significant findings in this research. Different expressions of storytelling invite reflections of the meaning of talking about demanding life events, the importance of listeners' position, and calls for reflections of competencies needed. I have taken a critical realist position in this study. I acknowledge both subjective and objective aspects of phenomena and believe that both aspects mutually influence and require one another. The way stories were told in the interviews call for attention to knowledge areas

and needed competencies, such as complex trauma disorders, attachment challenges, the aftermath of violence, and consequences of long-term use of substances can have for human mental and physical health. Problems concerning living conditions grow with the increased and problematic use of substances. In addition, many persons with PSU have poor finances and inadequate housing or no housing at all. Recovery, in addition to being relational and processual, is also intertwined with material and practical issues and constraints. It means that professionals supporting families in recovery also need to be attentive to economic and practical issues. While acknowledging the needs of several areas of knowledge and competencies, I direct my focus on this discussion to the sense of telling and listening.

Narrative perspectives have given voices to stories of health and illness from a first-person perspective (Hydén & Brockmeier, 2008). Frank (2010) suggested that the concept of broken narratives directs attention to a story's liminality, 'betwixt and between' socially constructed categories (Turner, 1967). Frank (2010, p. 122) pointed out that liminal spaces are "neither here nor there, and they are dangerous". For Frank broken narratives are not stories about liminal spaces, but stories told from within liminal spaces. The "listener feel pulled across the boundary they did not want to cross, into the zone where life is profoundly insecure" (Frank, 2010, p. 122). Some of the participants' stories in this study felt acute, ongoing, and with the uncertain course. Inspired by Frank's thoughts, I suggest that participants are talking from a liminal space, such as that between PSU and recovery, between safe and dangerous, between losing and getting the possibility of being the parent. Participants are trying to tell stories they or other family members are ashamed about. PSU is stigmatized in Norwegian society, and stigma casts shadows on those in close relationships with persons using substances (Dyregrov & Selseng, 2021). Storytellers are cautious about the listener's responses. As participants said, they observed the listener's responses and had little tolerance for interpretations and opinions

that appeared to be incorrect. "But I can’t bear the idea of someone getting the wrong idea about my brother and that they won’t understand that this is about a struggle and grief”, says one of the participants. It doesn't take much for the stories to remain unspoken.

Skårderud (2001, p. 1613) writes about the research shame as follows:

> A privatised shame can be difficult to identify. The shame is strongly linked to silence. Shame is the experience of one's indignity, and you don't like to talk about it. Those who experience anxiety or grief may experience compassion and care of the surroundings. The ashamed expect contempt.

For psychiatrist Skårderud, movement from shame to guilt in therapy is a possible relief because it "can mean a shift from a global, negative self-experience to blame for something more limited. It's a movement from being wrong to have made mistakes» (Skårderud, 2001, p. 1617). From that perspective, stories of the unforgivable can be seen as an individual movement from feeling shame to addressing guilt. But in family relations, the unforgivable as guilt can create distance and struggle. As a result, something between family members is insoluble and broken.

7.7. Closing reflections

In this analysis and discussion, I have shown how the story as a conceptual tool can provide a basis for reflecting on which stories are fruitful to tell and which stories one wants to be released from. Conceptual tools from systemic psychotherapy, such as circularity, allow the reflections that PSU and recovery are highly relational and that both the individual and the relational processes are unfolding over time. I suggest that the messy, complex, paradoxical, nuanced area of knowledge, which family life with PSU and recovery is, needs conceptual tools that are not simplified but give room for the multifaceted, in which different threads are woven together. Conceptual tools which seek to understand the complexity, such as the Deleuzian terms “rhizome” and “to assemblage” (Guattari & Deleuze, 1987, p. 25) can

portray this picture. An assemblage is a becoming, the process of arranging, organizing, fitting together elements (Wise, 2011). I have used these terms to describe how both family life and PSU are always in movement and between things, with no beginnings or ends. These conceptual tools allow the piecing together a momentary and moving collection of relationships. I suggest that understanding family life with PSU and recovery as processes that are always in between things and with multiple threads of differences and repetitions provides space for the complexity in families' lives.

7.8 Implications for practice

With presented stories and discussion, this study is practice-oriented and opens up many implications for practice, both for professionals in family therapy and substance use treatment and recovery services. With a focus on medical perspectives, with service structures built for treatment for individuals, and where family involvement occurs to a limited extent (Kalsas et al., 2020; Selbekk & Sagvaag, 2016), and with the short-term understanding of PSU related challenges, relational perspectives have had little space. This is not a new discussion in Norway, and Kalsas et al. (2020), for example, raise a strong recommendation that family and network-oriented work should be included in services both as part of the treatment directed for the individuals with PSU and for families as a whole. Therefore, my implications for practice should also be directed at politicians because the current organization of services creates little room for relational ways of working, and therefore the provision for families is random and sporicidal, without anchoring family perspectives in the framework of the services. I consider it essential that services such as family offices have knowledge of PSU and recovery challenges in families so that the tasks are not referred to the PSU field services alone.

My findings may help professionals recognise and be aware of what kind of stories they are telling. Counterstories, presenting perspectives given less validity and experiences that differ from the most common stories of PSU and families, are important reminders for practice. The descriptive example is how I doubted that a substance-using son could visit his father so often. My doubt shows how easily the counterstories and marginal voices can be silenced in the meeting with the professionals. The danger with areas of knowledge such as the PSU may be that the expert knowledge, with large samples, can easily triumph over relational competencies. Yet, in a long-term perspective and in family work, relational competence and understanding of processes that take place in families over a long period are needed.

It is often the acute and ongoing that involves professionals in families' lives, such as questions about treatment, conflicting family situations, or worry about inadequate care for children. It is important to support the family in an acute crisis, but I suggest that at the same time, knowledge of the long-term perspectives, both backward and forwards, is an essential contribution in these acute situations. For example, it may be significant that while the family's youth is offered a place in an institution, the placement aims to be carried out with attention to maintaining family relations and preventing fractures in the future. Likewise, I suggest that people in recovery processes should have the opportunity to be involved in parallel family recovery processes, both in terms of having the possibility to talk about and repair fractures, trust and challenges from the past and to get help and support for ongoing challenges.

As presented in this research project, the experience of PSU and recovery from a family perspective is complex, diverse, and multifaceted. For example, families experiencing long-lasting PSU and families in long-term recovery are in very different life situations. The same way families who recently revealed PSU and families who have lived with these challenges for several years have a different focus. Families in which upbringing has been characterised

by turbulence and neglect, maybe for generations, and families in which those challenges have not been present, have different struggles and different service needs. These are just examples, but the bottom line is that with such complexities, family members' own understanding of the challenges is the only possible professional starting point. As described with Deleuzian terms such as “rhizome” and “assemblage”, the professionals in the PSU field need both openness and understanding of all the richness of threads that exist in relational processes. When meeting a specific family, professionals need to piece together a momentary and moving understanding of support needs. I am referring to basic and central systemic psychotherapy knowledge and skills, which give a structure to the conversations in which several persons and perspectives are presented, and with a central systemic focus on understanding psychological difficulties in the context of social relationships and culture (Boston, 2000). As I concluded in the meta-ethnography (chapter three) (Lindeman et al., 2021), in the face of PSU, all attention is easily directed at “the problem”. The persons using substances and the other family members are concerned about “the problem”, and the attention from services is directed at “the problem”. Psycho-educative resources and models of family work in the PSU field can be very useful tools, but I believe that they can also push and silence the counterstories further in the margins.

Interviewing participants and listening to their stories has brought my attention to the conversation skills relevant for professionals meeting families. The awareness that family members may not have talked about traumatic experiences earlier and that the stories can be overwhelming, shameful, and broken calls for a competent listener. It is also important to remember that family members can be very sensitive to the listener's responses. I consider that participants want an attentive listener who does not challenge the story but listens and acknowledges their understanding at this given time. Not pushing the change seems important, as well as carefully listening for people's own initiatives to change. Facilitating

circular interactions between family members may provide understanding and acknowledgment. Interventive interviewing, presented by Tomm (1989) with circular and reflexive questions, is well suited for this purpose.

The value of people talking about their experiences to each other and to the attentive listening professionals is highlighted in several central systemic and narrative ways of working, known to family therapists in Norway (Lorås et al., 2017; Lorås & Ness, 2019). One example is the Open Dialogue approach (Seikkula, 2012) which aims to include all involved persons, such as family members and professionals in common conversations in order to facilitate a dialogue that helps to create a common language for the experiences of the problematic situation (Seikkula, 2012). The key point is that the change occurs in the actual dialogue between the participants' different voices (Seikkula, 2012). In such conversations, the professionals facilitate speech and listening positions that increase the likelihood of each voice being heard and the other's point of view being perceived (Kalsås et al., 2020). Such conversations can contribute to mutual understanding and repair attachment and relational wounds (Seikkula, 2012, Kalsås et al., 2020). Also, in narrative therapy the central idea is that humans create meaning in life by organizing experiences as stories. These stories impact how one sees oneself and one’s possibilities of action in life (White et al., 1990). Even if the conversation ends with the same conclusions the professional wanted to highlight initially, the path to recognition is often just as important as the actual recognition. The participants in this study talk about how actions they take can be perceived as a matter of life or death for their family members. I argue that it is crucial that such decisions depend on acknowledgments and choices people own themselves. They can't be rushed.

7.9. Questions for future research

The research project with sixteen participants has its strength in the comprehensive and detailed interviews and the possibility of a close reading of stories. Narrative analysis asks

specific questions about particular lives in a specific context (Emerson & Frosh, 2004). This study's strength is that it focuses on the nuanced and complex and, by doing that provides in-depth insight into the research topic. At the same time, this research project has limitations in terms of creating an extensive understanding of several aspects of family members' experiences of living with PSU and recovery. This study included mostly women participants. However, it is also important to understand the experiences of men. I acknowledge that different substances – ranging, for instance, from opioids with a high risk of overdoses to cannabis, which is accepted in some subcultures, to legal alcohol and medicines may have different consequences for family life.

I highlight the need for research about long-term developments in families, and especially about long-term recovery processes in families. While impacts of PSU on families seem to be well-documented, the research about long-term recovery is sparsely focused. The long-term recovery perspective to a substance-using family member is the aim of the ongoing Norwegian research project (Svendsen et al., 2021). This research processes among a group of individuals with PSU in recovery over many years (Svendsen et al., 2021). A similar study focusing on family recovery from a long-term perspective could have provided necessary knowledge to professionals about families' support needs.

8. CONCLUDING REMARKS

The aim of the project was to look at the topic of PSU and recovery from a family perspective and to acquire a more extensive understanding of how families live with PSU. Such knowledge is important to understand better family perspectives to PSU and long-term recovery processes. My aim was also to develop a greater understanding of the implications for the family therapy profession.

The findings of this study identified ten different stories that shed light on various aspects of how family members' experiences of living with PSU and recovery are told. The ten stories highlight the love and family ties, fear and preparedness, doubt, needs for protecting other family members, unforgivable incidents, and tough choices. The research project highlights how stories were told, with difficulties and chaos but also with direction and coherence. The stories provide insight into some of the insolvable and intolerable dilemmas related to life in families experiencing PSU or a long-term recovery process. I suggest that researchers and professionals in PSU and family services need more awareness and understanding of acute tensions and paradoxes in families. I believe that people in these families are talking from dangerous liminal spaces, such as that between trust and doubt, between love and threats, between life and death, and closeness and distance. They need professionals that make room for the complex family life with PSU and recovery and who do not simplify the intolerable dilemmas and paradoxes they are experiencing.

References

Adams, P. J. (2007). *Fragmented intimacy: Addiction in a social world*. New York: Springer

Adams, P. J. (2016). Switching to a social approach to addiction: implications for theory and practice. *International Journal of Mental Health and Addiction*, 14 (1): 86-94.

Ahmed, A. & Rogers, M. (2017). Polly's story: Using structural narrative analysis to understand a trans migration journey. *Qualitative Social Work*, 16 (2): 224-239.

Andersen, S. A. (2007). Kritisk realisme som perspektiv i socialt arbejde. *Den sociale højskole i Århus*.

Andersen, T. (1991). *The reflecting team: Dialogues and dialogues about the dialogues*. New York: WW Norton & Co.

Anderson, H. & Goolishian, H. (1992). The client is the expert: A not-knowing approach to therapy. I S. McNamee & K.J. Gergen (red.), Therapy as Social Construction (s. 25–39). SAGE Publications.

Andersson, C., Best, D., Irving, J., Edwards, M., Banks, J., Mama-Rudd, A. & Hamer, R. (2018). *Understanding recovery from a family perspective: A survey of life in recovery for families*. Sheffield. Sheffield Hallam University for Alcohol Research.

Arcidiacono, C., Velleman, R., Procentese, F., Albanesi, C. & Sommantico, M. (2009). Impact and coping in Italian families of drug and alcohol users. *Qualitative Research in Psychology*, 6 (4): 260-280.

Austin, A. M., Macgowan, M. J. & Wagner, E. F. (2005). Effective family-based interventions for adolescents with substance use problems: A systematic review. *Research on social work practice*, 15 (2): 67-83.

Bacon, I., McKay, E., Reynolds, F. & McIntyre, A. (2020). The lived experience of codependency: An interpretative phenomenological analysis. *International Journal of Mental Health and Addiction*, 18 (3): 754-771.

Barnard, M. (2005). *Drugs in the family: The impact on parents and siblings*: Joseph Rowntree Foundation.

Barnard, M. (2006). *Drug addiction and families*: Jessica Kingsley Publishers.

Bateson, G. (1972). The logical categories of learning and communication. In *Steps to an Ecology of Mind*, pp. 279-308. Chicago: The University of Chicago Press edition.

Beck, U. & Beck-Gernsheim, E. (2018). *The normal chaos of love*. New Jersey: John Wiley & Sons.

Best, D., Beckwith, M., Haslam, C., Alexander Haslam, S., Jetten, J., Mawson, E. & Lubman, D. I. (2016). Overcoming alcohol and other drug addiction as a process of social identity transition: The social identity model of recovery (SIMOR). *Addiction Research & Theory*, 24 (2): 111-123.

Bhaskar, R. (1997). On the ontological status of ideas. *Journal for the theory of social behaviour*, 27 (2-3): 139-147.

Bhaskar, R., Collier, A., Lawson, T. & Norrie, A. (1998). *Critical realism*. Proceedings of the Standing Conference on Realism and Human Sciences, Bristol, UK.

Bhaskar, R. & Danermark, B. (2006). Metatheory, interdisciplinarity and disability research: a critical realist perspective. *Scandinavian Journal of Disability Research*, 8 (4): 278-297.

Birkeland, B., Foster, K., Selbekk, A. S., Høie, M. M., Ruud, T. & Weimand, B. (2018). The quality of life when a partner has substance use problems: a scoping review. *Health and quality of life outcomes*, 16 (1): 1-14.

Blais, M., Côté, P.-B., Manseau, H., Martel, M. & Provencher, M.-A. (2012). Love without a home: A portrait of romantic and couple relationships among street-involved young adults in Montreal. *Journal of Youth Studies*, 15 (4): 403-420.

Blix, B. H., Hamran, T. & Normann, H. K. (2015). Roads not taken: A narrative positioning analysis of older adults' stories about missed opportunities. *Journal of Aging Studies*, 35: 169-177.

Blaasvær, N., Nøkleby, H. & Berg, R. C. (2017). *What Are the Consequences of Shared Physical Custody for Children? A Systematic Review* Knowledge Centre for the Health Services at The Norwegian Institute of Public Health Oslo: Norwegian Institute of Public Health.

Boscolo, L., Cecchin, G., Hoffman, L. & Penn, P. (1987). *Milan systemic family therapy: Conversations in theory and practice*. New York: Basic Books.

Boss, P. (1987). Family stress. In *Handbook of marriage and the family*, pp. 695-723. New York: Springer.

Boss, P., Bryant, C. M. & Mancini, J. A. (2016). *Family stress management: A contextual approach*. London: Sage.

Boston, P. (2000). Systemic family therapy and the influence of post-modernism. *Advances in psychiatric treatment*, 6 (6): 450-457.

Breimo, J. P. (2014). Koordinering og tilstedeværelse - om kjønnede forventninger til pårørende i rehabiliteringsprosesser. *Tidsskrift for kjønnsforskning*, 38 (3-04): 253-269. doi: 10.18261/ISSN1891-1781-2014-03-04-05.

Bråten, E. (2016). Kritisk realistisk antropologi-eksemplifisering av et ikke-konflatorisk perspektiv. *Norsk antropologisk tidsskrift*, 27 (2): 121-137.

Bufdir. (2019). *Samlivsbrudd - hva nå?* https://bufdir.no/Familie/Samlivsbrudd/: The Norwegian Directorate for Children, Youth and Family Affairs

Bunkholdt, V. & Kvaran, I. (2015). *Kunnskap og kompetanse i barnevernsarbeid*: Gyldendal akademisk.

Bye, E. K. & Rossow, I. (2021). Heavy drinkers and the contexts of drinking among adults in Norway. *Drug and alcohol dependence*, 229: 109127.

Cadigan, J. M., Duckworth, J. C., Parker, M. E. & Lee, C. M. (2019). Influence of developmental social role transitions on young adult substance use. *Current opinion in psychology*, 30: 87-91.

Carr, A. (2012). *Family therapy: Concepts, process and practice*. New Jersey: John Wiley & Sons.

Carter, B. & McGoldrick, M. (1989). The expanded family life cycle: A framework for family therapy. *Boston: Allyn y Bacon*.

CASP. (2019). CASP checklists-CASP-Critical Appraisal Skills Programme.

Casswell, S., You, R. Q. & Huckle, T. (2011). Alcohol's harm to others: reduced wellbeing and health status for those with heavy drinkers in their lives. *Addiction*, 106 (6): 1087-1094.

Cheng, T. C. & Lo, C. C. (2015). Change in adolescents' alcohol-use patterns, from non-drinking to non-heavy drinking or heavy drinking. *Journal of Drug Issues*, 45 (4): 447-459.

Choate, P. W. (2015). Adolescent alcoholism and drug addiction: The experience of parents. *Behavioral Sciences*, 5 (4): 461-476.

Church, S., Bhatia, U., Velleman, R., Velleman, G., Orford, J., Rane, A. & Nadkarni, A. (2018). Coping strategies and support structures of addiction affected families: A qualitative study from Goa, India. *Families, Systems, & Health*, 36 (2): 216.

Clifford, J. (1986). On ethnographic allegory. *Writing culture: The poetics and politics of ethnography*: 98-121.

Coleman, S. B. & Stanton, M. D. (1978). The role of death in the addict family. *Journal of Marital and Family Therapy*, 4 (1): 79-92.

Crow, J. R. & Myers-Bowman, K. S. (2011). "A Fear Like I've Never Felt": Experiences of Parents Whose Adult Children Deployed to Combat Zones. *Marriage & family review*, 47 (3): 164-195.

Crowley, J. L. & Miller, L. E. (2020). "Who's gonna love a junkie? But he does": Exploring couples' identity negotiations and dyadic coping in the context of opioid use disorder. *Journal of Social & Personal Relationships*, 37 (5): 1634-1652.

Davies, C. A. (2012). *Reflexive ethnography: A guide to researching selves and others*. Oxfordshire: Routledge.

Dawson, D. A., Grant, B. F., Chou, S. P. & Stinson, F. S. (2007). The impact of partner alcohol problems on women's physical and mental health. *Journal of studies on alcohol and drugs*, 68 (1): 66-75.

Dekkers, A., De Ruysscher, C. & Vanderplasschen, W. (2020). Perspectives on addiction recovery: focus groups with individuals in recovery and family members. *Addiction Research & Theory*, 28 (6): 526-536.

Dommermuth, L., Hart, R. K., Lappegård, T., Rønsen, M. & Wiik, K. A. (2015). Kunnskapsstatus om fruktbarhet og samliv i Norge. *Oslo: Statistisk sentralbyrå*.

Dube, S. R., Felitti, V. J., Dong, M., Chapman, D. P., Giles, W. H. & Anda, R. F. (2003). Childhood abuse, neglect, and household dysfunction and the risk of illicit drug use: the adverse childhood experiences study. *Pediatrics*, 111 (3): 564-572.

Dube, S. R., Miller, J. W., Brown, D. W., Giles, W. H., Felitti, V. J., Dong, M. & Anda, R. F. (2006). Adverse childhood experiences and the association with ever using alcohol and initiating alcohol use during adolescence. *Journal of Adolescent Health*, 38 (4): 444. e1-444. e10.

Dyregrov, K., Dyregrov, A. & Raundalen, M. (2000). Refugee families' experience of research participation. *Journal of traumatic stress*, 13 (3): 413-426.

Dyregrov, K. (2004). Bereaved parents' experience of research participation. *Social science & medicine*, 58 (2): 391-400.

Dyregrov, K., Møgster, B., Løseth, H. M., Lorås, L. & Titlestad, K. B. (2020). The special grief following drug related deaths. *Addiction Research and Theory*, 28 (5): 415-424.

Dyregrov, K. & Selseng, L. B. (2021). "nothing to mourn, he was just a drug addict" - stigma towards people bereaved by drug-related death. *Addiction Research & Theory*.

Edwards, M., Best, D., Irving, J. & Andersson, C. (2018). Life in recovery: a families' perspective. *Alcoholism Treatment Quarterly*, 36 (4): 437-458.

Emerson, P. & Frosh, S. (2004). *Critical narrative analysis in psychology: A guide to practice*. New York Springer.

Ervik, R., Ravndal, E. & Biong, S. (2019). Fedres relasjoner til sønner med narkotikaproblemer–tvetydige og motsetningsfulle. *Fokus på familien*, 47 (3): 200-216.

Fangen, K. (2010). *Deltagende observasjon*. Bergen: Fagbokforlaget.

Fekjær, H. O. (2004). *Rus: bruk, motiver, skader, behandling, forebygging, historie*. Oslo: Gyldendal akademisk.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V. & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American journal of preventive medicine*, 14 (4): 245-258.

Fereidouni, Z., Joolaee, S., Fatemi, N. S., Mirlashari, J., Meshkibaf, M. H. & Orford, J. (2015). What is it like to be the wife of an addicted man in Iran? A qualitative study. *Addiction Research & Theory*, 23 (2): 99-107.

Ferris, J. A., Laslett, A. M., Livingston, M., Room, R. & Wilkinson, C. (2011). The impacts of others' drinking on mental health. *Medical Journal of Australia*, 195: S22-S26.

Finlay, L. (2002). "Outing" the researcher: The provenance, process, and practice of reflexivity. *Qualitative health research*, 12 (4): 531-545.

Finnvold, J. E., Seland, I., Tveito, S. B., Schøyen, M. A. & Aarset, M. F. (2020). Familiens betydning. Kunnskapsoversikt om hverdagsliv, omsorg, samlivsbrudd og familiestøttende tiltak. *NOVA Rapport 1/2020*.

Fotopoulou, M. & Parkes, T. (2017). Family solidarity in the face of stress: responses to drug use problems in Greece. *Addiction Research & Theory*, 25 (4): 326-333.

Frank, A. W. (2004). Asking the right question about pain: Narrative and phronesis. *Literature and Medicine*, 23 (2): 209-225.

Frank, A. W. (2005). What is dialogical research, and why should we do it? *Qualitative health research*, 15 (7): 964-974.

Frank, A. W. (2010). *Letting stories breathe: A socio-narratology*. Chicago: University of Chicago Press.

Frank, A. W. (2012). Practicing dialogical narrative analysis. In Gubrium, J. A. H. J. F. (ed.) *Varieties of narrative analysis*, pp. 33-52. Thousand Oaks: Sage.

Frank, A. W. (2013). *The wounded storyteller: Body, illness, and ethics*. Chicago: University of Chicago Press.

Frank, A. W. (2018). What is narrative therapy and how can it help health humanities? *Journal of Medical Humanities*, 39 (4): 553-563.

Freedman, J. & Combs, G. (1996). Gender stories. *Journal of Systemic Therapies*, 15 (1): 31-46.

Frrokaj, E. & Tsamparli, A. (2016). Quality of sibling relationship and substance misuse: A comparative study. *The European Journal of Counselling Psychology*, 4 (1): 123-147.

Gabriel, A. (2017). *Substance misuse and the family: The exploration of relationships in the family system within sibling narratives*. London: University of East London.

Galvani, S., Roy, A. & Clayson, A. (2022). *Long-Term Recovery from Substance Use: European Perspectives*. Bristol: Policy Press.

Gambetta, D. (1988). Trust: Making and breaking cooperative relations. *Tijdschrift Voor Filosofie*, 52 (4).

Giddens, A. (2013). *The transformation of intimacy: Sexuality, love and eroticism in modern societies*. New Jersey: John Wiley & Sons.

Gjersing, L. R. (2019). *Narkotikautløste dødsfall 2020*. https://www.fhi.no/nettpub/narkotikainorge/konsekvenser-av-narkotikabruk/narkotikautloste-dodsfall-2020/.

Goffman, E. (2002). *The presentation of self in everyday life*. New York: Garden City.

Gran, S. & Størksen, P. (1990). Å flykte fra asken til ilden. *Fokus på familien*, 3: 194-169.

Greger, H. K., Myhre, A. K., Klöckner, C. A. & Jozefiak, T. (2017). Childhood maltreatment, psychopathology and well-being: The mediator role of global self-esteem, attachment difficulties and substance use. *Child abuse & neglect*, 70: 122-133.

Guattari, F. & Deleuze, G. (1987). A thousand plateaus. *Trans. Brian Massumi. Minneapolis: U of Minnesota Press*.

Guba, E. G. & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. *Handbook of qualitative research*, 2 (163-194): 105.

Gubrium, J. F. & Holstein, J. A. (1998). Narrative practice and the coherence of personal stories. *Sociological quarterly*, 39 (1): 163-187.

Gullestad, M. (1986a). Equality and Marital Love: The Norwegian case as an illustration of a general Western dilemma. *Social Analysis: The International Journal of Social and Cultural Practice* (19): 40-53.

Gullestad, M. (1986b). Symbolic "fences" in urban Norwegian neighbourhoods. *Ethnos*, 51 (1-2): 52-70.

Gullestad, M. (1991). The transformation of the Norwegian notion of everyday life. *American Ethnologist*, 18 (3): 480-499.

Gullestad, M. (1996). From obedience to negotiation: Dilemmas in the transmission of values between the generations in Norway. *Journal of the Royal Anthropological Institute*: 25-42.

Gullestad, M. (2002). Invisible fences: Egalitarianism, nationalism and racism. *Journal of the Royal Anthropological Institute*, 8 (1): 45-63.

Halek, K., Murdoch, M. & Fortier, L. (2005). Spontaneous reports of emotional upset and health care utilization among veterans with posttraumatic stress disorder after receiving a potentially upsetting survey. *American Journal of Orthopsychiatry*, 75 (1): 142-151.

Hedges, F. (2005). *An introduction to systemic therapy with individuals: a social constructionist approach*. Macmillan International Higher Education.

Hennum, N. (2004). Å formidle seg selv som kjærlig mor og far i en norsk kontekst. *Fokus på familien*, 32 (3): 147-156.

Herlofson, K. & Daatland, S. O. (2016). Forskning om familiegenerasjoner. En kunnskapsstatus. *NOVA Rapport 2/2016*

Herlofson, K., Daatland, S. O. & Veenstra, M. (2019). Generasjoner imellom. Holdninger til familiens ansvar øst og vest i Europa. *Nordisk Østforum* 33: 34–53.

Hodges, M. & Copello, A. (2015). "How do I tell my children about what my mum's like?" Conflict and dilemma in experiences of adult family members caring for a problem-drinking parent. *Families, Relationships and Societies*, 4 (1): 87-101.

Hofstede, G. (2010). The GLOBE debate: Back to relevance. *Journal of International Business Studies*, 41 (8): 1339-1346.

Holley, C. K. & Mast, B. T. (2009). The impact of anticipatory grief on caregiver burden in dementia caregivers. *The Gerontologist*, 49 (3): 388-396.

Holloway, I. & Biley, F. C. (2011). Being a qualitative researcher. *Qualitative health research*, 21 (7): 968-975.

Hollway, W. & Jefferson, T. (2000). *Doing qualitative research differently: Free association, narrative and the interview method*. London: Sage.

Hollway, W. & Jefferson, T. (2008). The free association narrative interview method. In Given, L. (ed.) *The SAGE Encyclopedia of Qualitative Research Methods.* , pp. 296–315. London: Sage.

Holstein, J. A. & Gubrium, J. F. (2003). A constructionist analytics for social problems. In James A. Holstein, G. M. (ed.) *Challenges and choices: Constructionist perspectives on social problems*, pp. 187-208. New York: Aldine de Gruyter

Howard, K. N., Heston, J., Key, C. M., McCrory, E., Serna-McDonald, C., Smith, K. R. & Hendrick, S. S. (2010). Addiction, the sibling, and the self. *Journal of Loss and Trauma*, 15 (5): 465-479.

Howell, K. (2013). *An Introduction to the Philosophy of Methodology*: SAGE

Hydén, L.-C. (1995). Berättelsen i psykologin Om narrativ teori och metodologi inom psykologin. *Nordisk Psykologi*, 47 (2): 104-122.

Hydén, L.-C. & Brockmeier, J. (2008). *Health, illness and culture: Broken narratives*. Oxfordshire: Routledge.
Hydén, L. C. (1997). Illness and narrative. *Sociology of health & illness*, 19 (1): 48-69.
Hydén, M. (2008). Narrating sensitive topics. In Andrews, M. S., C. & Tamboukou, M. (ed.) *Doing Narrative Research.* , pp. 223-239. London: Sage.
Hyggen, C., Brattbakk, I. & Borgeraas, E. (2018). Muligheter og hindringer for barn i lavinntektsfamilier. En kunnskapsoppsummering. *NOVA Rapport 11/2018*.
Høie, M. M. & Sjøberg, B.-M. D. (2007). *" Forbannede, elskede barn": narkotikamisbruk sett i lys av pårørendes erfaringer*. Oslo: Cappelen akademisk.
Incerti, L., Henderson-Wilson, C. & Dunn, M. (2015). Challenges in the family: problematic substance use and sibling relationships. *Family Matters* (96): 29-38.
Jackson, D. & Mannix, J. (2003). Then suddenly he went right off the rails: Mothers' stories of adolescent cannabis use. *Contemporary Nurse*, 14 (2): 169-179.
Jackson, D., Usher, K. & O'Brien, L. (2007). Fractured families: parental perspectives of the effects of adolescent drug abuse on family life. *Contemporary Nurse*, 23 (2): 321-330.
Kalam, A. & Mthembu, T. G. (2018). Parents' experiences of parenting an adolescent abusing substances. *Social Work*, 54 (4): 469-480.
Kalsas, O. R., Selbekk, A. S. & Ness, O. (2020). "I get a whole different view": Professionals experiences with family-oriented practice in addiction treatment. *Nordic Studies on Alcohol and Drugs*, 37 (3): 243-261.
Kassam-Adams, N. & Newman, E. (2005). Child and parent reactions to participation in clinical research. *General hospital psychiatry*, 27 (1): 29-35.
Kitterød, R. H. (2005). Når mor og far bor hver for seg. Ansvar og omsorg for barna før og etter bidragsreformen. *Statistics Norway*.
Kitterød, R. H. & Lyngstad, J. (2014). She said, he said: Comparing mothers' and fathers' reports on the non-resident father's contact with his children. *Demographic Research*, 30: 899-910.
Kitterød, R. H., Lidén, H., Lyngstad, J. & Wiik, K. A. (2016). Delt bosted for barna etter samlivsbrudd–en praksis for folk flest? *Sosiologisk tidsskrift*, 24 (1): 27-50.
Kougiali, Z. G., Fasulo, A., Needs, A. & Van Laar, D. (2017). Planting the seeds of change: Directionality in the narrative construction of recovery from addiction. *Psychology & health*, 32 (6): 639-664.
Krause, I.-B. (2012). *Culture and the reflexive subject in systemic psychotherapy*. Systemic Thinking and Practice Series. London: Karnac.
Kumpfer, K. L., Alvarado, R. & Whiteside, H. O. (2003). Family-based interventions for substance use and misuse prevention. *Substance use & misuse*, 38 (11-13): 1759-1787.
Kvale, S. & Brinkmann, S. (2015). *Interview: Det kvalitative forskningsinterview som håndværk*. Cobenhagen: Hans Reitzels Forlag.
Kvale, S., Brinkmann, S., Anderssen, T. M. & Rygge, J. (2015). *Det kvalitative forskningsintervju (2. utg.)*. Oslo: Gyldendal akademisk.
Kvello, Ø. (2015). Barn i risiko: Skadelige omsorgssituasjoner (2. utg.). *Oslo: Gyldendal akademisk*.
Kvaavik, E. & Rossow, I. M. (2018). Alkohol i Norge. *Norwegian Institute of Public Health*.
Langdridge, D. (2006). *Psykologisk forskningsmetode: en innføring i kvalitative og kvantitative tilnærminger*. Trondheim: Tapir.
Laudet, A. B. (2007). What does recovery mean to you? Lessons from the recovery experience for research and practice. *Journal of substance abuse treatment*, 33 (3): 243-256.
Lilleaas, U.-B. & Fivel, P. I. (2011). For mye av det gode? – Kvinners involvering i menns helse og sykdom. *Tidsskrift for kjønnsforskning*, 35 (4): 310-326.
Lindeman, S. & Selseng, L. B. (2022). Being a partner in long-term recovery: stories from female partners in Norway. In Galvani, S., Roy, A. & Clayson, A. (eds) *Long-Term Recovery from Substance Use European Perspectives*.

Lindeman, S. K., Titlestad, K. B., Lorås, L. & Bondas, T. (2021). An unknown invisible intrusion. Impact of an adult family member's problematic substance use on family life: a meta-ethnography. *Drugs: Education, Prevention and Policy*: 1-13.

Lindemann, E. (1994). Symptomatology and management of acute grief. *Am J Psychiatry*, 151 (6): 155-160.

Lorås, L., Bertrando, P. & Ness, O. (2017). Researching systemic therapy history: In search of a definition. *Journal of Family Psychotherapy*, 28 (2): 134-149.

Lorås, L. & Ness, O. (2019). *Håndbok i familieterapi*. Bergen: Fagbokforlaget.

Lotherington, A. T., Obstfelder, A. & Ursin, G. (2018). The personal is political yet again: Bringing struggles between gender equality and gendered next of kin onto the feminist agenda. *NORA-Nordic Journal of Feminist and Gender Research*, 26 (2): 129-141.

Lukens, E. P., Thorning, H. & Lohrer, S. (2004). Sibling perspectives on severe mental illness: Reflections on self and family. *American Journal of Orthopsychiatry*, 74 (4): 489-501.

Løberg, A. H., Lindeman, S. K. & Lorås, L. (2022). Keeping the balance. The efforts of bereaved siblings prior to their brothers' or sisters' drug-related death. *Journal of Family Therapy*.

Malia, J. A. (2006). Basic concepts and models of family stress. *Stress, trauma, and crisis*, 9 (3-4): 141-160.

Malterud, K. (2002). Kvalitative metoder i medisinsk forskning–forutsetninger, muligheter og begrensninger. *Tidsskrift for Den norske legeforening*.

Maltman, K., Savic, M., Manning, V., Dilkes-Frayne, E., Carter, A. & Lubman, D. I. (2020). 'Holding on'and 'letting go': a thematic analysis of Australian parent's styles of coping with their adult child's methamphetamine use. *Addiction Research & Theory*, 28 (4): 345-353.

Markus, H. R. & Kitayama, S. (1991). Culture and the self: Implications for cognition, emotion, and motivation. *Psychological review*, 98 (2): 224.

McAlpine, A. (2013). *Experiences of adult siblings of illicit drug users*. Perth: Edith Cowan University.

McCann, T. V., Polacsek, M. & Lubman, D. I. (2019). Experiences of family members supporting a relative with substance use problems: a qualitative study. *Scandinavian journal of caring sciences*, 33 (4): 902-911.

McGoldrick, M., Preto, N. A. G. & Carter, B. A. (2015). *The expanding family life cycle: Individual, family, and social perspectives*. Boston, MA: Pearson.

McLeod, J. & Sundet, R. (2020). Working with stuckness in psychotherapy: Bringing together the bricoleur model and pluralistic practices. In Tobias G. Lindstad, E. S., Jaan Valsiner (ed.) *Respect for thought*, pp. 361-376. New York: Springer.

Mishler, E. G. (1986). The analysis of interview-narratives. In Sarbin, T. R. (ed.) *Narrative psychology: The storied nature of human conduct* pp. 233–255. Westport: Praeger Publishers/Greenwood Publishing Group.

Monaghan, M. & Wincup, E. (2013). Work and the journey to recovery: Exploring the implications of welfare reform for methadone maintenance clients. *International Journal of Drug Policy*, 24 (6): 81-86.

Moriarty, H., Stubbe, M., Bradford, S., Tapper, S. & Lim, B. T. (2011). Exploring resilience in families living with addiction. *Journal of primary health care*, 3 (3): 210-217.

Mudry, T., Nepustil, P. & Ness, O. (2019). The relational essence of natural recovery: natural recovery as relational practice. *International Journal of Mental Health and Addiction*, 17 (2): 191-205.

Mørland, J. & Waal, H. (2019). «Hele Felleskatalogen» i behandling av rusmiddellidelser. *Tidsskrift for Den norske legeforening*.

Neale, J. & Brown, C. (2016). 'We are always in some form of contact': friendships among homeless drug and alcohol users living in hostels. *Health & Social Care in the Community*, 24 (5): 557-566.

Nesvåg, S. (2012). Ulike forståelser og perspektiver på problematisk rusmiddelbruk og avhengighet. I S. Biong & S. Ytrehus (Red.). *Helsehjelp til personer med rusproblemer*, 1: 55-76.

Nordgren, J., Richert, T., Svensson, B. & Johnson, B. (2020). Say no and close the door? Codependency troubles among parents of adult children with drug problems in Sweden. *Journal of Family Issues*, 41 (5): 567-588.

Näsman, E. & Alexanderson, K. (2017). Föräldrar med missbruksproblem: möten mellan barns och föräldrars perspektiv. *Socialmedicinsk tidskrift*, 94 (4): 447-456.

O'Grady, C. P. & Skinner, W. W. (2012). Journey as destination: a recovery model for families affected by concurrent disorders. *Qualitative Health Research*, 22 (8): 1047-1062.

Ólafsdóttir, J., Hrafnsdóttir, S. & Orjasniemi, T. (2018). Depression, anxiety, and stress from substance-use disorder among family members in Iceland. *Nordic Studies on Alcohol and Drugs*, 35 (3): 165-178.

Ólafsdóttir, J., Orjasniemi, T. & Hrafnsdóttir, S. (2020). Psychosocial distress, physical illness, and social behaviour of close relatives to people with substance use disorders. *Journal of Social Work Practice in the Addictions*, 20 (2): 136-154.

Ólafsdóttir, J. M. (2020). *Addiction within Families. The impact of substance use disorder on the family system*. Rovaniemi Faculty of Social Sciences at the University of Lapland and the Faculty of Social Work at the School of Social Sciences at the University of Iceland.

Orford, J., Rigby, K., Miller, T., Tod, A., Bennett, G. & Velleman, R. (1992). Ways of coping with excessive drug use in the family: A provisional typology based on the accounts of 50 close relatives. *Journal of Community & Applied Social Psychology*, 2 (3): 163-183.

Orford, J., Natera, G., Davies, J., Nava, A., Mora, J., Rigby, K., Bradbury, C., Copello, A. & Velleman, R. (1998). Stresses and strains for family members living with drinking or drug problems in England and Mexico. *Salud Mental*, 21 (1): 1-13.

Orford, J., Copello, A., Velleman, R. & Templeton, L. (2010a). Family members affected by a close relative's addiction: The stress-strain-coping-support model. *Drugs: education, prevention and policy*, 17 (sup1): 36-43.

Orford, J., Velleman, R., Copello, A., Templeton, L. & Ibanga, A. (2010b). The experiences of affected family members: A summary of two decades of qualitative research. *Drugs: education, prevention and policy*, 17 (sup1): 44-62.

Orford, J., Natera, G., Copello, A., Atkinson, C., Mora, J., Velleman, R., Crundall, I., Tiburcio, M., Templeton, L. & Walley, G. (2013). *Coping with alcohol and drug problems: The experiences of family members in three contrasting cultures*. Oxfordshire: Routledge.

Orford, J. (2017). How does the common core to the harm experienced by affected family members vary by relationship, social and cultural factors? *Drugs: Education, Prevention and Policy*, 24 (1): 9-16.

Orr, L. C., Barbour, R. S. & Elliott, L. (2013). Carer involvement with drug services: a qualitative study. *Health Expectations*, 16 (3): 60-72.

Overton, B. L. & Cottone, R. R. (2016). Anticipatory grief: a family systems approach. *The Family Journal*, 24 (4): 430-432.

Ozechowski, T. J. & Liddle, H. A. (2002). Family-based therapy. *Substance abuse and dependence in adolescence: Epidemiology, risk factors, and treatment*: 203-226.

Patomäki, H. & Wight, C. (2000). After postpositivism? The promises of critical realism. *International Studies Quarterly*, 44 (2): 213-237.

Patterson, J. M. (1988). Families experiencing stress: I. The Family Adjustment and Adaptation Response Model: II. Applying the FAAR Model to health-related issues for intervention and research. *Family systems medicine*, 6 (2): 202.

Patterson, J. M. & Garwick, A. W. (1994). The impact of chronic illness on families: A family systems perspective. *Annals of behavioral medicine*, 16 (2): 131-142.

Pinnegar, S. & Daynes, J. G. (2007). Locating narrative inquiry historically. *Handbook of narrative inquiry: Mapping a methodology*: 3-34.

Pinquart, M. & Sörensen, S. (2006). Gender differences in caregiver stressors, social resources, and health: An updated meta-analysis. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, 61 (1): 33-45.

Polkinghorne, D. E. (1988). *Narrative knowing and the human sciences*. Albany, NY: Suny Press.
Price-Robertson, R., Obradovic, A. & Morgan, B. (2017). Relational recovery: beyond individualism in the recovery approach. *Advances in Mental Health*, 15 (2): 108-120.
Ramm, A. (2022). *«Medavhengighet» på tynn faglig grunn* Oslo: psykologtidsskriftet.no.
Reis, L. M. d., Sales, C. A. & Oliveira, M. L. F. d. (2017). Narrative of a drug user's daughter: impact on family daily routine. *Escola Anna Nery*, 21.
Reiter, M. D. (2014). *Substance abuse and the family*. Oxfordshire: Routledge.
Rhodes, T., Bernays, S. & Houmoller, K. (2010). Parents who use drugs: Accounting for damage and its limitation. *Social Science & Medicine*, 71 (8): 1489-1497.
Rhodes, T., Rance, J., Fraser, S. & Treloar, C. (2017). The intimate relationship as a site of social protection: Partnerships between people who inject drugs. *Social Science & Medicine*, 180: 125-134.
Riessman, C. K. (2008). *Narrative methods for the human sciences*: Sage.
Rodriguez, L. M., Neighbors, C. & Knee, C. R. (2014). Problematic alcohol use and marital distress: An interdependence theory perspective. *Addiction Research & Theory*, 22 (4): 294-312.
Roy, A. & Buchanan, J. (2016). The paradoxes of recovery policy: exploring the impact of austerity and responsibilisation for the citizenship claims of people with drug problems. *Social Policy & Administration*, 50 (3): 398-413.
Saft, S. (2014). Rethinking Western individualism from the perspective of social interaction and from the concept of ba. *Journal of Pragmatics*, 69: 108-120.
Sandøy, T. A. (2018). *Narkotikabruk i Norge*: Obtained from URL: https://www.fhi.no/nettpub/narkotikainorge/bruk-av.
Sayer, R. A. (1992). *Method in social science: A realist approach*. Hove: Psychology Press.
Scarnier, M., Schmader, T. & Lickel, B. (2009). Parental shame and guilt: Distinguishing emotional responses to a child's wrongdoings. *Personal Relationships*, 16 (2): 205-220.
Schmid, R., Schielein, T., Binder, H., Hajak, G. & Spiessl, H. (2009). The forgotten caregivers: Siblings of schizophrenic patients. *International Journal of Psychiatry in Clinical Practice*, 13 (4): 326-337.
Schultz, P. & Alpaslan, A. H. N. (2016). Our brothers' keepers: Siblings abusing chemical substances living with non-using siblings. *Social Work*, 52 (1): 90-112.
Schultz, P. & Alpaslan, A. H. (2020). Playing the second fiddle - The experiences, challenges and coping strategies of concerned significant others of partners with a substance use disorder: Informing social work interventions. *Social Work (South Africa)*, 56 (4): 428-446.
Seikkula J. (2012). Åpne samtaler [Open Dialogues]. Oslo, Norway: Universitetsforlaget.
Selbekk, A., Faugli, A., Kufås, E., Løvås, M. & Ruud, T. (2021). Kunnskapsoppsummering om situasjon og hjelp til barn og partnere av personer med rusproblemer.
Selbekk, A. S., Sagvaag, H. & Fauske, H. (2015). Addiction, families and treatment: a critical realist search for theories that can improve practice. *Addiction Research & Theory*, 23 (3): 196-204.
Selbekk, A. S. & Sagvaag, H. (2016). Troubled families and individualised solutions: An institutional discourse analysis of alcohol and drug treatment practices involving affected others. *Sociology of health & illness*, 38 (7): 1058-1073.
Selbekk, A. S., Adams, P. J. & Sagvaag, H. (2018). "A Problem Like This Is Not Owned by an Individual" Affected Family Members Negotiating Positions in Alcohol and Other Drug Treatment. *Contemporary Drug Problems*, 45 (2): 146-162.
Selseng, L. B. (2017). Formula stories of the "substance-using client" Addicted, unreliable, deteriorating, and stigmatized. *Contemporary Drug Problems*, 44 (2): 87-104.
Sermijn, J., Devlieger, P. & Loots, G. (2008). The narrative construction of the self: Selfhood as a rhizomatic story. *Qualitative inquiry*, 14 (4): 632-650.
Sermijn, J. & Loots, G. (2015). The cocreation of crazy patchworks: becoming rhizomatic in systemic therapy. *Family process*, 54 (3): 533-544.
Shin, S. H., Hong, H. G. & Hazen, A. L. (2010). Childhood sexual abuse and adolescent substance use: A latent class analysis. *Drug and alcohol dependence*, 109 (1-3): 226-235.

Sin, J., Spain, D., Jordan, C. & Griffiths, C. A. (2014). Siblings of individuals with severe mental illness. *The Journal of Mental Health Training, Education and Practice*.

Skårderud, F. (2001). Skammens stemmer–om taushet, veltalenhet og raseri i behandlingsrommet. *Tidsskrift for Den norske legeforening*.

Wise, J. (2011). Assemblage. In C. Stivale (Ed.), *Gilles Deleuze: Key Concepts* (pp. 91-102). Acumen Publishing.

Smith-Genthôs, K. R., Logue, E. M., Low, B. E. & Hendrick, S. S. (2017). The forgotten ones: siblings of substance abusers. *Journal of loss and trauma*, 22 (2): 120-134.

Smith, B. (2016). Narrative analysis. In Evanthia Lyons, A. C. (ed.) *Analysing qualitative data in psychology*, pp. 202-221. London: Sage.

Smith, J. M., Estefan, A. & Caine, V. (2018). Mothers' experiences of supporting adolescent children through long-term treatment for substance use disorder. *Qualitative health research*, 28 (4): 511-522.

Sparkes, A. C. (2005). Narrative analysis: exploring the whats and hows of personal stories. *Qualitative research in health care*, 1 (1): 191-209.

Spector-Mersel, G. & Knaifel, E. (2018). Narrative research on mental health recovery: two sister paradigms. *Journal of Mental Health*, 27 (4): 298-306.

Squire, C. (2008). Approaches to narrative research. In Molly Andrews, C. S. M. T. (ed.) *Doing Narrative Research*. London: SAGE

Stanton, M. D. & Todd, T. C. (1982). *The family therapy of drug abuse and addiction*. New York: Guilford Press.

Steinglass, P. (1987). A systems view of family interaction and psychopathology. In *Family interaction and psychopathology*, pp. 25-65. Boston, MA.: Springer.

Stærk, A., Westmark, T. & Lindeman, S. (2021). Narrativ terapi– å utvide historier om livet. In Binder, P.-E., Lorås, L. & Thuen, F. (eds) *Håndbok i individualterapi*. Bergen: Fagbokforlaget.

Sutrisna, M. (2009). *Research methodology in doctoral research: understanding the meaning of conducting qualitative research*. Proceedings of the Association of Researchers in Construction Management (ARCOM) Doctoral Workshop held in Liverpool John Moores University. Conducted by ARCOM Liverpool, UK: ARCOM.

Svendsen, T. S., Veseth, M., McKay, J. R., Bjornestad, J., Erga, A. H., Moltu, C. & Nesvåg, S. (2021). Securing Participant Engagement in Longitudinal Substance Use Disorder Recovery Research: A Qualitative Exploration of Key Retention Factors. *Journal of Psychosocial Rehabilitation and Mental Health*: 1-13.

Syrstad, E. & Slettebø, T. (2020). To understand the incomprehensible: A qualitative study of parents' challenges after child removal and their experiences with support services. *Child & Family Social Work*, 25 (1): 100-107.

Takahara, A. H., Galera, S. A. F., Zanetti, A. C. G., Gonçalves, A. M. d. S., Protti-Zanatta, S. T. & Zerbetto, S. R. (2019). The experience of grandmothers in the care of the adolescent who consumes psychoactive substances. *Escola Anna Nery*, 23.

Tamutiene, I. & Laslett, A.-M. (2017). Associative stigma and other harms in a sample of families of heavy drinkers in Lithuania. *Journal of Substance Use*, 22 (4): 425-433.

Tamutienė, I. & Jogaitė, B. (2019). Disclosure of alcohol-related harm: Children's experiences. *Nordic studies on alcohol and drugs*, 36 (3): 209-222.

Thagaard, T. (2005). *Følelser og fornuft: kjærlighetens sosiologi*. Oslo: Abstrakt.

The Children Act. *Act relating to Children and Parents (the Children Act)*. https://lovdata.no/lov/2020-06-19-72.

The Norwegian Directorate of Health. (2017). Nasjonal faglig retningslinje for behandling og rehabilitering av rusmiddelproblemer og avhengighet [National professional guideline for treatment and rehabilitation of substance problems and addiction].

Tinnfält, A., Fröding, K., Larsson, M. & Dalal, K. (2018). "I Feel It In My Heart When My Parents Fight": Experiences of 7–9-Year-Old Children of Alcoholics. *Child and adolescent social work journal*, 35 (5): 531-540.

Titlestad, K. B., Lindeman, S. K., Lund, H. & Dyregrov, K. (2019). How do family members experience drug death bereavement? A systematic review of the literature. *Death studies*: 1-14.

Titlestad, K. B., Stroebe, Margaret & Dyregrov, K. (2020). How do drug-death-bereaved parents adjust to life without the deceased? A qualitative study. *OMEGA-Journal of Death and Dying*, 82 (1): 141-164.

Titlestad, K. B., Mellingen, S., Stroebe, M. & Dyregrov, K. (2021). Sounds of silence. The "special grief" of drug-death bereaved parents: A qualitative study. *Addiction Research & Theory*, 29 (2): 155-165.

Todd, T. C. & Selekman, M. (1990). Principles of family therapy for adolescent substance abuse. *Journal of Psychotherapy & the Family*, 6 (3-4): 49-70.

Tomm, K. (1989). Systemisk intervjumetodik: En utveckling av det terapeutiska samtalet. Mareld.

Topor, A., Borg, M., Di Girolamo, S. & Davidson, L. (2011). Not just an individual journey: Social aspects of recovery. *International journal of social psychiatry*, 57 (1): 90-99.

Turner, V. (1967). Betwixt and between: The liminal period in rites de passage. The forest of symbols: Aspects of Ndembu Ritual. *Itaca, NY: Cornell University Press*.

UKDPC. (2008). Finding common ground. (accessed: 13.02.2022).

Usher, K., Jackson, D. & O'Brien, L. (2007). Shattered dreams: Parental experiences of adolescent substance abuse. *International Journal of Mental Health Nursing*, 16 (6): 422-430.

Vedeler, G. H. (2011). Familien som ressurs i psykososialt arbeid, del I. *Fokus på familien*, 39 (4): 263-282.

Vederhus, J.-K., Kristensen, Ø. & Timko, C. (2019). How do psychological characteristics of family members affected by substance use influence quality of life? *Quality of Life Research*, 28 (8): 2161-2170.

Velleman, R., Arcidiacono, C., Procentese, F., Copello, A. & Sarnacchiaro, P. (2008). A 5-step intervention to help family members in Italy who live with substance misusers. *Journal of Mental Health*, 17 (6): 643-655.

Veseth, M., Moltu, C., Svendsen, T. S., Nesvåg, S., Slyngstad, T. E., Skaalevik, A. W. & Bjornestad, J. (2019). A stabilizing and destabilizing social world: close relationships and recovery processes in SUD. *Journal of Psychosocial Rehabilitation and Mental Health*, 6 (1): 93-106.

Wade, M., Prime, H., Johnson, D., May, S. S., Jenkins, J. M. & Browne, D. T. (2021). The disparate impact of COVID-19 on the mental health of female and male caregivers. *Social Science & Medicine*, 275: 113801.

Walker, A. J. (1985). Reconceptualizing family stress. *Journal of Marriage and the Family*: 827-837.

Walsh, F. (2012). Family resilience: Strengths forged through adversity. In Walsh (ed.) *Normal family processes: Growing diversity and complexity*, pp. 399–423. New York: The Guilford Press.

Walsh, F. (2016). Family resilience: A developmental systems framework. *European journal of developmental psychology*, 13 (3): 313-324.

Wegner, L., Arend, T., Bassadien, R., Bismath, Z. & Cros, L. (2014). Experiences of mothering drug-dependent youth: influences on occupational performance patterns. *South African Journal of Occupational Therapy*, 44 (2): 1-11.

Wegscheider, S. (1981). *Another chance*. Palo Alto, CA: Science & Behavior Books.

Weidman, A. (1983). Adolescent substance abuse: Family dynamics. *Family Therapy*, 10 (1): 47.

Weimand, B., Birkeland, B., Ruud, T. & Høie, M. (2020). "It's like being stuck on an unsafe and unpredictable rollercoaster": Experiencing substance use problems in a partner. *Nordic Studies on Alcohol and Drugs*, 37 (3): 227-242.

Weisner, C., Parthasarathy, S., Moore, C. & Mertens, J. R. (2010). Individuals receiving addiction treatment: are medical costs of their family members reduced? *Addiction*, 105 (7): 1226-1234.

Werner, A. & Malterud, K. (2016). Children of parents with alcohol problems performing normality: A qualitative interview study about unmet needs for professional support. *International journal of qualitative studies on health and well-being*, 11 (1): 30673.

White, M., Wijaya, M. & Epston, D. (1990). *Narrative means to therapeutic ends*. New York: WW Norton & Company.

WHO. (2019). *Global status report on alcohol and health 2018*. Geneva: World Health Organization.

World Medical Association. (2013). World Medical Association. Declaration of Helsinki: ethical principles for medical research involving human subjects. *Jama*, 310 (20): 2191-2194.

Wright, E. M., Fagan, A. A. & Pinchevsky, G. M. (2013). The effects of exposure to violence and victimization across life domains on adolescent substance use. *Child abuse & neglect*, 37 (11): 899-909.

Wyder, M. & Bland, R. (2014). The recovery framework as a way of understanding families' responses to mental illness: Balancing different needs and recovery journeys. *Australian Social Work*, 67 (2): 179-196.

Zarse, E. M., Neff, M. R., Yoder, R., Hulvershorn, L., Chambers, J. E. & Chambers, R. A. (2019). The adverse childhood experiences questionnaire: Two decades of research on childhood trauma as a primary cause of adult mental illness, addiction, and medical diseases. *Cogent Medicine*, 6 (1): 1581447.

Aarseth, H. (2018). Familie og intimitet i endring–sosiologiske perspektiver. *Fokus på familien*, 46 (2): 84-102.

Appendices

Table 1. The participants' details.

Rose	50 – 60 years	mother	Illegal substances in family ten years, bereaved
Fiona	40 – 50 years	sister	Illegal substances in family 30 years, ongoing substance use
Philip	30 – 40 years	Recovery	Illegal substances in family 20 years, recovery
Lars	20 – 30 years	Recovery	Illegal substances in family ten years, recovery
Hanna	40 – 50 years	sister	Illegal substances in family 30 years, ongoing substance use
Frida	30 – 40 years	daughter	Alcohol in family 30 years, ongoing substance use

Marion	40 – 50 years	mother	Illegal substances in family 15 years, ongoing substance use
Celia	40 – 50 years	mother	Illegal substances in family five years, ongoing substance use
Veronica	30 – 40 years	Ex-partner	Illegal substances in family 15 years, recovery
Helen	20 – 30 years	Ex-partner	Illegal substances in family ten years, ongoing substance use
Anna	40 – 50 years	partner	Alcohol in family 20 years, bereaved
Lise	50 – 60 years	recovery	Illegal substances in family 30 years, recovery
Diane	50 – 60 years	partner	Illegal substances in family 15 years, recovery
Madeline	20 – 30 years	Ex-partner	Illegal substances in family ten years, ongoing substance use
Linda	60 – 70 years	mother	Illegal substances in family 40 years, ongoing substance use
Nina	40 – 50 years	daughter	Illegal substances in family 40 years, bereaved

Author(s)	1. Was there a clear statement of the aims of the research?	2. Is a qualitative methodology appropriate?	3. Was the research design appropriate to address the aims of the research?	4. Was the recruitment strategy appropriate to the aims of the research?	5. Were the data collected in a way that addressed the research issue?	6. Has the relationship between researcher and participants been adequately considered?	7. Have ethical issues been taken into consideration?	8. Was the data analysis sufficiently rigorous?	9. Is there a clear statement of findings?	10. How valuable is the research?	Rating
Arcidiacono et al. (2009)	Yes	Yes	Yes	Can't tell	Yes	Yes	No	Yes	Yes	Valuable and necessary	Low Risk of Bias
Asante & Lentoor, 2017	Yes	Yes	Yes	Yes	Yes	Can't tell	Yes	Yes	Yes	Valuable and necessary	Low Risk of Bias
Barnard (2005)	Yes	Yes	Yes	Can't tell	Can't tell	Can't tell	Can't tell	Can't tell	Yes	Valuable	High Risk of Bias
Choate (2015)	Yes	Yes	Can't tell	Yes	Yes	Yes	Yes	No	Yes	Valuable and necessary	Low Risk of Bias
Choate (2011)	Yes	Yes	Yes	Can't tell	Can't tell	Can't tell	No	Can't tell	Can't tell	Valuable	High Risk of Bias
Church et al.(2018)	Yes	Yes	Yes	Can't tell	Yes	Can't tell	Yes	Yes	Yes	Valuable and necessary	Low Risk of Bias
Fereidouni et al. (2015)	Yes	Yes	Yes	Yes	Yes	Can't tell	Yes	Can't tell	Yes	Valuable and necessary	Low Risk of Bias
Fotopoulou & Parkes (2017)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Valuable and necessary	Low Risk of Bias
Hodges & Copello (2015)	Yes	Yes	Yes	Can't tell	Yes	No	Yes	Yes	Yes	Valuable and necessary	Low Risk of Bias

Appendix 2. Search strategy (Lindeman et al., 2021).

CINAHL

The search was carried out on Wednesday, 24. April 2019.

#	Query	Results
S87	S15 AND S86	2,939
S86	S16 OR S17 OR S18 OR S19 OR S20 OR S21 OR S22 OR S23 OR S24 OR S25 OR S26 OR S27 OR S28 OR S29 OR S30 OR S31 OR S32 OR S33 OR S34 OR S35 OR S36 OR S37 OR S38 OR S39 OR S40 OR S41 OR S42 OR S43 OR S44 OR S45 OR S46 OR S47 OR S48 OR S49 OR S50 OR S51 OR S52 OR S53 OR S54 OR S55 OR S56 OR S57 OR S58 OR S59 OR S60 OR S61 OR S62 OR S63 OR S64 OR S65 OR S66 OR S67 OR S68 OR S69 OR S70 OR S71 OR S72 OR S73 OR S74 OR S75 OR S76 OR S77 OR S78 OR S79 OR S80 OR S81 OR S82 OR S83 OR S84 OR S85	886,226
S85	glaser*	490
S84	strauss* n2 corbin*	327
S83	corbin* n2 strauss*	327
S82	foucault*	616
S81	husserl*	206
S80	merleau n1 ponty*	159
S79	van n1 kaam*	68
S78	van n1 manen*	610
S77	spiegelberg*	32
S76	colaizzi*	763
S75	heidegger*	768
S74	narrative analys?s	2,677
S73	constant n1 comparison	1,167
S72	constant n1 comparative	7,789

S71	discouse* n3 analys?s	3
S70	discouse* n3 analys?s	3
S69	discourse* n3 analys?s	4,809
S68	content analysis	37,363
S67	questionnaire*	413,495
S66	observational method*	21,998
S65	theme* OR thematic	90,027
S64	cluster sampl*	5,708
S63	life experience*	28,831
S62	lived experience*	6,510
S61	life world or life-world or conversation anlys?s or personal experience* or theoretical saturation	9,444
S60	account or accounts or unstructured or open-ended or open ended or text* or narrative*	136,819
S59	focus n1 group*	44,193
S58	purpos* N4 sampl*	29,418
S57	theoretical sampl*	2,136
S56	biographical method	64
S55	human science	1,689
S54	field n1 research	1,970
S53	field n1 stud*	5,439
S52	humanistic or existential or experimential or paradigm*	28,247
S51	action research or cooperative inquir* or co operative inquir* or co-operative inquir*	8,785

S50	social construct* OR postmodern* OR post-structural* OR post structural* OR poststructural* OR post modern* OR post-modern* OR feminis* OR interpret*	90,796
S49	participant observ*	11,749
S48	data n1 saturat*	662
S47	emic or etic or hermeneutic$ or heuristic$ or semiotic$	5,280
S46	women's stor*	1,080
S45	life stor*	1,742
S44	grounded n1 analys?s	580
S43	grounded n1 research	368
S42	grounded n1 studies	1,779
S41	grounded n1 study	1,779
S40	grounded n1 theor*	16,495
S39	ethnograph*	10,864
S38	ethnonursing	279
S37	(MH "Cluster Sample+")	4,291
S36	(MH "Life Experiences+")	32,077
S35	(MH "Phenomenological Research")	13,662
S34	(MH "Phenomenology")	3,153
S33	(MH "Theoretical Sample")	1,532
S32	(MH "Field Studies")	2,873
S31	(MH "Observational Methods+")	19,779
S30	(MH "Purposive Sample")	25,960
S29	(MH "Qualitative Validity+")	1,492
S28	(MH "Constant Comparative Method")	6,704

S27	(MH "Ethnonursing Research")	197
S26	(MH "Ethnological Research")	5,903
S25	(MH "Ethnographic Research")	7,007
S24	(MH "Content Analysis")	29,862
S23	(MH "Discourse Analysis")	4,149
S22	(MH "Focus Groups")	37,486
S21	(MH "Questionnaires")	339,642
S20	(MH "Research, Nursing")	19,688
S19	(MH "Qualitative Studies")	94,234
S18	(MH "Grounded Theory")	13,982
S17	(MH "Audiorecording")	39,504
S16	(MH "Interviews+")	192,534
S15	S9 AND S13 AND S14	5,699
S14	TI ((family OR families OR parent* OR child* OR daughter* OR son OR sons OR sibling* OR brother* OR sister* OR mother* OR father* OR spouse* OR wife OR wives OR husband* OR partner* OR next of kin OR significant other* OR relative*) N3 (relation* OR dynamic* OR interact* OR impact* OR affect* OR conflict* OR coping OR cope* OR copes OR attitude* OR experience* OR perception* OR perspective* OR burden*)) OR AB ((family OR families OR parent* OR child* OR daughter* OR son OR sons OR sibling* OR brother* OR sister* OR mother* OR father* OR spouse* OR wife OR wives OR husband* OR partner* OR next of kin OR significant other* OR relative*) N3 (relation* OR dynamic* OR interact* OR impact* OR affect* OR conflict* OR coping OR cope* OR copes OR attitude* OR experience* OR perception* OR perspective* OR burden*))	101,868
S13	S10 OR S11 OR S12	870,112
S12	TI ((family OR families OR parent* OR child* OR daughter* OR son OR sons OR sibling* OR brother* OR sister* OR mother* OR father* OR spouse* OR wife OR wives OR husband* OR partner* OR next of kin OR significant other* OR relative*)) OR AB ((family OR families OR parent* OR child* OR daughter* OR son OR sons OR sibling* OR brother* OR	810,537

	sister* OR mother* OR father* OR spouse* OR wife OR wives OR husband* OR partner* OR next of kin OR significant other* OR relative*))	
S11	(MH "Family Attitudes+")	21,895
S10	(MH "Family+")	193,708
S9	S1 OR S2 OR S3 OR S4 OR S5 OR S6 OR S7 OR S8	187,252
S8	(MH "Substance Abusers+")	7,321
S7	TI alcoholi* OR AB alcoholi*	10,607
S6	TI (drug use* OR drug abuse* OR drug misuse* OR drug overuse*) OR AB (drug use* OR drug abuse* OR drug misuse* OR drug overuse*)	50,235
S5	TI (alcohol use* OR alcohol abuse* OR alcohol misuse* OR alcohol overuse*) OR AB (alcohol use* OR alcohol abuse* OR alcohol misuse* OR alcohol overuse*)	29,251
S4	TI (substance use* OR substance abuse* OR substance misuse* OR substance overuse*) OR AB (substance use* OR substance abuse* OR substance misuse* OR substance overuse*)	32,106
S3	TI ((substance* OR drug* OR alcohol*) N3 (addict* OR dependen* OR habit*)) OR AB ((substance* OR drug* OR alcohol*) N3 (addict* OR dependen* OR habit*))	12,868
S2	(MH "Substance Dependence+")	80,879
S1	(MH "Substance Abuse+")	58,005

PsycINFO

The search was carried out on 24. April 2019.

Database(s): PsycINFO 1987 to April Week 3 2019
Search Strategy:

#	Searches	Results
1	exp drug abuse/	93238
2	exp Drug Dependency/	21344
3	exp Alcohol Abuse/	38925

4	((substance* or drug* or alcohol*) adj3 (addict* or dependen* or habit*)).ab,ti.	31179
5	(substance use* or substance abuse* or substance misuse* or substance overuse*).ab,ti.	61714
6	(alcohol use* or alcohol abuse* or alcohol misuse* or alcohol overuse*).ab,ti.	33928
7	(drug use* or drug abuse* or drug misuse* or drug overuse*).ab,ti.	41376
8	"alcoholi*".ab,ti.	22581
9	1 or 2 or 3 or 4 or 5 or 6 or 7 or 8	167421
10	exp FAMILY/	45268
11	exp family relations/	98255
12	dysfunctional family/	749
13	(Family or families or "Next of kin" or "Significant other" or parent* or child* or daughter* or son or sons or sibling* or brother* or sister* or mother* or father* or spouse* or wife or wives or husband* or partner* or relative*).ab,ti.	1034588
14	10 or 11 or 12 or 13	1040187
15	((Relation* or Dynamic* or Interact* or Impact* or Affect* or Conflict* or Coping or cope or copes or experience* or perception* or perspective* or burden*) adj3 (Family or families or Next of kin or Significant other* or parent* or child* or daughter* or son or sons or sibling* or brother* or sister* or mother* or father* or spouse* or wife or wives or husband* or partner* or relative*)).ab,ti.	194437
16	9 and 14 and 15	9596
17	interviews/	6510
18	exp Grounded Theory/	3407
19	exp "Experiences (Events)"/ or exp Life Experiences/	52295
20	qualitative research/	1
21	exp Interviewing/	2574
22	exp questionnaires/	15897
23	discourse analysis/	7966
24	exp Content Analysis/	12447
25	exp Ethnography/	7739
26	exp NARRATIVES/	18261

27	ethnology/	441
28	exp PHENOMENOLOGY/	11777
29	ethnonursing.ab,ti.	57
30	"phenomenol*".ab,ti.	35373
31	(grounded adj1 theor*).ab,ti.	15604
32	(grounded adj1 study).ab,ti.	205
33	(grounded adj1 studies).ab,ti.	52
34	(grounded adj1 research).ab,ti.	289
35	(grounded adj1 analys?s).ab,ti.	227
36	"life stor*".ab,ti.	3158
37	"women's stor*".ab,ti.	320
38	(emic or etic or hermenutic$ or semiotic$).ab,ti.	4480
39	(data adj1 saturat*).ab,ti.	275
40	"participant observ*".ab,ti.	7767
41	(social construct* or postmodern* or post-structural* or post structural* or poststructural* or post modern* or post-modern* or feminis* or interpret*).ab,ti.	170958
42	(action research or cooperative inquir* or co operative inquir* or co-operative inquir*).ab,ti.	7258
43	(humanistic or existential or experient* or paradigm*).ab,ti.	110758
44	(field adj1 stud*).ab,ti.	6804
45	human science.ab,ti.	472
46	(field adj1 research).ab,ti.	2950
47	biographical method.ab,ti.	39
48	"theoretical sampl*".ab,ti.	519
49	(purpos* adj4 sampl*).ab,ti.	8728
50	(focus adj1 group*).ab,ti.	32189
51	(account or accounts or unstructured or open-ended or open ended or text* or narrative*).ab,ti.	287500

52	(life world or life-world or conversation analys?s or personal experience* or theoretical saturation).ab,ti.	11671
53	"lived experience*".ab,ti.	12370
54	"life experience*".ab,ti.	8352
55	"cluster sampl*".ab,ti.	1413
56	(theme* or thematic).ab,ti.	112584
57	"observational method*".ab,ti.	740
58	"questionnaire*".ab,ti.	229085
59	content analysis.ab,ti.	20593
60	(discourse adj3 analys*).ab,ti.	6573
61	(discurs* adj3 analys*).ab,ti.	798
62	(constant adj1 comparative).ab,ti.	3094
63	(constant adj1 comparison).ab,ti.	1268
64	"narrative analys*".ab,ti.	2188
65	(heidegger* or colaizzi* or spiegelberg*).ab,ti.	1946
66	(van adj1 manen*).ab,ti.	490
67	(van adj1 kaam*).ab,ti.	423
68	(merleau adj1 ponty*).ab,ti.	693
69	(husserl* or foucault*).ab,ti.	3516
70	(corbin* adj2 strauss*).ab,ti.	618
71	(strauss* adj2 corbin*).ab,ti.	618
72	"glaser*".ab,ti.	972
73	17 or 18 or 19 or 20 or 21 or 22 or 23 or 24 or 25 or 26 or 27 or 28 or 29 or 30 or 31 or 32 or 33 or 34 or 35 or 36 or 37 or 38 or 39 or 40 or 41 or 42 or 43 or 44 or 45 or 46 or 47 or 48 or 49 or 50 or 51 or 52 or 53 or 54 or 55 or 56 or 57 or 58 or 59 or 60 or 61 or 62 or 63 or 64 or 65 or 66 or 67 or 68 or 69 or 70 or 71 or 72	932575
74	16 and 73	2968

SocINDEX

The search was carried out on 28. April

S61	S14 AND S60	1,522
S60	S15 OR S16 OR S17 OR S18 OR S19 OR S20 OR S21 OR S22 OR S23 OR S24 OR S25 OR S26 OR S27 OR S28 OR S29 OR S30 OR S31 OR S32 OR S33 OR S34 OR S35 OR S36 OR S37 OR S38 OR S39 OR S40 OR S41 OR S42 OR S43 OR S44 OR S45 OR S46 OR S47 OR S48 OR S49 OR S50 OR S51 OR S52 OR S53 OR S54 OR S55 OR S56 OR S57 OR S58 OR S59	392,788
S59	TI (glaser*) OR AB (glaser*)	404
S58	TI (corbin* n2 strauss*) OR AB (corbin* n2 strauss*)	91
S57	TI (husserl* or foucault*) OR AB (husserl* OR foucault*)	4,665
S56	TI (merleau n1 ponty*) OR AB (merleau n1 ponty*)	232
S55	TI (van n1 kaam*) OR AB (van n1 kaam*)	16
S54	TI (van n1 manen*) OR AB (van n1 manen*)	36
S53	TI (heidegger* or colaizzi* or spiegelberg*) OR AB (heidegger* or colaizzi* or spiegelberg*)	823
S52	TI (narrative analys?s) OR AB (narrative analys?s)	2,136
S51	TI (constant n1 comparison) OR AB (constant n1 comparison)	219
S50	TI (constant n1 comparative) OR AB (constant n1 comparative)	311
S49	TI (discurs* n3 analys?s) OR AB (discurs* n3 analys?s)	600
S48	TI (discourse* n3 analys?s) OR AB (discourse* n3 analys?s)	4,142
S47	TI (content analysis) OR AB (content analysis)	8,557
S46	TI (observational method*) OR AB (observational method*)	427
S45	TI (theme* or thematic) OR AB (theme* or thematic)	37,282
S44	TI (lived experience*) OR AB (lived experience*)	3,297

S43	TI (life world or life-world or conversation analys?s or personal experience*) OR AB (life world or life-world or conversation analys?s or personal experience*)	8,724
S42	TI (account or accounts or unstructured or opend-ended or open ended or text* or narrative*) OR AB (account or accounts or unstructured or opend-ended or open ended or text* or narrative*)	128,949
S41	TI (focus n1 group*) OR AB (focus* n1 group*)	10,090
S40	TI (purpos* n4 sampl*) OR AB (purpos* n4 sampl*)	1,410
S39	TI (theoretical sampl*) OR AB (theoretical sampl*)	293
S38	TI (biographical method) OR AB (biographical method)	183
S37	TI (human science) OR AB (human science)	2,573
S36	TI (field n1 research) OR AB (field n1 research)	3,640
S35	TI (field n1 stud*) OR AB (field n1 stud*)	4,893
S34	TI (humanistic or existential or experiential or paradigm*) OR AB (humanistic or existential or experiential or paradigm*)	27,661
S33	TI (action research or cooperative inquir* or co operative inquir* or co-operative inquir*) OR AB (action resarch or cooperative inquir* or co operative inquir* or co-operative inquir*)	41
S32	TI (social construct* or postmodern* or post-structural* or post structural* or poststructural* or post modern* or post-modern* or feminis* or interpret*) OR AB (social construct* or postmodern* or post-structural* or post structural* or poststructural* or post modern* or post-modern* or feminis* or interpret*)	47,043
S31	TI (participant observ*) OR AB (participant observ*)	5,539
S30	TI (data n1 saturat*) OR AB (data n1 saturat*)	24
S29	TI (emic OR etic or hermeneutic$ OR heuristic$ OR semiotic$) OR AB (emic OR etic or hermeneutic$ OR heuristic$ OR semiotic$)	6,738
S28	TI (women's stor*) OR AB (women's stor*)	1,678
S27	TI (life stor*) OR AB (life stor*)	2,589

S26	TI (grounded n1 analys*) OR AB (grounded n1 analys*)	464
S25	TI (grounded n1 research) OR AB (grounded n1 research)	264
S24	TI (grounded n1 stud*) OR AB (grounded n1 stud*)	430
S23	TI (grounded n1 theor*) OR AB (grounded n1 theor*)	3,426
S22	TI (phenomenol*) OR AB (phenomenol*)	5,637
S21	TI (ethnograph*) OR AB (ethnograph*)	25,070
S20	TI (ethnonursing) OR AB (ethnonursing)	6
S19	TI (questionnaire*) OR AB (questionnaire*)	41,946
S18	TI (qualitative validity) OR AB (qualitative validity*)	105
S17	TI (qualitative stud*) OR AB (qualitative stud*)	13,503
S16	TI (audiorecord*) or AB (audiorecord*)	21
S15	TI (interview*) or AB (interview*)	100,323
S14	(TI ((Relation* or Dynamic* or Interact* or Impact* or Affect* or Conflict* or Coping or cope or copes or attitude* attitude* OR experience* OR perception* OR perspective* OR burden*) N3 (Family or families or Next of kin or Significant other* or parent* or child* or daughter* or son or sons or sibling* or brother* or sister* or mother* or father* or spouse* or wife or wives or husband* or partner* or relative*)) OR AB ((Relation* or Dynamic* or Interact* or Impact* or Affect* or Conflict* or Coping or cope or copes or attitude* attitude* OR experience* OR perception* OR perspective* OR burden*) N3 (Family or families or Next of kin or Significant other* or parent* or child* or daughter* or son or sons or sibling* or brother* or sister* or mother* or father* or spouse* or wife or wives or husband* or partner* or relative*))) AND (S9 AND S12 AND S13)	5,005
S13	TI ((Relation* or Dynamic* or Interact* or Impact* or Affect* or Conflict* or Coping or cope or copes or attitude* attitude* OR experience* OR perception* OR perspective* OR burden*) N3 (Family or families or Next of kin or Significant other* or parent* or child* or daughter* or son or sons or sibling* or brother* or sister* or mother* or father* or spouse* or wife or wives or husband* or partner* or relative*)) OR AB ((Relation* or Dynamic* or Interact* or Impact* or Affect* or Conflict* or Coping or cope or copes or attitude* attitude* OR experience* OR perception* OR perspective* OR burden*) N3 (Family or families or Next of kin or Significant other* or parent* or child* or daughter* or son or sons or sibling*	87,845

	or brother* or sister* or mother* or father* or spouse* or wife or wives or husband* or partner* or relative*))	
S12	S10 OR S11	499,421
S11	TI (Family or families or "Next of kin" or "Significant other" or parent* or child* or daughter* or son or sons or sibling* or brother* or sister* or mother* or father* or spouse* or wife or wives or husband* or partner* OR relative*) OR AB (Family or families or "Next of kin" or "Significant other" or parent* or child* or daughter* or son or sons or sibling* or brother* or sister* or mother* or father* or spouse* or wife or wives or husband* or partner* OR relative*)	497,328
S10	DE "FAMILIES" OR DE "FAMILIES & psychology" OR DE "FAMILY adaptability" OR DE "FAMILY attitudes" OR DE "FAMILY communication" OR DE "FAMILY conflict" OR DE "FAMILY crises" OR DE "FAMILY health" OR DE "FAMILY relations" OR DE "FAMILY stability" OR DE "FAMILY studies" OR DE "DYSFUNCTIONAL families"	40,341
S9	S1 OR S2 OR S3 OR S4 OR S5 OR S6 OR S7 OR S8	87,769
S8	TI alcoholi* OR AB alcoholi*	13,494
S7	TI (alcohol use* or alcohol abuse* or alcohol misuse* or alcohol overuse*) OR AB (alcohol use* or alcohol abuse* or alcohol misuse* or alcohol overuse*)	20,257
S6	TI (drug use* or drug abuse* or drug misuse* or drug overuse*) OR AB (drug use* or drug abuse* or drug misuse* or drug overuse*)	36,526
S5	TI (substance use* or substance abuse* or substance misuse* or substance overuse*) OR AB (substance use* or substance abuse* or substance misuse* or substance overuse*)	24,202
S4	TI ((substance* or drug* or alcohol*) N3 (addict* or dependen*or habit*)) OR AB ((substance* or drug* or alcohol*) N3 (addict* or dependen*or habit*))	5,498
S3	DE "ALCOHOLIC fathers" OR DE "ALCOHOLICS" OR DE "ALCOHOLISM"	14,163
S2	DE "DRUG abuse" OR DE "DRUG abusers" OR DE "DRUG addiction" OR DE "DRUG addicts"	20,552
S1	DE "SUBSTANCE abuse"	13,430

SveMed+

The search was carried out 28. April.

1	exp:"substance related disorders"	1406
2	exp:"alcoholics"	1
3	exp:"drug users"	62
5	substance overuse	1
6	substance abuse	3280
7	substance misuse	13
8	substance use	210
9	drug use	748
10	drug abuse	3261
11	drug misuse	29
12	drug overuse	17
13	alcohol overuse	0
14	alcohol misuse	12
15	alcohol abuse	847
16	alcoholic OR alcoholics OR alcoholism	2261
17	alcohol OR drug OR substance	13118
18	addict OR depend OR habit	1292
19	#17 AND #18	560
20	#1 OR #2 OR #3 OR #5 OR #6 OR #7 OR #8 OR #9 OR #10 OR #11 OR #12 OR #13 OR #14 OR #15 OR #16 OR #19	4641
21	exp:"family"	4083
24	Family OR families OR "Next of kin" OR "Significant other" OR parent OR child or daughter or son or sibling or brother or sister or mother or father or spouse or wife or wives or husband or partner or relative	8364
25	#21 OR #24	8364
26	#20 AND #25	297

Web of Science - Social Science Index

The number of hits in Web of Science was very high, and a large proportion were not relevant. The search was therefore limited to Social Science Index (i.e. just one of the databases in Web of Science). The search results were subsequently limited to relevant areas of research, and hits within non-relevant areas were removed (e.g. medicine, pharmacology, infectious diseases).

62 11,939 #58 AND #11

Refined by: [excluding] WEB OF SCIENCE CATEGORIES: (MEDICINE GENERAL INTERNAL OR HEALTH POLICY SERVICES OR SOCIAL SCIENCES BIOMEDICAL OR CLINICAL NEUROLOGY OR HEALTH CARE SCIENCES SERVICES OR NEUROSCIENCES OR PHARMACOLOGY PHARMACY OR INFECTIOUS DISEASES OR SOCIAL SCIENCES INTERDISCIPLINARY OR OBSTETRICS GYNECOLOGY) AND [excluding] WEB OF SCIENCE CATEGORIES: (PEDIATRICS OR GERONTOLOGY OR GERIATRICS GERONTOLOGY OR ENVIRONMENTAL SCIENCES OR NUTRITION DIETETICS OR LAW) AND [excluding] WEB OF SCIENCE CATEGORIES: (UROLOGY NEPHROLOGY OR SURGERY OR MEDICAL INFORMATICS OR SPORT SCIENCES OR AUDIOLOGY SPEECH LANGUAGE PATHOLOGY OR HOSPITALITY LEISURE SPORT TOURISM OR OPERATIONS RESEARCH MANAGEMENT SCIENCE OR ORTHOPEDICS OR TRANSPORTATION OR PARASITOLOGY OR EMERGENCY MEDICINE OR BIOTECHNOLOGY APPLIED MICROBIOLOGY OR TROPICAL MEDICINE OR BIOLOGY OR IMMUNOLOGY OR ENVIRONMENTAL STUDIES OR PERIPHERAL VASCULAR DISEASE OR BIOCHEMISTRY MOLECULAR BIOLOGY OR RESPIRATORY SYSTEM OR DENTISTRY ORAL SURGERY MEDICINE OR TOXICOLOGY OR GEOGRAPHY OR AREA STUDIES OR MEDICINE LEGAL OR FOOD SCIENCE TECHNOLOGY OR SOCIAL SCIENCES MATHEMATICAL METHODS OR GASTROENTEROLOGY HEPATOLOGY OR COMPUTER SCIENCE INTERDISCIPLINARY APPLICATIONS OR LINGUISTICS OR LANGUAGE LINGUISTICS OR REHABILITATION OR POLITICAL SCIENCE OR ALLERGY OR CARDIAC CARDIOVASCULAR SYSTEMS OR BUSINESS FINANCE OR INFORMATION SCIENCE LIBRARY SCIENCE OR ENGINEERING CIVIL OR ERGONOMICS OR MATHEMATICAL COMPUTATIONAL BIOLOGY OR HISTORY OR RHEUMATOLOGY OR OTORHINOLARYNGOLOGY OR DERMATOLOGY OR TRANSPLANTATION OR ENDOCRINOLOGY METABOLISM OR ENGINEERING INDUSTRIAL OR HISTORY PHILOSOPHY OF SCIENCE OR MATHEMATICS INTERDISCIPLINARY APPLICATIONS OR ZOOLOGY OR ECONOMICS OR PHYSIOLOGY OR ANESTHESIOLOGY OR CRITICAL CARE MEDICINE OR CELL BIOLOGY OR BUSINESS)

Indexes=SSCI Timespan=All years

61 12,611 #58 AND #11

Refined by: [excluding] WEB OF SCIENCE CATEGORIES: (MEDICINE GENERAL INTERNAL OR HEALTH POLICY SERVICES OR SOCIAL SCIENCES BIOMEDICAL OR CLINICAL NEUROLOGY OR HEALTH CARE SCIENCES SERVICES OR NEUROSCIENCES OR PHARMACOLOGY PHARMACY OR INFECTIOUS DISEASES OR SOCIAL SCIENCES INTERDISCIPLINARY OR OBSTETRICS GYNECOLOGY) AND [excluding] WEB OF SCIENCE CATEGORIES: (PEDIATRICS OR GERONTOLOGY OR GERIATRICS GERONTOLOGY OR ENVIRONMENTAL SCIENCES OR NUTRITION DIETETICS OR LAW)

Indexes=SSCI Timespan=All years

60 13,901 #58 AND #11

Refined by: [excluding] WEB OF SCIENCE CATEGORIES: (MEDICINE GENERAL INTERNAL OR HEALTH POLICY SERVICES OR SOCIAL SCIENCES BIOMEDICAL OR CLINICAL NEUROLOGY OR HEALTH CARE SCIENCES SERVICES OR NEUROSCIENCES OR PHARMACOLOGY PHARMACY OR INFECTIOUS DISEASES OR SOCIAL SCIENCES INTERDISCIPLINARY OR OBSTETRICS GYNECOLOGY)

Indexes=SSCI Timespan=All years

59 18,364 #58 AND #11

Indexes=SSCI Timespan=All years

58 1,367,667 #57 OR #56 OR #55 OR #54 OR #53 OR #52 OR #51 OR #50 OR #49 OR #48 OR #47 OR #46 OR #45 OR #44 OR #43 OR #42 OR #41 OR #40 OR #39 OR #38 OR #37 OR #36 OR #35 OR #34 OR #33 OR #32 OR #31 OR #30 OR #29 OR #28 OR #27 OR #26 OR #25 OR #24 OR #23 OR #22 OR #21 OR #20 OR #19 OR #18 OR #17 OR #16 OR #15 OR #14 OR #13 OR #12

Indexes=SSCI Timespan=All years

57 56,449 TS=participant observ*

Indexes=SSCI Timespan=All years

56 113,509 TS=qualitative stud*

Indexes=SSCI Timespan=All years

55 233 TS=audiorecord*

Indexes=SSCI Timespan=All years

54 274,399 TS=interview*

Indexes=SSCI Timespan=All years

53 1,294 TS=(grounded NEAR/1 analys?s)

Indexes=SSCI Timespan=All years

52 324 TS=((van NEAR/1 manen*) OR (van NEAR/1 kaam*))

Indexes=SSCI Timespan=All years

51 639 TS=glaser*

Indexes=SSCI Timespan=All years

50 307 TS=(corbin* NEAR/2 strauss*)

Indexes=SSCI Timespan=All years

49 5,952 TS=(husserl* OR foucault*)

Indexes=SSCI Timespan=All years

48 581 TS=merleau ponty*

Indexes=SSCI Timespan=All years

47 2,253 TS=(heidegger* OR colaizzi* OR spiegelberg*)

Indexes=SSCI Timespan=All years

46 18,147 TS=narrative analys?s

Indexes=SSCI Timespan=All years

45 1,310 TS=(constant NEAR/1 comparison)

Indexes=SSCI Timespan=All years

44 2,312 TS=(constant NEAR/1 comparative)

Indexes=SSCI Timespan=All years

43 1,120 TS=(discurs* NEAR/3 analys?s)

Indexes=SSCI Timespan=All years

42 10,800 TS=(discourse* NEAR/3 analys?s)

Indexes=SSCI Timespan=All years

41 58,840 TS=content analysis

Indexes=SSCI Timespan=All years

40 241,941 TS=questionnaire*

Indexes=SSCI Timespan=All years

39 14,696 TS=observational method*

Indexes=SSCI Timespan=All years

38 87,256 TS=(theme* OR thematic)

Indexes=SSCI Timespan=All years

37 13,310 TS=cluster sampl*

Indexes=SSCI Timespan=All years

36 89,557 TS=(life experience*)

Indexes=SSCI Timespan=All years

35 47,690 TS=(lived experience*)

Indexes=SSCI Timespan=All years

34 68,014 TS=(life world OR life-world OR conversation analys?s OR personal experience* or theoretical saturation)

Indexes=SSCI Timespan=All years

33 382,945 TS=(account OR accounts OR unstructured OR open-ended OR open ended or text* OR narrative*)

Indexes=SSCI Timespan=All years

32 10,752 TS=(purpos* NEAR sampl*)

Indexes=SSCI Timespan=All years

31 38,605 TS=(focus NEAR/1 group*)

Indexes=SSCI Timespan=All years

30 7,886 TS=(purpos* NEAR/4 sampl*)

Indexes=SSCI Timespan=All years

29 16,013 TS=theoretical sampl*

Indexes=SSCI Timespan=All years

28 682 TS=biographical method

Indexes=SSCI Timespan=All years

27 25,388 TS=human science

Indexes=SSCI Timespan=All years

26 8,505 TS=(field NEAR/1 research*)

Indexes=SSCI Timespan=All years

25 11,334 TS=(field NEAR/1 stud*)

Indexes=SSCI Timespan=All years

24 92,813 TS=(humanistic or existential or experiential or paradigm*)

Indexes=SSCI Timespan=All years

23 65 TS=(action research OR cooperative inquir* ORco operative inquir* OR co-operative inquir*)

Indexes=SSCI Timespan=All years

22 244,112 TS=(social construct* OR postmodern* OR post-structural* OR post structural* OR poststructural* OR post modern* OR post-modern* OR feminis* OR interpret*)

Indexes=SSCI Timespan=All years

21 552 TS=(data NEAR/1 saturat*)

Indexes=SSCI Timespan=All years

20 29,480 TS=(emic OR etic OR hermeneutic$ OR Heuristic$ OR semiotic$)

Indexes=SSCI Timespan=All years

19 1,759 TS=women's stor*

Indexes=SSCI Timespan=All years

18 11,471 TS=life stor*

Indexes=SSCI Timespan=All years

17 920 TS=(grounded NEAR/1 research)

Indexes=SSCI Timespan=All years

16 2,001 ts=(grounded NEAR/1 (study OR studies))

Indexes=SSCI Timespan=All years

15 13,936 TS=(grounded NEAR/1 theor*)

Indexes=SSCI Timespan=All years

14 20,943 TS=phenomenol*

Indexes=SSCI Timespan=All years

13 33,548 TS=ethnograph*

Indexes=SSCI Timespan=All years

12 51 TS=ethnonursing

Indexes=SSCI Timespan=All years

11 39,409 #10 AND #9 AND #8

Indexes=SSCI Timespan=All years

10 2,277,185 TS=(Relation* or Dynamic* or Interact* or Impact* or Affect* or Conflict* or Coping or cope or copes or experience* or perception* or perspective* or burden*)

Indexes=SSCI Timespan=All years

9 1,154,092 TS=(Family or families or "Next of kin" or "Significant other" or parent* or child* or daughter* or son or sons or sibling* or brother* or sister* or mother* or father* or spouse* or wife or wives or husband* or partner* or relative*)

Indexes=SSCI Timespan=All years

8 208,788 #7 OR #6 OR #5 OR #4 OR #3 OR #2 OR #1

Indexes=SSCI Timespan=All years

7 30,240 TS=(alcohol addict* OR alcohol habit* OR alcohol dependen*)

Indexes=SSCI Timespan=All years

6 33,593 TS=(drug addict* OR drug habit* OR drug dependen*)

Indexes=SSCI Timespan=All years

5 25,259 TS=(substance addict* OR substance habit* Or substance dependen*)

Indexes=SSCI Timespan=All years

4 25,750 TS=alcoholi*

Indexes=SSCI Timespan=All years

3 107,909 TS=(drug use* or drug abuse* or drug misuse* or drug overuse*)

Indexes=SSCI Timespan=All years

2 75,391 TS=(alcohol use* or alcohol abuse* or alcohol misuse* or alcohol overuse*)

Indexes=SSCI Timespan=All years

1 77,717 TS=(substance use* or substance abuse* or substance misuse* or substance overuse*)

Indexes=SSCI Timespan=All years

Appendix 3. Studies Contributing to the Review Findings (Lindeman et al., 2021)

Subthemes	**Arcidiacono**	**Church**	**Fotopoulou**	**Fereidouni**	**Hodges**	**McCann**	**Moriarty**	**Näsman**	**Ólafsdóttir**	**Reis**	**[a]Tamutienė**	**[b]Tamutiene**	**Tinnfalt**	**Weimand**	**Werner**
Overwhelming problems	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Exhausted family members	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Messy lives and broken relations	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Trying to understand	X	X	X	X	X	X	X			X	X	X	X	X	X
Hoping for change	X	X	X	X	X	X	X			X	X	X	X	X	X
Fighting for survival	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
A family matter	X	X	X	X	X	X		X	X	X	X	X	X	X	X
A family secret	X	X	X	X	X		X			X	X	X	X	X	X
A professional blind spot	X	X	X	X	X		X	X		X	X	X	X	X	X

[a]Tamutiene (2017)
[b]Tamutienė (2019)

Appendix 4: example of my field notes

8.1.-20

I arrived at the first meeting well before the agreed time. The meeting place is central but slightly outside the core center. That is, the vast majority depends on taking either light rail, bus or driving their own car. I took the light rail and walked the rest. The house is temporarily locality because the treatment center rents place in an area where there is a lot of office buildings. A lot of traffic work is also underway, so it wasn't easy to figure out where to go. The room is on the upper floor of a store. It wasn't a good sign, so I had to google and ask. When I found the front door, I also found the sign, which was a large handwritten sheet stating that the drop-in offer was here and that because the door was closed after office hours, one had to call a specific mobile number one was then picked up. I arrived early, so the door was still open.

The offer was on the building's third floor. There were both stairs and an elevator. The staircase looked worn out. The treatment center itself, an outpatient clinic for various addiction conditions, had its own door on the third floor. I came right into the waiting room. New furniture, trinkets, information signs, coffee, and biscuits were all available. There was also a stand where one should report their arrival, but it was closed now. I sat down in the waiting room because I was so early. As I sat there, it got past two therapists I already knew. They both came to talk to me and wondered what I was doing there. I got the impression that they were unsure whether the outpatient clinic was permanently located in these premises. The treatment center, which was formerly a private foundation, has recently been taken over and organised under state health enterprises in this part of the country. This happened only a few months ago, so much is still characterized by uncertainty.

I was excited to know more of the people who ran the drop-in offer and people who used this offer. I called the cell phone number I'd been given. It was for a person I don't know very well, but whom I had greeted at a friend's birthday party some years ago. She seemed nice then. She picked me up from the reception, and we walked past many closed office doors to an open landscape with a seating area with small tables and armchairs. She told me that's where we would have the meeting, and I saw that chocolate, biscuits, and coffee were already in place. Staff was initially due to have a small preparatory meeting in the canteen. The canteen was a large room with several long tables. There were coffee machines and kettles, dishwashers, and refrigerators in the kitchen—many signs about how to use the kitchen part and where to place the boss.

Appendix 5. Example of resume story in Norwegian.

Datteren min har alltid vært plaget med angst, men som barn og ungdom var hun flink til å finne sin måte å leve med det. Hun hadde et aktivt liv, med mange interesser og hun fulførte skolen og fikk seg en jobb. Så traff hun en mann og ble gravid veldig fort. Vi, stefaren hennes og jeg, hadde hørt rykter om at han hadde hatt rusproblemer. Alt begynte å forandre seg. Når barnebarnet vårt var et år gammel, så ville ikke datteren min gå tilbake til arbeidet igjen. Jeg tenkte at det kanskje var på grunn av morsrollen, men samtidig kjente jeg på at det var noe som ikke stemte. Det var noe i måten hun unnlot å møte blikket vårt på, og at vi måtte være barnevakter veldig ofte. Det liknet ikke henne, fordi hun hadde gledet seg til å bli mor. Forholdet til barnefaren tok slutt, og hun flyttet til oss med barnet. Da merket jeg endringene, men jeg tror nok at jeg i begynnelsen satte på meg skylapper og fant unnskyldninger til hennes unormale oppførsel. Hun begynte å være veldig mye oppe i garasjen vår. Så fortalte hun en kveld gråtende at hun hadde fått en bekymringsmelding fra barnevernet. Da spurte jeg om hun hadde et rusproblem, men hun nektet det, og jeg trodde på henne. En natt ringte hun gråtende fra barnevernsvakten. Da hadde det vært en politirazzia i leiligheten hun befant seg i, med barnet. Det var så tragisk å tenke på at jeg som har jobbet med liknende ting selv ikke så tegnene tidligere. Vi undersøkte vesken hennes, og der fant vi en pose med noe hvitt i. Vårt sovende barnebarn hadde hånden sin over den vesken hvor pulveret var. Jeg vet ikke helt hvorfor jeg tok et bilde av det, men det var noe med den kontrasten mellom det pulveret og den lille barnehånden. Det er et bilde som har hjulpet meg i mange avgjørelser senere.

Jeg undersøkte garasjen og der var det veldig mye rus. Jeg ringte til politiet, og så kom sinnet over hva hun hadde utsatte oss alle for og ikke minst sin egen sønn. Det viste seg at hun allerede var under en undersøkelse fra barnevernet. Jeg koblet på familien min fordi jeg klarte ikke å ha med henne å gjøre selv, akkurat da. Det var en tøff prosess, fordi jeg har aldri kjent noen nære personer som har brukt rus. Jeg visste ingenting. Det var tøft for meg å forholde meg til datteren min. Jeg ble så usikker, fordi hun virket så oppegående. Jeg kunne ikke forstå at hun kunne bruke rus, og hun så heller ikke ruset ut. I dag vet jeg at hun tok amfetamin og GHB, og egentlig alt hun kunne ta.

Vi ble klar over hennes store rusutfordringer samtidig at vi tok over omsorgen for barnebarnet vårt. Det har vært kjempetøft fordi jeg på en måte mistet ett barn, samtidig som jeg fikk ett også. Jeg måtte si høyt at nå må jeg ut av mammaskoene for å gå inn i litt mer utvidete mormorsko. Men jeg har lovet henne at jeg skal ta vare på sønnen hennes helt til hun er klar for å ta vare på ham. Jeg har en oppgave å holde tilsyn når datteren og barnebarnet mitt har samvær. Datteren min kjemper hardt for å holde seg rusfri når hun har samvær. Men jeg ser at når hun har fått innvilget en ekstra overnatting, så blir hun veldig fort irritabel. Det er tøft både for hun og for meg, men så ser jeg også gleden hennes over å være med på hyttetur og ha familierelasjoner.

Hun lever farlig, og har omgang med menn som er voldelige og farlige. Da kan jeg kjenne på en redsel for hva slags folk hun egentlig er sammen med, og om de kan komme inn i våre liv. Jeg har noen ganger hentet henne hjem i svært dårlig forfatning når barnebarnet vårt ikke har vært hjemme. Når barnet er hjemme, kan jeg ikke hjelpe henne. Det er helt umenneskelig å komme opp i sånne situasjoner der du vet at her gjelder det hennes liv, og så kan jeg ikke hjelpe. Jeg kan i slike øyeblikk håpe at hun bare hadde tatt mer rus og gjort det slutt, fordi jeg orker ikke å ha denne redselen mer. Jeg har ikke dårlig samvittighet for at jeg tenkte slik, fordi det er faktisk helt naturlig å tenke sånn fordi du er så utslitt. Jeg mener det ikke, eller jeg

mener det kanskje i de øyeblikkene, hvor hun utsetter oss alle for mye eller hvor jeg må forklare til barnet hennes at hun ikke kan komme likevel eller hvor jeg hører at hun er svært ruset i telefonen og jeg kjenner på avsmak.

Jeg var i kjempesorg over det som skjedde med datteren min. Så var det sorg over faren til barnet som ruste seg og var etterlyst av politiet . Midt opp i dette står det en liten gutt som savnet sin mor og sin far. Kanskje det likevel var lettere å møte barnets sorg fordi jeg kjente litt den sorgen selv. Datteren min mener kun det beste for barnet og godtar at jeg har omsorgen, men klart det er en prosess for oss begge to. I begynnelsen følte jeg at jeg orket det ikke. Jeg tvilte på om jeg var så sterk. Så skulle jeg samtidig gå ut av arbeidet jeg likte, og i liten kommune møter jeg mange som jeg kjenner som arbeidstaker og som samtidig er involvert i belsutniger rundt barnebarnet mitt. Men det å hele tiden tråkke rundt mennesker som kjenner din situasjon gjorde meg egentlig sterkere. Jeg tenkte at det står faktisk ikke mitt navn på dette.

Jeg har mange ganger vært i situasjoner hvor det er samtidig stor bekymring for datteren min, mens jeg må beholde roen og ta vare på barnebarnet mitt. Den påkjenningen var umenneskelig i starten, og de raidene klarer jeg ikke å være med på lenger. Det er nok et forsvarsmekanisme, men jeg har valgt å være det for barnebarnet mitt og ta følelsesmessig avstand fra datteren min. Jeg tror kamskje at det er verre for meg enn for datteren min, fordi hun har blitt veldig selvsentrert. Jeg kjenner henne ikke igjen, fordi hun er egentlig en av de mest omtenksomme personene som jeg har kjent, nesten til grenser til det litt unormale. Men nå kjennes det som at fordi hun har det så vondt, så forventer hun at sønnen hennes og resten av oss skulle også ha det vondt. Hvorfor har ikke alle rundt meg vondt når jeg har det vondt – det er sånn egotripp som jeg taklet dårlig. Mange rundt meg har nok hatt mer vondt av datteren min, og syntes at jeg har vært beinhard. Men de har nok ikke klart å tenke på sønnen hennes sånn som jeg har tenkt på han. Men de har forstått mitt valg når jeg har forklart deet til dem. Det hadde vært tøft å miste dem også. De synes det er grusomt å ikke ikke ha henne med i familiesettinger. Det er vanskelig for oss alle å forstå at dette kan skje i voksen alder. De har en sorg, og jeg ser at de har det tøft når de ser henne., men de har valgt å støtte meg.

Hvis barnebarnet mitt hadde vært i et annet hjem eller ikke blitt født, hadde jeg holdt datteren min i mitt favn. Jeg hadde plaget livet av henne. Jeg hadde vært det verste mareritttet hun noen gang kunne tenke seg fordi at jeg ville ha henne tilbake igjen koste hva det koste ville, Det en slik datteren min kjenner meg som. Det er også slik hele familien kjenner meg som. Så denne motløsheten at du ikke kan gjøre noe er forferdelig. Det har jeg også snakket med datteren min om. Hun har også bedt at jeg aldri skal gi henne opp, og det gjør jeg ikke heller. Men jeg ha måttet ta mye avstand, fordi det er for tøft for meg. Det er ingenting som alle disse vanskelige følelsene, alle disse vonde turene. Jeg har fått telefoner hvor det formidles at der er ikke sikker på at hun overlever eller at de ikke kan finne henne. Så legger jeg på, og går og leker med sønnen hennes, samtidig som jeg ikke vet om moren hans er død. Det var så vondt akkurat som noen som rev absolutt alt jeg hadde og stod for og var. Jeg kjente på at dette her er så vondt at det klarer jeg ikke å bearbeide. Denne følelsen kan jeg ikke tillate meg selv å få, fordi jeg vet ikke hvor mange ganger jeg ville klare den

Jeg har blitt mye flinkere til å beskytte meg selv. Dette er en vei hun har valgt. Dette er hennes vei, og hun må gå den. Det er lite jeg kan nå gjøre som en mamma. Men jeg tar vare på sønnen hennes og da må hun forstå at det bregrenser meg. Broren hennes har egentlig tatt

dette veldig hardt, men samtidig er han litt sånn er livet og så går han videre. Det er kanskje det som er hans måte å håndtere dette, men det har vært veldig tøft å se at det søskenforholdet som var mellom de er ikke der mer. Jeg ser at deres forhold er nok helt ødelagt, men ingen av dem har turt å si det. Datteren min har heller ikke skjønt det. Hun kaller ham lillebroren min, og jeg ser at det koster mye for ham å høre på henne. Samboeren min har vært stefar til datteren min helt fra hun var liten, så han har jo sitt sorg i dette. Når jeg tenker meg om, så var jeg alt for lite opptatt av det i begynnelsen. Han led nok i stillhet i lang tid. Han er synes det er sårt å tenke på det som har skjedd for datteren min. Jeg kunne se at han satt apatisk uten å tenke på hvorfor han er det. Han bare satt der uten å vite hva han skulle si eller gjøre, mens jeg svirret rundt og var med på møter her og møter der. Han sa at han ble matt av å se på meg. Han var så mye flinkere enn meg til å kjenne på hvordan han faktisk hadde det. Så jeg skjønte at jeg måtte sette meg ned for å høre hvordan han hadde det og tåle å høre på svarene. Vi brukte faktisk en helg til å snakke om alt det som hadde skjedd de siste årene. Jeg var så overrasket over hvor vondt han hadde det. Det viktigste var at jeg lærte at vi var faktisk to i det, to som må være der for hverandre, to i hverdagen til barnevarnet vårt.

Appendix 6: REK Norway

REK
REGIONALE KOMITEER FOR MEDISINSK OG HELSEFAGLIG FORSKNINGSETIKK

Region:	Saksbehandler:	Telefon:	Vår dato:	Vår referanse:
REK vest	Ingvild Haaland	55978498	03.06.2019	2019/274/REK vest
			Deres dato: 12.05.2019	Deres referanse:

Vår referanse må oppgis ved alle henvendelser

Ottar Ness
Dragvoll

2019/274 Hvordan familier hvor det er rusutfordringer lever med bekymringer og redsler relatert til rusmiddelavhengighet?

Forskningsansvarlig: Norges teknisk-naturvitenskapelige universitet
Prosjektleder: Ottar Ness

Vi viser til Tilbakemelding mottatt 12.05.2019. Tilbakemeldingen er behandlet av leder for REK vest på fullmakt, med hjemmel i helseforskningsloven § 10.

Prosjektomtale
Prosjektbeskrivelse Dette kvalitative doktorgradsstudiet har som mål å forstå mer om hva det innebærer for familier å leve med et familiemedlem som har rusutfordringer, og skaffe mer kunnskap om hvordan familier lever med bekymringer og redsler knyttet til rusavhengighet. Prosjektet ønsker å gi mer kunnskap om en slik livssituasjon for fagpersoner, som møter disse familiene i forskjellige helse- og sosiale tjenester. Slik kunnskap kan bidra til å redusere stigma, og forbedre livskvalitet og fungering for en stor gruppe mennesker. Forskningsspørsmålene i prosjektet er: Hvordan lever familier hvor det er rusutfordringer med bekymringer og redsler knyttet til rusmiddelavhengighet? Hvilke holdninger familiene og andre rundt familien har til risiken om rusrelatert død? Hvordan opplever de forskjellige familiemedlemmene (partner, foreldre, søsken, brukeren selv og voksne barn) bekymringer og frykt knyttet til rusutfordringer? Hvordan har bekymringer og frykt knyttet til rusmiddelavhengighet

Vurdering

Prosjektsøknaden ble først behandlet av komiteen i møtet 06.03.2019.

REK vest ba om tilbakemelding på følgende:
- Beskrivelse av innhold/tema for intervjuer
- Redegjørelse for tilbaketrekking av samtykke i selvhjelpgruppene
- Redegjørelse for risiko og beredskap for deltakerne
- Reviderte informasjonsskriv og samtykkeskjema etter ovennevnte merknader
- Revidert protokoll etter ovennevnte merknader

Tilbakemelding fra prosjektleder:

Forsvarlighet
Komiteen har ønsket mer informasjon om innhold/tema i intervju, risiko og beredskap for inkluderte deltakere, og klargjøring angående frivillighet for deltakere i feltgrupper for prosjektets forsvarlighet kan

Appendix 7: TREC London

The Tavistock and Portman NHS

Tavistock and Portman Trust Research Ethics Committee (TREC)

APPLICATION FOR ETHICAL REVIEW OF RESEARCH INVOLVING HUMAN PARTICIPANTS

This application should be submitted alongside copies of any supporting documentation which will be handed to participants, including a participant information sheet, consent form, self-completion survey or questionnaire.

Where a form is submitted and sections are incomplete, the form will not be considered by TREC and will be returned to the applicant for completion.

For further guidance please contact Paru Jeram ( )

PROJECT DETAILS

Current project title	Life experiences of families of people with substance use difficulties		
Proposed project start date	1.6.2019	**Anticipated project end date**	**31.12.2021**

APPLICANT DETAILS

Name of Researcher	Sari Linderman
Email address	
Contact telephone number	+4797528863

CONFLICTS OF INTEREST

Will any of the researchers or their institutions receive any other benefits or incentives for taking part in this research over and above their normal salary package or the costs of undertaking the research?
YES ☐ **NO** ☒
If **YES**, please detail below:

Is there any further possibility for conflict of interest? YES ☐ **NO** ☒
If **YES**, please detail below:

FOR ALL APPLICANTS

Is your research being conducted externally* to the Trust? (for example; within a Local Authority, Schools, Care Homes, other NHS Trusts or other organisations). *Please note that 'external' is defined as an organisation which is external to the Tavistock and Portman NHS Foundation Trust (Trust)	**YES** ☒ **NO** ☐

If **YES**, please supply details below.
My research is being conducted in Norway, but it is doctorate project connected the Tavistock and Portman NHS Foundation Trust

Appendix 8. Information sheet for individual interviews.

PARTICIPANT INFORMATION SHEET TEMPLATE FOR ADULTS

[

invitation to participate in a research project

How do families in which substance use is present live with probLEmatic substance use?

This is a request for your participation in a research project. I have contacted you because you have lived close to substance abuse challenges in your family, and because you yourself or others that you know have given us your name.

The purpose of this research is to explore how families in which one or several family members have substance use challenges live with the impact of substance use. The aim is to learn more about, and contribute to greater understanding of, how family members are experiencing such a life situation and how health and social services can better meet the needs of families families in these kinds of life situations.

I will ask you to participate in a conversation between you and me lasting for about 1-1 ½ hours, in a place and at a time that suits you. The interview will be recorded on tape and transcribed. It will only be me who will know about your identity. The interview will be made anonymous. All materials, audio recording and data will be deleted when the project finishes. The questions I would like to talk with you about addresses your experiences living close to substance misuse challenges in your family.

This Doctoral study is carried out in association with the Tavistock and Portman Trust/the Essex University in London, UK. All the interviews will be conducted in Norway and those requested will have had experiences as family members of such life situations and have turned 18 years (parent of children over 18 year, siblings, partners, children over 18 year or persons who has or have had substance abuse challenges yourself) .

What IS THE Project ABOUT?

In order to collect data for my research theme I would like to carry out 15 interviews. The interviews will be recorded on tape and transcribed and they will be conducted in the course of the year 2019. I , Sari Lindeman, am a doctoral student is Sari Lindeman, who is employed at Western University of Applied Sciences in Bergen. My doctorate project is associated with the Tavistock Portman Trust/the Essex University in London, UK and is a Professional Doctorate program in systemic psychotherapy. The supervisors for the project is Britt Krause, Tavistock-Portman Trust, Hilary Palmer, Tavistock-Portman trust and Ottar Ness, NTNU.

I will conduct all the interviews and they will each last approximately 1 – 1,5 hours. All data will be treated confidentially and in a proper manner in accordance with guidelines given by Norwegian Data Protection Committee. This means that I have a duty of confidentiality towards all personal information which I collect. The data will be anonymised and deleted when the doctoral project is completed, and latest year 2025.

Sari Lindeman has a duty to confidentially under Norwegian law and she is as a researcher obligated to preserve the silence about all information she receives.

FORESEEABLE BENEFITS AND PREDICTABLE RISKS AND BURDENS OF TAKING PART

New knowledge about living in a family where there is substance abuse challenges will contribute to improved support and help services. Most people who participate in a personal research interview find the expereince meaningful. For some an interview may answer questions about difficult life experiences. While for others it may create a need to talk with someone in the aftermath. If such a need arises for you, you can contact me, Sari Lindeman, tel. 97528863 or email slin@hvl.no and I will talk with you myself or direct you to another professional.

Voluntary participation and the possiblity to withdraw consent

Participation in the project is voluntary. If you wish to take part, you will need to sign the declaration of consent. You can, at any given time and without reason withdraw your consent.

If you decide to withdraw participation in the project, you can demand that your personal data be deleted, unless however, the personal data have already been analysed or used in scientific publications. If you at a later point, wish to withdraw consent or have questions regarding the project, you can contact Sari Lindeman, slin@hvl.no, mobil 97528863.

What will happen to YOUR personal data

Any personal data that has been recorded about you will only be used as described in the purpose of the project. You have the right to access information that has been recorded about you and the right to stipulate that any error(s) in the information that is recorded is/are corrected. You also have the right to know which security measures have been/will be taken when your personal data is processed.

All information will be processed and used without your name or personal identification number, or any other information that is directly identifiable to you. A code links you and your personal data via an identifier list. Only Sari Lindeman will have access to this list.

Information about you will be anonymised and deleted a maximum of five years after the project has ended.

Approval

The Regional Committee for Medical and Health Research Ethics has reviewed and approved the Research Project and Tavistock Research Ethics Committee (TREC) has approved the Research Project.

In accordance with the General Data Protection Regulation the controller doctorate student Sari Lindeman is independently responsible to ensure that the processing of your personal data has a

legal basis. This project has legal basis in accordance with the EUs General Data Protection Regulation, article 6a, article 9 nr.2 and your consent.

You have the right to submit a complaint on the processing of your personal data to the Norwegian Data Inspectorate (Datatilsynet).

contact information

If you have any questions regarding the research project, you can get in touch with Sari Lindeman, +4797528863, email slin@hvl.no.

If participants have any concerns about the conduct of the investigator, researcher(s) or any other aspect of this research project, they should contact Inga-Britt Krause PhD, Lead of Professional Doctorate in Systemic Psychotherapy Tavistock Centre, 120 Belsize Lane, London NW3 5BA, Tel.: 020 8938 2590, Email: bkrause@tavi-port.nhs.uk. It is possible to make this contact in Norwegian.

Appendix 9. Information sheet field work.

PARTICIPANT INFORMATION SHEET TEMPLATE FOR ADULTS

invitation to participate in a research project

How do families IN WHICH substance use is present live with AN impact Of substance use?

This is a request for your participation in a research project. I would like to ask your consent to have me as a visitor in your self-help group for relatives within the substance dependence field / self-help group for people with substance dependent challenges. I would like to visit in your group the period 2.1. – 31.1.2022.

The purpose of this research is to explore how families where one or several family members have substance abuse challenges are living with substance use and the risks connected to substance use. The aim is to learn more about, and contribute to greater understanding of, how family members are experiencing such a life situation and how health and social services can better meet the needs of families in these kinds of life situations.

This doctoral study is carried out associated with the Tavistock and Portman Trust/the Essex University in London, UK. All the interviews, field work and focus group interviews will be conducted in Norway. Those taking part have to have had experiences as family members in such life situations and should be above 18 years of age.

What IS THE Project ABOUT?

The goal of my fieldwork is to attune myself to my research topic and better understand the theme of my research. I will am carry out several personal interviews and a focus group interview, and my hope is to be able to ask better questions after visiting and talking with you.

I will not take notes during my visits, but I will keep notes of my observations and impressions later and these notes will be used in my research project.

I, Sari Lindeman, am the leader of this project and I am employed at Western University of Applied Sciences in Bergen. My doctorate project is in association with the Tavistock Portman Trust/the Essex University in London, UK and a Professional Doctorate program in systemic psychotherapy. The supervisors for the project are Britt Krause, Tavistock-Portman Trust and Ottar Ness, NTNU.

All data will be treated confidentially and in a proper manner in accordance with guidelines given by Norwegian Data Protection Committee. This means that I will have a duty of confidentiality towards all personal information that I collect. The data will be anonymissed and deleted when the doctoral project is completed, and latest year 2025.

Sari Lindeman has a duty of confidentially under Norwegian law and she is as a researcher obligated to preserve the silence about all information she receives.

FORESEEABLE BENEFITS AND PREDICTABLE RISKS AND BURDENS OF TAKING PART

New knowledge about living in a family where there is substance abuse challenges will contribute to improve support and help services. Most people taking part in a focus group interview experience this, but for some answering questions about difficult life experiences can create a need to talk with someone else in the aftermath. If such a need arises with you, you can contact Sari Lindeman, tel. 97528863 or email slin@hvl.no and I will talk with you myself or direct you to a another professional.

Voluntary participation and the possiblity to withdraw consent

Participation in the project is voluntary. It is your right stop your participation at any time and you can withdraw your consent without any reason or explanation. If you decide to withdraw participation in the project, you can demand that your personal data be deleted, unless however, the personal data have already been analysed or used in scientific publications. If you at a later point, wish to withdraw consent or have questions regarding the project, you can contact Sari Lindeman, slin@hvl.no, mobil 97528863.

What will happen to YOUR personal data concerning health?

Any personal data about you or our group will only be used as described in the purpose of the project.

All information will be processed and used without your name or personal identification number, or any other information that is directly identifiable to you.

Information about you will be anonymised and deleted a maximum of five years after the project has ended.

Approval

The Regional Committee for Medical and Health Research Ethics has reviewed and approved the Research Project [*insert reference number from REC* and Tavistock Research Ethics Committee (TREC) has approved the Research Prosject.

In accordance with the General Data Protection Regulation the controller doctorate student Sari Lindeman is independently responsible to ensure that the processing of your personal data has a legal basis. This project has legal basis in accordance with the EUs General Data Protection Regulation, article 6a, article 9 nr.2 and your consent.

You have the right to submit a complaint on the processing of your personal data to the Norwegian Data Inspectorate (Datatilsynet).

contact information

If you have any questions regarding the research project, you can get in touch with Sari Lindeman, +4797528863, email slin@hvl.no.

If participants have any concerns about the conduct of the investigator, researcher(s) or any other aspect of this research project, they should contact Inga-Britt Krause PhD, Lead of Professional

Doctorate in Systemic Psychotherapy Tavistock Centre, 120 Belsize Lane, London NW3 5BA, Tel.: 020 8938 2590, Email: bkrause@tavi-port.nhs.uk. It is possible to make this contact in Norwegian.

I consent to participating in the research project

City/Town and date	Participant's Signature
	Participant's Name (in BLOCK LETTERS)

Appendix 10: Developing stories, examples of analysis of “what”-stories

Examples of interviews	Questions from Frank: How this story works on people and affect what people can see as real, as possible, and as worth doing or best avoided? Questions from Riessman: Why was the narrative developed that way and told in that order, how does he/she locate herself in relation to the audience, how does he/she locate characters in relation to one another and relation to herself	Stories
And there have been times where he hasn't believed it, so he's just said I'll come and get him. So, I've said no, he has a fever you can't have him then. For that, we have agreed that you should not have him when he has a fever Then I took a picture of the fever target. I sent it to him and it all. Also, it's just like he just turns 180 degrees, and then there are messages like that, but I have a plan I'm going to now And then I turn my head in black, lock all the doors and curtains, sit down on the second floor, and watch movies. So that's kind of how it shouldn't be like that (ex-partner 1.)	Fear of ex-partner coming to take her child Preparedness for a situation that he is coming. There is something to fear of, and it is important to be prepared.	*A story of fear and preparedness* is about how participants talk about how having PSU in a family means stress and upsetting situations. Fear causes an unpredictable existence, which participants describe as a constant preparedness for something frightening and dangerous to happen.
I knew that when he was arguing on the phone because you kind of gets that feeling after every gut feeling. So you know what's going on a week before, in a way. Then I knew I was just waiting for the car to come to my house. Oh my god. I just have to. Then the fool. Running out because I thought he was not going in because there the kids, my son and stepson were at home, so I ran out	Preparedness can get a gut feeling. Fear. Protecting children from ex-partners. There is something you have to protect the children from	*A story of fear and preparedness* *Story of protecting other family members from PSU* The story of protecting other family members from PSU is strongly evident in participants' interviews. PSU is presented to transform

and jumped into the car. (ex-partner 2.)		the person using substances into a dangerous and irresponsible person. Protection from PSU is described as a solid motivation for actions.
Where he suddenly hears that there is a huge shouting or loud voice. I just think what it is that's going on where I walk up to him, and he just. Yes, who is it that, maybe my dad he's angry with, at least he scolds and me, my girl and my partner, I don't know if they go into freeze, I don't know what's going on they stand then at least and just look. I realize it's about to escalate so I just go upstairs and just say to myself just take her away with you. I close the door, just pretend we live in one little house and it's stuffy, and I just think just get her away, you just have to go, and he can't calm down. He's so angry then by all sorts of weirdness he just freaks out at mom and dad and is angry that he just yelled and screamed. (Sibling 1.)	Terrifying situation Brother impacted by substances in conflict with parents Everybody is in a freeze Want to protect her daughter. Fear There is something you have to protect the children from	*A story of fear and preparedness* *Story of protecting other family members from PSU*
Before, I always went and waited. I couldn't relax. I remember when I went into treatment with the physiotherapist, he said many times that you are not lying down. You, your whole muscles, are holding you up. It's just not going to do it. When you're lying down, you're going to be relaxed, and I didn't. I went all the time and waited. I started working as a psychologist for the reason that I was constantly on standby that's what made it. I could not understand why I was so activated all the time and then felt too scared and angry. I thought I was too angry and especially at my children. I yelled a lot and didn't want to be like that. And then it was about, found out that it was the constant readiness, and then there is such a focus on it all the time that	Can’t relax, constantly on standby. Waiting something to happen. Everything else is noise. Something bad can happen, and you have to be prepared.	

everything else in your life becomes noise. Sari: but what was it like to live with constant readiness? I: terrible, it was absolutely terrible. It is so that I feel sorry for those who lived with me because of that. I wasn't quite there. I think I was like that something was going to happen that I was so ready for anything all the time, and it was very like that. I was very scared, and I think I was very anxious, really. (Sibling 2.)		
I think it's so inhumane that it's incredibly difficult. I think it's really hard to imagine because I think we might think differently when we get into stuff like that. We may be acting irrationally, and we think then, I think there was a moment I thought, oh my God, you couldn't just finish it. I kind of said that to my husband and that sometimes I hope that because I can't stand it, I can't bear to have this fear that someone is going to punish her, and then they take us. So, you're thinking. Then I walked into something that I've never before gone into somehow. A little bit of that kind of horror.	Fear of friends of daughter, for daughter. Being so afraid that she thought that it is better that her daughter dies. There is something to be really fear of. Preparedness.	