Positioning fatherhood in therapy:

A search for cultures of wellness and hope in treatment contexts for alcohol problems

Hilary Wongraven

Mastergradsoppgave i Familieterapi og systemisk praksis

Diakonhjemmet Høgskole 2007

K: When you work clinically, you tend to get pretty immersed in your own stuff. And I think that we therapists should lift our gaze and see what's happening in society and get involved. Both politically and in other ways. Men today are expected to be at home more. I have read that when young men who are about to be fathers are asked about their expectations about being a father, their scores on expectations on being at home a lot and spending a lot of time together with the child, are very high. Whilst that is not what happens in practice. When the mother has been at home and 80% of the year has passed, she has a pretty good grip on the home and the child – so the father never really gets onto the playing field. So we need to see that these men lose a lot. In fact – 20 years ago – men with a substance abuse problem lost less.

From the interview with Kristin.

Acknowledgements

I would like to thank all my informants, both for willingly making themselves available for interviews on the subject of fatherhood and for their generous sharing of knowledges about their work. My thanks, too, to their clinic directors who passed on my requests for interviews and made me feel that the fatherhood issue was important to address. Above all, I extend my sincere thanks to Professor Jim Sheehan whose supervision constituted a perfect mix of inspiration, support and constructive feedback during the entire research process.

I am grateful to my own clinic directors for allowing me to organize my working life in ways that made this project possible. My thanks also go to the many patients and colleagues at work who have expressed interest for this research. I have found that very encouraging.

Tanja Christiansen did proofreading and gave helpful comments from an outsider's perspective to the field of psychotherapy. I have greatly appreciated both.

Lastly, I want to thank friends and family for their emotional support and understanding during the past two years. It has been invaluable.

Contents

1	**Introduction**	**page**	**1**
1.1	**The theme and aim of the research project**	**page**	**1**
2	**Practices and perspectives on the issues at hand**	**page**	**6**
2.1	**A developmental view on researches and practices in alcohol treatment**	**page**	**6**
2.2	**Wellness research in the alcohol treatment field**	**page**	**9**
2.3	**Research on families in welfare-state Norway**	**page**	**9**
2.4	**Gender research on men and parenting issues**	**page**	**10**
3	**My approach to this research**	**page**	**12**
3.1	**Introduction to my approach**	**page**	**12**
3.2	**Theorizing fatherhood in alcohol treatment: a research framework**	**page**	**12**
3.3	**Therapists as experts on alcohol and fatherhood: some ethical implications**	**page**	**16**
3.4	**Links between research theme, the methods I chose and validity issues**	**page**	**19**
3.5	**Choices when collecting data**	**page**	**20**
3.6	**Sampling**	**page**	**22**
3.7	**Choices when analysing data**	**page**	**23**
3.8	**The content analysis in Part One**	**page**	**24**
3.9	**The discourse analysis in Part Two**	**page**	**25**
3.10	**Working through the analytical process**	**page**	**26**
3.11	**Meetings on many levels: some cultural tales**	**page**	**27**
3.12	**Writing this report**	**page**	**31**
3.13	**Some limitations in my approach**	**page**	**32**

4 Multiple fatherhoods on multiple levels **page 33**
4.1 Introduction to my analysis **page 33**
4.2 About my informants **page 33**

Part One: How therapists positioned their selves page 35

4.3 Introduction to Part One **page 35**
4.4 Knowledges therapists drew on when addressing fatherhood **page 35**
Professional knowledges page 35
Knowledges gained from own personal life experience page 36
Knowledges from practical experience page 37
Making knowledges public page 38
Ethics as an active partner to knowledges page 39
4.5 Therapists' point of departure when addressing fatherhood **page 40**
Addressing fatherhood via the child page 40
Therapists as experts on child care page 41
Starting directly with the father page 42
Destabilizing tendencies page 42
4.6 Therapist approaches to fatherhood seen with a gender filter **page 43**
Mother-oriented or equality-oriented positioning on fatherhood page 43
Mother-oriented positioning dominated in practice page 44
Equality oriented positioning promoted equality in the therapeutic relationship page 45
Should men work with men page 47
Women and the power issue page 48
4.7 Using stories to hold on to hope **page 49**
Fathers who change their fatherhood during therapy page 49
4.8 Conclusions from Part One **page 50**

Part Two: When therapists positioned the selves of others page 52

4.9 Introduction to Part Two page 52

4.10 The two stories: professional parenting and contemporary fatherhood page 53

4.11 The professional parenting story page 54

Dominating discourses about parenting page 54

Assessing risks around children during therapy with fathers page 56

Destabilizing tendencies page 57

Wellness oriented discourse occurred together with specific stories about children page 57

4.12 The contemporary fatherhood story page 59

Patients as men and fathers in role conflict page 60

Negotiating stories of gender-appropriate fatherhood practices page 61

When collaborative discourse dominated interviews page 64

4.13 Conclusions from Part Two page 65

5 A researcher re-positions her self page 68

6 References and sources page 71

Appendices

1 Introduction

1.1 The theme and aim of the research project

This research project uses socio-constructive, cultural perspectives to explore the thoughts and proclaimed actions of therapists working in the Norwegian field of treatment for alcohol problems regarding a number of issues which might be unexpected in that context. I have asked therapists working in four different clinics treating adults for alcohol problems, *not* about how they talk to their patients about their alcohol problems, but how they talk to their patients about probably one of the most common, everyday subjects for most adults, namely being a parent. Furthermore, the project explores not therapist "talk" about parenting as a general issue, but as an issue complicated by culturally rooted concepts relating to issues of gender and social deviance. I have asked therapists to tell me about their conversations with male patients who are fathers. My initial starting point for raising the subject is related to my own professional background and experience. I am a trained family therapist with a foreign background, presently working in a Norwegian treatment clinic for adults with alcohol problems. Personal cultural "otherness" is relevant in that respect. Being a child of white, English colonial parents in the context of Rhodesia, Africa, more than half a century ago, for me the cultural premises for what is a "good" childhood were originally set by that upbringing. Most white people in Rhodesia drank a lot in those days – especially men. Not many seemed to question that. For better or worse, men were needed, their incomes were needed and their status was needed. "Just-get-on-with-it" traditions dominated; there was nothing that came close to resembling the Norwegian state welfare system which might have intervened in parenting practices. My own father's alcohol consumption was high, yet neither our family nor society around us seemed to consider that a problem. Many years later I moved to Norway, then in my mid-twenties and already a mother. The contrast to my background in Africa was enormous. Being a foreigner, I lacked knowledge and cultural respect for Norwegian established "truths". I became a kind of participatory observer, an endless traveller in the Norwegian cultural world of expectations and practices. Some of my earliest and most important explorations were within beliefs about childhood and parenthood.

I have now expanded my travels to include the world of therapy. I continue to want to remain not certain about where to go, and to hope to learn how to appreciate the journey. Systemic training helps me to be relatively comfortable with seeking solutions outside the framework within which a problem was originally defined. I have been trying to put this into

practice at the clinic where I am presently employed. There, more than two thirds of those seeking treatment for their alcohol problems are men. Many of them are fathers. Simple, informal statistics from my own caseload during the past 16 months show that more than half of my patients were fathers and that most of these were fathering minors. At the initiation of therapy, all had contact with their children, yet all feared losing contact. Some were in conflict with the mothers about access to their children, while in other cases the children themselves had rejected their fathers as a result of loss of trust. Some feared that child care authorities would prevent access. These men told me how much they thought about and were influenced by their concern for their families, especially their preoccupation with their children. Feedback on their behaviour from those who were closest had the greatest impact. Many sought treatment as a result of family pressure, and many "stuck out" treatment because they wanted to become better fathers. Although the treatment context indicated that we should have been talking about their alcohol problems, we at times set aside that "main" problem and worked on parenting instead.

Since I have a previous working background as a family therapist for parents and their drop-out teenagers under the umbrella of regional child care authorities, the reader might have expected me to know how to go about that. Yet it has not always been easy to know how to do this in practice. I found that when addressing links between therapy, fathering, alcohol and children, I was forced to confront my own opinions, statements and conducts round such issues. It would also be possible to argue, why not leave the whole parenting issue to child care authorities, who have been entrusted with such tasks? [1]Despite the fact that much of the family related research on parents with alcohol problems states that their children are at risk, and despite my own familiarity with child care authorities, I had only limited cooperation with the latter in my own casework. Was I struggling alone with the issues at hand, or might there be other therapists who were engaged in similar struggles? By exploring these issues in a small research project, I hope that the research analysis will help provide more comprehensive answers to that question. In my research I started by asking other therapists what they say and do, and move on to reflect over what might be at stake when therapists either do or do not address men's fatherhood within the context of alcohol treatment. Therapeutic interventions

[1] The Act on child care services regulates cultural codes for how parents should adequately fulfil their childrens' "needs" for love, help and control during the childhood period (Hennum 2002: 111). This Act requires all professionals working within the Norwegian health care system to be aware of situations that may lead to the child care authorities initiating measures. However, professionals are only *obliged* to contact child care if they are seriously concerned that a child is being neglected, or if the child care authorities specifically request information (Article 33 of the Norwegian Health Personnel Act). Other than that, cooperation must be voluntary, with the patient's permission.

directed towards parenting are small but important expressions of the Norwegian model of the welfare state, a huge system whereby Norwegian society organizes life for its inhabitants with regard to culture, politics, health, law and general social life. I explore how such expressions of the Norwegian model of the welfare state might enter the therapy room in one guise or another, and discuss what effect it has on the parties concerned. The socio-constructive, cultural approach makes it possible for me to lay bare and discuss some of the power issues at stake when therapists – and researchers – would seem to command truths or "knowledges" about therapy, fathering, alcohol and children. Awareness around such issues may make it easier for therapists to question and perhaps even challenge some of the ideas and practices which dominate the field. Such awareness may open for some untraditional and more positive "knowledges" that to a greater degree favour deviant fathers. Positive contributions of such a nature would be most welcome in the therapy room, for in my conversations with fathers who are surrounded by a storm of criticism, we often battle to hold on to hope and the will to change.

Statistics at the clinic where I work reflect national statistics: many more men than women in Norway seek treatment for their alcohol problems (Fekjær 2004: 215). Although gender-related research on the meaning today's Norwegian men attribute to the drinking of alcohol is lacking, the fact that the terms "normal drinking" and "problem drinking" are so commonly used indicates that "normal" drinking is appropriate behaviour for men. Statistics on alcohol consumption indicate that Norwegian men have always drunk more alcohol than women, although the gap between the sexes is closing now in that respect. (Fekjær 2004: 61; NOU 2003: 4: 24-25). Furthermore, both international (Klingemann 2001) and national research (Fekjær 1996 and 2004) shows that most people either see no need to stop drinking, or if they want to stop, they do so without seeking treatment. This means that therapists working in the field are addressing a minority group who *deviate* from the main group, – a point I ask the reader to bear in mind as we move through the discussions that follow.

Today there are more than 200 facilities to help people who have problems with or are dependent on harmful intoxicant substances, and a good number of these offer some form of treatment. Responsibility for treatment was recently taken over by the health care sector, although most facilities have an organisational history from the social services. Although many more people have problems with alcohol than with other intoxicating substances (NOU 2003: 4), most clinics offer treatment for substance abuse as a general problem.

It is difficult to know to what extent therapists in the various clinics address *parenting* with their patients. Family perspectives are predominantly used when targeting special groups, for example when the target patient is a child, or a teenager using illegal intoxicant substances, or a mother. The gender imbalance is telling. We know that parenting issues are more often raised with mothers, despite the fact that far more men voluntarily seek treatment for their alcohol problems, and it is likely that many of them are fathers. Among other things, parenting talks with mothers are on the agenda in all regional residential facilities for the mandatory treatment of pregnant women with an addiction problem. Such facilities usually offer parallel "voluntary" residential treatment facilities to parents with children below school age, but fathers do not appear to be target patients.[2] Men seem to dominate in clinics focusing on general treatment to adults. Here, therapists appear to be relatively free to decide how they want to address cooperation with family. Most large clinics offer some form of separate group treatment for family members, such as groups for patients' adult children, or partners to patients. Some also emphasize the importance of integrating family in all the treatments they offer, but I do not know what consequences this has in practice. I harbour suspicions that some treatment facilities may be paying mere lip service to government claims in 2003 that family orientated therapy could be effective for adults as well as teenagers, and that treatment for couples gives as good or better results compared to individual treatment (NOU 2003: 4). In their Plan of Action against problems with intoxicants 2006-2008, the Norwegian government challenges *practitioners* in the field to give greater priority to patients' underlying problems, and more specifically to pay more attention to family needs arising in connection with the patients' addiction problems. However, concrete plans for putting this into practice were still lacking when the Plan went to press. It also calls for more *research* on gender related issues and on the effect of alcohol problems on families involved (Regjeringens handlingsplan mot rusmiddelproblemer 2006-2008: 10-14).

The main aim of this project has been both to stimulate reflexive[3] processes and add to practice skills for therapists working within any treatment system for men with alcohol problems, especially where the treatment may include fathers of minors. This is my contribution to making treatment for fathers with alcohol problems more meaningful and more successful. I have in mind the needs of individual therapists, although the fact that

[2] It is child care authorities who refer these families, so they are under a lot of pressure.
[3] I interpret this word in accordance with Hoffman's authorship on the subject. She uses a dictionary definition of the word reflexive as "the bending or folding back of a part on itself" and illustrates the idea of reflexivity with the symbolic picture of an ideal partnership, where there is equality in participation despite differences in positions (Hoffman 1992: 17).

greater attention is being paid to the issue of male parenthood and therapy has the potential to add to wider social debates on gender and parenting practices. However, while therapeutic treatment in itself does offer many challenges within a broad context, this research aims to shed light on a relatively limited issue within a narrow context. Based on that context, my research explores what therapists themselves report regarding how they address a father's fatherhood, in contexts where the principal issue for the therapy is the patient's problems with alcohol.

Main research question:

What do therapists say about how they address a father's parenthood when the main issue for therapy is his problems with alcohol?

2 Practices and perspectives on the issues at hand

2.1 A developmental view on researches and practices in alcohol treatment

I see treatment ideologies as cultural constructs, where international and national trends in politics, social research and practices carried out in treatment facilities interact and are mutually interdependent (Babor et al. 2003). Seen as a whole, there is very little mention of men as gendered beings in the literature which follows here.[4] However, since men dominate in statistics over those who have alcohol problems, I have presumed that authors are mainly referring to men when families, or women or children are not being specifically mentioned. Judging what works best for who in treatment has always been difficult. After much international research on the subject for the past decades, answers appear clearer now than they did (compare for example Hester & Miller 1989 to Brown 2001 or Heather 2001). Relatively early, international research findings showed that improvements experienced by people who sought therapy for their alcohol problems could often be traced to improvements in their lives outside the therapy room, amongst other things in the sphere of intimate relationships (e.g. Peele 1985). By the 1970s and 1980s ample research was being done in USA on alcohol and the family (cf. Barnes & Augustino's bibliography in 1987). Much of that adhered to the disease model [5]. Interaction with the practice field resulted in the production of a well of family friendly treatment literature for "alcoholic" families and children of "alcoholics". Many of these were treatment guides or models formulated by experienced practitioners working with substance abuse, such as Kaufman & Kaufman (1979, 1st edition) or Treadway (1989). Towards the end of the '80s the disease discourse started to meet competition from the field of psychology. At the same time even more attention was given to *children* of "alcoholics". For example, while Robinson published a practitioner's handbook on Children of Alcoholics based on the disease model in 1989, Brown had already published a developmental perspective on adult children of alcoholics a year earlier (1988) and two years later editors Windle and Searles further challenged the treatment field by offering a collection of research papers viewing alcohol problems in a bio-psychosocial

[4] This is not surprising. In contrast to women, when men are mentioned in the field of (national) health and social affairs, it is seldom as *gendered* beings (Fjeldstad 2005: 86).
[5] The American disease model of alcoholism proposes that most people can drink moderate amounts of alcohol quite safely, but claims that some people get afflicted with the disease of alcoholism and because of that they should totally abstain from using alcohol (Epstein 2001: 44).

perspective (1990). As treatment models became more varied, it became increasingly common to consider how different theoretical perspectives could produce different ways of understanding alcohol problems. Handbooks of treatment approaches started appearing, designed to help practitioners better match treatment to problem (e.g. the prestigious Institute of Medicine's handbook in 1990).

However, there seems to have been less diversity in treatment models being suggested when family perspectives were considered appropriate. Most treatment models for families appeared to be based on the principles underlying the work of Salvador Minuchin and his theories of structural family therapy – even in some of the newest publications on treating families (for example, the "Sequential Family Addictions Counceling Model" proposed by Juhnke & Hagedorn in 2006)**.** In Norway, research on what treatment works continued to lag behind international knowledge, but more research has been carried out since, resulting in greater knowledge (compare for instance Waal & Duckert 1996: 2 with NOU 2003: 4). Social politics also played their part in the choices that were made. In the late '80s there were especially hefty debates in Norway about the welfare state and who the state should be helping. By that time some of the larger Norwegian clinics had already started reaching out to patients' families. Then, in 1991, a highly influential but disputed researcher, Kari Killen, published her book "Sveket" which greatly influenced the work of child care authorities in Norway for the next two decades. The field of substance abuse also produced some research on parental and child research, mainly by a few key practitioners working in the field. These works vividly described problems experienced in relation to children of "alcoholics", problems with teenagers using drugs, and problems regarding addicted mothers and their young or unborn children. Researchers such as Frid Hansen and Aase Sundfær – both ”heavyweighters" in the field of addiction treatment with plenty of practical experience as clinical therapists – found new ways of looking at mothers and their parenthood (Hansen 1990 and 1992, Sundfær 1992). Concrete results followed. The research attracted considerable publicity, and relatively soon Norwegian legislation was changed so that enforced treatment for pregnant women became possible and all the Norwegian Health Regions had to set up residential treatment facilities for such mothers and their children.

Despite the significant contributions to clinical understanding and therapeutic practice, I feel there this research continued to reproduce certain flaws. Much of the earlier work was rich in psychopathological descriptions and although almost all contemporary research findings modify the original picture painted – by indicating factors which enhance our understanding of children's resilience and their capacity for self agency (e.g. Sundfær 2004;

Moe 2004) – the earlier descriptions focusing on pathology still seem to dominate both the media and expressed opinions of many practitioners working in the field. Another drawback is that findings have mainly been presented either within psychiatric-medical or psychological frames of understanding, accompanied by structuralistic argumentation – without considering whether these approaches themselves might constitute a problem. Researchers have listed what I call "flaws and defects" relating to addictive parents parenthood, as if ideal or "normal" parenthood were a stable, unchanging and culture-free dimension.[6] Even the language used by the authors conveys the impression of a relatively invisible researcher, apparently unfettered by his or her culture and thus able to objectively judge parenting. I have not been able to identify research which combines the field of addiction and parenthood in a socio-constructionist, family therapeutic framework where the researcher positions herself in her work, and where "truths" in the research report are considered to be culturally negotiable contentions. Nor have I found other Norwegian research linking family therapy, parenting and alcohol. Furthermore, there do not seem to have been any significant changes in the research situation on these issues in the last few years. On the contrary, since the turn of the century the practice field seems to have been ahead of research. Among such practitioners, family therapists working in Norwegian clinics for family protection or for substance abuse have made notable contributions. Nearly all post-modern influences on family therapy *theory* seriously challenge the usefulness of psychopathology as a way of addressing problems (Berg 1992, Berg & de Shazer 1993, Anderson 1993 and 1997, Weakland 1993, Chang & Phillips 1993, Freedman & Combs 1996, Strong & Paré 2004). Undoubtedly facilitated by the fact that Norway and Scandinavia have themselves produced family therapists whose work has received international acclaim (Phillipe Caillé, Tom Andersen, Jacob Seikkula), there are a few practitioners who allow themselves to be inspired by national and international currents and who publish their work in small, national or Scandinavian journals covering the field. However, the focus of ongoing research publications continues to be mostly on women and children, or teenagers. Few of the 90 research projects registered with the newly established *National Institute for research on substance abuse* relate to parental or family issues.

[6] Hennum is one of the few who have studied the culture of *"normal"* Norwegian parenthood from a social constructions' point of view. She found that cultural expectations require parents to secure the growing-up process of children so that it can be named "a happy childhood" (Hennum 2002: 111-160).

2.2 Wellness research in the alcohol treatment field

The alcohol-related research which I consider to be most relevant for this project comes from the field of psychology. Psychologist Bente Storm Mowatt Haugland - a resilience researcher within the field of developmental psychopathology - did her PhD (2004) on how children adjust, seen in relation to various elements of stress caused by their fathers' abuse of alcohol. She has tried to identify which protective factors are effective in connection with "clusters" of high risk factors around children and their parents. What I have found most interesting about her work are the wellness and resilience findings: results from Paper 1 indicate that parents can help protect their children by maintaining family routines and rituals and in Paper VI she presents a tentative model which can help therapists address parenting issues within the framework of therapy for substance abuse. However, while her work credibly and constructively suggests factors that can protect children, my focus is more on therapists and fathers. I am also critical of the fact that she has presented her findings in accordance with structuralistic traditions (using stable, global standards of measurements, aiming at "objectivity"), thereby rendering both researcher herself and any therapist who might use her model personally and culturally invisible.

2.3 Research on families in welfare-state Norway

Another contribution to knowledge about parenting in Norway came in 2004 when editors Ellingsæter & Leira published a collection of papers on the relationship between family relations and family politics, citing in the preface that the book presented *"new empirical knowledge, new analytical angles, criticism of conventional understandings, renewal of research themes and interests that have been dormant and new knowledges on fields that have not been sufficiently researched"* (Ellingsæter & Leira 2004, my translation). I will use some of the issues raised in this work as background input for this research project. These papers refer to a socio-political debate asserting that Norway has taken more steps to *de-familiarize* reproduction than any other western country. There also appears to be a clash between public ideals of parenthood and the private practice of parenthood by people in general. Part of this is connected to the rise in parental split-ups. It is anticipated that four of every ten children born in Norway in the 1990s will at some time in their childhood not live together with their biological parents (Noack 2004: 56). Some of these live alone with one of the parents: Both the legal system and the welfare system are relatively well adjusted to the fact that more and more adults choose not to live together. Some children will live in families together with

stepmothers or stepfathers and perhaps other not biologically related siblings, but with visiting arrangements to the other biological parent. In connection with such developments the Norwegian state has introduced what could be called pioneering measures with the *intention of re-familiarizing* reproduction in the direction of greater gender equality. For example, fathers now have the legal right to take some leave in connections with the birth of children; their legal visiting rights to their children are improved, and it has become easier for men to obtain custody in connection with parental conflict. The present government's goal for this year includes building sufficient day-care centres for children to enable both parents to work if they wish. A side effect of this is that the care of children increasingly becomes a professional concern. In sum, the public ideal of what modern Norwegian fatherhood should be promotes gender equality in the provision of child care, – providing a professional idea of what appropriate child care should be as an alternative model to the traditional version of parenthood. Yet Noack claims (2004) that patterns in family practices defy at least some of those ideals. Hard statistical facts show that the gap between fathers and their children is growing. Ellingsæter & Leira refer to recent statistical updates (2004: 153) which indicate that mothers more often stay at home with their children. They point out that when split-ups occur between parents the children more often follow their mothers and that contact between fathers and their children is diminishing. That means that so far, an adjusted version of the traditional model of maternal care-giving continues to be given priority in Norway. It also means that what I am experiencing in my therapy room is not necessarily a consequence of (deviant) fathers' alcohol problems but more a lived example of general trends in the practice of "normal" parenting in Norway.

2.4 Gender research on men and parenting issues

The last area of research which I want to briefly mention here is gender research on parenting, which has influenced both Norwegian people's socio-political professed ideals of parenting and how they attempt to put these into practice. Here I will only refer to postmodern, poststructural research in Scandinavia. This started by focusing on female parenting. Researchers such as Agnes Andenæs, Hanne Haavind, Dorte Marie Søndergaard, Harriet Bjerrum Nielsen, Margareta Hydén and Eva Magnusson are just some of those who have looked at women's parenthood within a more interpretive, social constructionist framework (e.g. in Haavind 2000). Poststructural, critical research on men as gendered bodies followed in Scandinavia as a natural continuation of the critical gender research on women. By the turn of

the century the Scandinavian research on men had already become internationally significant – even leading – in the field. Jørgen Lorentzen, one of a group of prominent researchers on men and gender in Norway, points out that this is due to the connections between research and politics: The Scandinavian gender research on men is part of the fight for equality of the sexes and democratic movements being pioneered in those countries (Lorentzen 2006a: 133). Within Norway specifically, research on men's ways of being fathers is being done on all levels and within many different fields.[7] Some of those I know about who are presently further exploring the changing role of (Norwegian) men and the development of modern fathering are researchers such as Øystein Gullvåg Holter (e.g.1989, 1993, 2003a, 2003b, 2007a, 2007b), Jørgen Lorentzen (e.g. 2006a, 2006b), Helene Aaseth (e.g. 1994, 2007) and Knut Oftung (e.g. 2000 and 2005). Other names that often attract attention are psychologist and researcher Frode Thuen, Bergen University, who has done a lot of work on divorce issues and men, consumer researcher and social anthropologist Runar Døving and even the Minister for children and equality of status, Karita Bekkemellom, or authors of books discussing newer perspectives on fatherhood such as Løkke (2000) or Brandth & Kvande (2003).

In the chapters that follow I start by exploring the theories which I have given preference to in this research, together with the ethical implications of my choices. I move on to present the concrete methods used, and describe processes with regard to planning, preparation, implementation and analytical approach. I present my analysis in two parts, showing how I have applied my preferred theories and discussing what I found in the light of these. Each part is followed by a brief summary and conclusion. Finally I adopt a reflexive position and return to where I started – in order to see in what ways the research work has led to a re-positioning of my self as researcher, and as a therapist.

[7] In contrast, international research which views "normal" fatherhood from a social constructionists' point of view is lacking. Commenting on their own research on Australian fathers, Lupton & Barclay claim that the "social, cultural and symbolic dimensions of fatherhood" have received little attention (1997: 4).

3 My approach to this research

3.1 Introduction to my approach

The chapter which follows here first presents the theoretical framework for research project, explaining how it has been shaped by social constructionist theory and feminist influences within family therapy and gender research. I then outline the qualitative research methods adopted before moving on to describing and discussing choices I made during the research process.

3.2 Theorizing fatherhood in alcohol treatment: a research framework

In this research I have privileged knowledges that are sourced in theories on social constructionism and other associated social theories within the fields of family therapy and gender research. From a poststructural, social constructionist point of view, there are no objective truths or knowledges in the world; we are not able to remove ourselves from the system which we observe. Seen in this way, reality becomes something which we construct within the limits and possibilities of our physical and social contexts and that again opens for many interpretations of reality. In real life, some knowledges and some realities or ways of seeing and thinking become privileged, while others become obscured. I adopt family therapist Hoffmann's definition of social constructionism as a theory that "*posits an evolving set of meanings that emerge unendingly from the interactions between people*" (Hoffmann 1990: 3). I see people's problems as constantly changing narratives; any mutual understanding of realities occurring in therapeutic conversations is dependent on mutual consent between those who converse. Therapists need therefore to take into account the multiplicity of choices of how to understand "facts". This way of thinking effectively dethrones the therapist from her position of being an expert on how her patient should be. The work that follows here is an attempt to exemplify in practice what Hoffman meant when she called social constructionism "*a second-order view ….a lens about lenses*". Like Hoffman, I also reject the neutrality concept in the Milan model in family therapy, and try to take a stand against any oppressive practices which might occur when therapists talk about alcohol and fathering. I also place emphasis on the post-structural interpretations of narrative therapist White: he sees therapy as a way to help people change by changing the way they interpret *the meanings* of their life experiences. At the same time he identifies some wider political, social and personal consequences of social constructionism. I am especially interested in the connection between

White and the work of philosopher and cultural historian Michel Foucault (c.f. amongst others; White & Epson 1990: 19-29, White 1997: 220-235 and White 2000: 148-149). An important focus for Foucault was how Western cultures have developed traditions and practices which give priority to the human being as a subject operating within larger social, political, legal, economical, philosophical and scientific contexts. He proposed that people do not have an essential, pre-existing and fixed identity as a "self". Rather, selfhood or subjectivity is constituted through a complex process by which a person positions herself within these larger contexts. His concept of discourse is closely connected to this idea of selfhood. Foucault sees discourse not just as a way of representing (talking, writing about or visually portraying) phenomena and practices in this world, but more as systems of thought and production which in themselves create the way we perceive reality. What we observe as "normal" are the discourses that have hegemony, that dominate within the social world. Seen in this way, discourse becomes *"a structure of knowledge that influences systems of practice*" (Chambron 1999: 57).
Foucault proposed that *"discursive practices are characterized by the [..] definition of a legitimate perspective for the agent of knowledge and the fixing of norms for the elaboration of concepts and theories. Thus, each discursive practice implies a play of prescriptions that designate its exclusions and choices*" (Foucault 1977). In this way, the "self" or person as a subject becomes constituted, maintained and even changed by discursive practices. Foucault was mostly concerned with delineating the patterns of effects by which practices and discourses are revealed. He claimed that discursive practice tends to occur more in clusters of repetitive rather than individual action. In this way people position their "selves" and discipline their "selves" in the way they portray their lives, ensuring they can be defined as "normal". Foucault has been criticized for his lack of emphasis on self agency (e.g. by feminist Nancy Fraser in 1989). Yet understanding some of the ways in which some powerful discourses of truths or knowledges might exclude or marginalize others does offer opportunities for using Foucauldian interpretations in subversive ways. In the following I will be examining some of the openings this has provided for my research.

If we temporarily set aside the challenges to therapists who might address fatherhood in the framework of alcohol treatment, how can we view concepts of "normal" parenthood and fatherhood when interpreted with a gender sensitized, social constructionistic, Foucauldian filter? A traditional model of parenthood has been the nuclear family, where the father is the main breadwinner and the mother cares for the children. This model is now being seriously

challenged in the western world. Ellingsæter & Leira's findings (2004) regarding developments in Norwegian families are not exceptional. Gender researchers Mac an Ghaill & Haywood point out a general trend in contemporary, nuclear families in Western society, namely that they come in different, looser, more extended and often more experimental forms and sizes than was the case just a few decades ago (2007: 44). However, discourse on ”good” parenthood and fatherhood influences (and is influenced by) other cultural discourse in a society, – such as what "good" childcare is, how people express their gender and how a society interprets these ideas *while* that society is itself developing. My assumption at the outset of this research project is that there are some differences in the interpretation of parenthood in Norwegian society, compared with, for example, societies in USA, Canada and other European or even other Scandinavian countries. These differences are likely to be so large that research coming from outside this country on the subject of parenthood ideals or deviance from such ideals, is not equally relevant for Norwegian conditions[8]. Some American researchers and family therapists have found that contextual factors in the family and the community are even more important for fathers than for mothers (Doherty, Kouneski & Erickson 1998). Because of this, I argue that one should to a greater extent address the culturally bound "Norwegian" aspect of my project's theme, since the failure to take account of cultural issues in interpreting parenthood can easily result in both research and practices with an underlying moralistic tone. Scandinavian researchers whose work views parenthood in a dynamic perspective, and who explore the development of parenthood discourses, come from fields such as sociology, social anthropology and gender research. From a family therapist's point of view, I have found the field of gender research an especially helpful – though unfamiliar to me – source of theoretical approaches to understanding fatherhood. The poststructural, social constructionistic filter has led me to an awareness of how cultural interpretations of gender and fatherhood intersect with White's ideas on therapy and with a social constructionist view on the drinking of alcohol. Although gender research on men in Norway is at a very early stage, and there continues to be a gap in Norwegian research on men, gender issues and parenting (Andersen 2003), it is within this "pioneering" field that I position my theories about therapists' male patients that are fathers to minors. In terms of Norwegian gender research these theories probably lie somewhere between what could be described as equality oriented issues and problem oriented issues. I limit myself to discussing

[8] For example, laws in Sweden make joint custody of children obligatory when parents decide to part ways. That is not the case in Norway. For that reason, some of the challenges being met by Swedish fathers only apply for Sweden (Bergman & Hobson 2002).

feminist theory which has been sourced in Foucauldian ways of viewing the world, such as the work of Butler (1990), Davies & Harré (1990), Hare-Mustin (1994) and Søndergaard (2000). Here gender is seen as something that we "do", or "perform" in our daily practices – a process by which we are constructed with a gendered identity. On a meta-level, gender is seen as a concept which is decided and *negotiated* in a cultural framework (Butler 1990 and 2004). This way of understanding opens for a multiple of possible ways of "doing" fatherhood as a gender determined concept. For the purpose of this research I have regarded the concept of fatherhood as a social construction of male selfhood – depicting a situation where a man has stepped into some form of culturally recognised position in the family as a responsible care-giver for children. The research becomes an exploration of how (Norwegian) therapists might express their own cultural ideals of how they understand their patient's fatherhood, or how it should or could be "done". How aware are therapists of their own stakes in the issues at hand, and to what extent do they make that visible to the fathers they talk to? Also, what possibilities do they envision for fatherhood to be performed differently? My research questions can also be linked to theories of masculinities and un-masculinities as they have been developed by Scandinavian gender researchers during the past decade.[9] These theories emphasizes complexity in concepts of masculinity. Ekenstam proposes (2006: 41-47) that the two dimensions masculinity and un-masculinity are dynamically interrelated, mutually dependent and in a constant state of change. Various ideals of masculinity compete for hierarchy in relation to one another. Seen in relation to the theory of masculinity and un-masculinity, drunkardness was considered to be morally reprehensible and highly un-masculine behaviour in pre-war Norway (Tjeder 2006: 73). Echoes of such discourse can also be traced in modern Norwegian culture, and in the words of my informants. The influence from political, social and cultural contexts has been important for this research in that respect. There is much emphasis on the value of individual choice in postmodern Norway, both in relation to ways of living and what relationships people maintain. Ways of living, legal, financial and even welfare systems are already so well coordinated that being parents and having a family do not necessarily have to be one and the same thing. Couples appear to be primarily concerned with the issue of relationship. This illustrates what Mac an Ghaill & Haywood have described as the transition from the family as an institutional concept to the family as a negotiable relationship (2007: 45). This change in interpretation of the meaning of

[9] Here I refer in particular to two books which have recently been released, gathering papers written by a group of Scandinavian researchers presently working on concepts of masculinities. The first book was released in 2006 and has been edited by Lorentzen & Ekenstam (Lorentzen & Ekenstam 2006b). The second was released in 2007 and has been edited by Gullvåg Holter (Gullvåg Holter 2007a).

a family or parenthood or fatherhood, could – if we allowed it to – change our possibilities for living out these concepts. So, to what extent do we see our possibilities for negotiation and choice? When discussing therapy for men, feminist therapists Allen & Laird emphasize (1991: 85) how important it is for therapists to be sensitive to links between socio-cultural contexts and interpretations of gender. They believe that public stories of manhood as well as private meanings in the family are the home of "*very powerful myths of masculinity*". I find that a valid point for this research. I experience that male patients whose drinking has become a problem – either for their selves or for others – seem to meet a series of dilemmas. Since certain traditional ideals of masculinity support the drinking of alcohol, *stopping* the drinking can be an implicit threat to men's masculine identity. Many men who drink heavily also have a network of friends who drink heavily and they are afraid of losing these friends. However, they do register heavy disapproval coming from others in their social context. Some have lost their jobs, are in economical difficulties and have nowhere to live (Fekjær 2004: 216). Some have put their mental and physical health in jeopardy. Many are in conflict with family members (ibid). In some, or all of these ways, they have deviated from accepted social norms and have lost status.

3.3 Therapists as experts on alcohol and fatherhood: some ethical implications

A common criticism of social constructionism is that it leads to an "anything goes" view of the world. In his book "Taking sides in social research" Hammersley maintains that since social constructionism denies harmony of views on values and on enlightenment itself, then it also denies the whole purpose of research (2000: 32). In order to counter this criticism I contend that ethical reflection needs to consistently accompany any use of this theoretical framework both in therapy and research. Epistemologically I position myself between the moderate stance on social constructionism as promoted by Longino who *"argues for a social epistemology in which ideal and value issues tied to socio-cultural practices are interwoven with empirical ones in scientific inquiry"* (Schwandt 2000: 199) and the more radical interpretations of constructionism as promoted by Kenneth Gergen (1994) and some of the postmodern feminist researchers (Olesen 2000: 225). Gergen's stance on the relationship between ethics and empiricism is that it is "*an illusion (to believe) that it is possible to develop a set of principles or codes which can be invariantly applied irrespective of context"* (Gergen & Kaye 1992: 181). I acknowledge, for example, that drinking alcohol is an action

which creates concrete physiological changes in the drinker's body. My interest however lies more in exploring the multitude of meanings that people in these postmodern times attribute to the drinking of alcohol and any socio-cultural phenomena which occur around that act. Following lines staked out by prominent anthropologists within the field of alcohol research such as Gusfield, McDonald and Heath (cf. Moore 2001: 476), my general postulate is that drinking alcohol is a *cultural act of meaning*, and as such is constantly constructed in time and place. This cultural focus is not an attempt to deny the validity social, psychological or even medical "facts" associated with alcohol, but rather an attempt to place such "facts" within a framework which might open for alternative perspectives on therapy being "done" to fathers with alcohol problems. I see talks about drinking as being constructs of meaning which have been greatly influenced by outer social discourses (Room 2001: 38) bearing down upon "reality" as experienced in a local context by fathers, their families and their therapists. Most constructs about alcohol are directed toward individuals. These include variations of a "disease" model with theories about alcoholism as derived from the AA movement, and versions of an "individual lifestyle-choice" [10] model. Another model is mostly research-based. In this, alcohol is generally described as a potentially harmful intoxicant with social and political status as always legal, and mostly acceptable as opposed to most other intoxicant substances. Echoes of discourses from some or all of these models can be found both within Norwegian literature on alcohol problems and within the national spread of treatment systems and their professional or voluntary helpers (Berg 1994, Pedersen 1998, Duckert 2003, Fekjær 2004). Discourses reflecting attachment to the various models are also represented via my informants in this research. Wherever possible, I use the construct "alcohol problems" within the general context of definitions of substance abuse, referring to cases where the problems with the person's use of the intoxicant substance alcohol are so major that professional treatment is sought.

When addressing fatherhood within the framework of a treatment system for alcohol problems, therapists are liable to be challenged and stressed by the *conflict* of meanings that arise around the intoxication issue.[11] The fact that fathers (or mothers) have been, do, or may

[10] I use the term "individual lifestyle-choice" when referring to treatment models which propose that alcohol problems are predominantly caused by a person's life style. The claim is that patients are likely to be able to moderate or control their drinking more easily if they change their habits. Among those who tend to emphasize "individual lifestyle-choice" philosophies in Norway is clinician and researcher Fanny Duckert (2003).

[11] The conflict in relationships of parenting couples is often more than verbal. Commenting on the first national report on intra-violence in couple relationships, published in 2005, Haaland et al. point out (2005: 1-5) that although the statistics for violence perpetrated by men are higher than the those for women, the *mutual* use of physical power and violence is considerable. The report also indicates that those who have the lesser status in

become intoxicated is likely to upset some or all of the parties involved: patient, therapist, partners and children. Such scenarios are familiar from my own and other therapists' practice at the clinic where I work. In such cases *any* therapist could be overcome by a sense of urgency and be tempted to lean on her "expertise" to solve the issues at hand. Yet there are some pitfalls related to interpretations of what "really" happens in the lives of patients and their families. For example, fathers and children may have different experiences of alcohol abuse. In the eyes of their families, their therapist and society at large, such contrasting experiences of a father's alcohol abuse may create different views on what is best for their children. At the same time, the abuse itself may give rise to inherently risky moral objections. Social constructionist theories claim that it is not possible to safely establish "correct" descriptions of reality. There are dangers in therapists being too sure.[12] I choose to avoid such complexities by choosing theories that enhance possibilities for a win-win situation for therapists, fathers, their children and whole families. This strategy can be criticized on the grounds that serious problems are not being sufficiently addressed. I do not attempt to deny that this research project does not directly address serious problems suffered by fathers or their families and children. On the contrary, arguments proposed here are more in accordance with a recent shift in ideological focus from research on "misery" to more research on "wellness".[13] Some practitioners have already made some interesting observations in that respect. White has described how children in fact can *contribute to* shaping their parents' parenthood practice more in line with their own wishes (2000: 14-21), while Norwegian practitioner Aase Sundfær in her most recent report from a longitudinal study of addictive mothers describes how Hanne declared that her alcohol abusing father was her greatest source of support (2004: 90). [14]

---

relationships which can be characterized by asymmetry are often *also* exposed to controlling *strategies* from their partner.

[12] Here I refer to Barnard's article (2005) discussing some of the ethical difficulties that arose when researchers compared findings on what *parents* with a substance abuse problem had said with findings on what their *children* had said – and found that these differed from one another.

[13] In the field of clinical psychology there is a parallel interest for shifting therapist focus from illness to wellness (Seligman & Csikszentmihályi 2000; Linley & Joseph 2004).

[14] I have similar experience: After hearing in a particularly moving session last spring how a child found support in her father, I noted in my research diary: *"Some fathers can contribute with their love, fallibility, vulnerability – and even lapses and weaknesses".*

3.4 Links between research theme, the methods I chose and validity issues

The methods I have used in the research can be defined as qualitative methods. These are considered preferable to quantitative methods when the research aims at getting a deeper understanding of people and finding out how they gave meaning to their experiences (Malterud 2003: 32-33). I have wanted to explore what my informants said on two levels: On a local contextual level I wanted to learn *from* them how they were addressing and solving the fathering issue. On a second, meta-level I was more curious to learn *about* them – that is to say, to understand how the cultural framework of Norwegian society at large was influencing their ways of seeing and talking to the fathers they met in an alcohol treatment context. My choices have been strongly influenced by the theoretical framework for my research. I am curious to know whether this is simply a gender issue, since traditionally it is mothers who have the first and the last word on child-raising and care-giving, and there are more women working as therapists than men. Or could my informants' talk be part of a larger social discourse about what expressions and experiences of fatherhood are socially appropriate? I use the research project to communicate ideas about how powerful discourses of society influence our lives and opinions and choices both within therapy and in the "world out there". Yet the project's emphasis is on dynamism and the inevitable role disharmony plays in processes of change.

I have aimed for a modest research design that is nevertheless intended to fit with the mix of influences bearing down on the research theme as it has unfolded. One difficulty has been to find ways for the report to capture the multifaceted processes involved in the research. Sections that follow can be seen as contextual layers and the reader can move from layer to layer as she sees fit.

When addressing the question of validity I have chosen a modest interpretation of the term as expressed by Lincoln & Guba (2000). They point out that validity as seen from a postmodern point of view requires sensitivity to seven points of intersection between ethics and the epistemology of the research (Lincoln & Guba 2000: 182). Six of those seven points of intersection have been discussed both specifically and generally throughout this report: I addressed the first point – that of positionality – by introducing my person and explaining my position as a clinician and a researcher. The second point refers to creating research sites as arbiters of quality. Since I am not in position to carry through such a task, I have ignored that point. The third point raises the issue of voice and polyvocality. I have emphasized

polyvocality – but have practiced (positive) discrimination in the sense that marginalized meanings have been given a privileged position. Self reflexivity is the fourth point. Although this report contains some elements of self criticism, it lacks objectivity as the term would be understood by essentialists and tends to focus more on elements of change than is usual in research projects. The fifth point – that of reciprocity – has been toned down. Reciprocity with my informants was important for me during interviews, but I have had little or no contact with most informants after the interviews. The sixth point refers to the sacred regard for researchers to contribute to human flourishing. I have given much space to that issue. Valuable research data with a more pathological orientation may have been neglected, due to my emphasis on "wellness" principles. The last and seventh point, referring to validity raises the question as to whether and how researchers might share any benefits coming from their work with others. The learning process has already been valuable to me in my own practice. If possible, I would also like to adapt this work for publication, which would make my work more generally available to other researchers and practitioners.

3.5 Choices when collecting data

Deciding how to collect data proved to be more complicated than I anticipated. I wanted the research to benefit my patients who were fathers. To begin with it therefore seemed obvious to consider them as the best source of information. On the other hand, there were reasons to question such a procedure. Application procedures for permission to do research on patients are handled by the Regional Committee for Ethics in Medical Research, and can be difficult to obtain. A multitude of criteria need to be met regarding issues of confidentiality. Perhaps the most central issue is that of patients' vulnerability, which is especially relevant when a patient is currently undergoing treatment. Current ethical principles in medical research involve weighing the risks of seeking knowledge from people in a vulnerable situation (or where that person's ability to consent is reduced) against the potential benefits of the research (Thagaard 2003: 26). After reflecting on these issues I moved on to consider other ways of learning about therapy with fathers, which would not involve direct contact with patients. This led to some general reflections about how power inequalities seem to be inherent in the relationship between patients seeking therapy and their therapists (Hare-Mustin 1994: 24). These inequalities are especially obvious when the problem is alcohol. Most therapists working in the field would recognize a typical starting point for patients as feeling "one down" and more or less humiliated because they have not managed to do what most people

seem to do so easily, namely "just stop" drinking. In comparison, their therapists are experts on intoxicants and addiction problems, they are supported and elevated by the structural status provided by the addiction treatment context and they are probably also good personal representatives of the group who have no problems in just stopping drinking. If – due to these inequalities of power – the therapist has greater authority in determining what will be discussed in therapy, how does this affect therapist talks with patients about fatherhood? In this way my attention moved to therapists and their possible *ways of seeing* these fathers. Numerous ways of achieving this existed. Patton mentions three main ways of obtaining qualitative data: fieldwork observations, the study of documents or conducting semi-structured interviews (2002: 4). Silverman points out that open-ended interviews can be a good way of collecting cultural information while identifying moral discourses on the issues at hand (2001: 105). He refers to an analysis of interviews with parents of handicapped children done by Baruch in1982, where Baruch saw parents' talk as situated accounts "*aimed at displaying the status of morally adequate parenthood*" (cited in Silverman 2001: 106). I found inspiration in this idea – both during the planning process and later, when doing the analysis. Another advantage of doing interviews pointed out by Willig is that this method provides fewer logistic challenges than participatory observation or focus groups and is compatible with a range of analytic choices (2001: 21-22). At that stage there appeared to be an advantage in delaying final decisions about how to analyse my data. For these reasons I decided to *collect data by conducting semi-structured interviews of therapists presently working within the field of treatment for alcohol problems and whose target group included patients who were fathers to minors.* The interviews were structured in such a way that they sought general information about how therapists said they worked with the fatherhood issue without breaching laws of patient confidentiality.[15] With respect to interview method and style, our conversations could be classified within the genre that Holstein & Gubrium refer to as "active" interviews (2004). This is more adapted to an ideology that rejects the belief that an interviewer is neutral and data collection takes place in an objective way; rather it acknowledges that researcher and informant collaborate in creating meaning together. Silverman points out that active interview data also enables researchers to concentrate on both the *whats* and the *hows* when she is interpreting her material (Holstein & Gubrium 2004: 55). Since I was aiming to collect data that covered both those aspects, I found this style best suited to my needs. To help me with my questioning I used an interview guide which I had

[15] Therapists have good routines for anonymizing cases and giving relevant information in general terms without breaking their vows.

prepared during the planning process, with key words to remind me of my research theme and nine groups of questions which functioned as a check list while we were talking. Here I asked therapists to tell me how they introduce their own thoughts on parenthood into their conversations with their patients who are fathers. I wanted to hear more about how they usually moved forward during the therapeutic process and I also asked them to tell me a small story where they felt that positive change in fatherhood practice occurred. We talked together for one to one and a half hours, and I recorded everything on a high quality minidisk machine without making notes while we talked.

3.6 Sampling

Paths to my informants grew out of a combination of my own and others' deliberations: some ethical and some practical. Practical arguments favoured keeping the project relatively small, due to financial and time limitations. I was bearing nearly all costs for the project, working full time and had limited leave for study. A simple approach could have been to interview therapists at the clinic where I worked, based on the contributors' voluntary interest and an assumption that since therapy takes place in some form of personal and private space it is largely outside a treatment clinic's control. However, such assumptions would be contrary to my own experience and to theoretical premises of this work. Although I had no reason to assume that therapists at "my" clinic used an approach similar to my own, I felt that such a selection of interviewees would limit information unnecessarily. By opening for some information from the clinic or treatment system I could take into account diversity in professional cultures or treatment ideology, together with any cultural diversity that might be caused by geographical distance. Seen from Hoffmann's second-order view, the research would be more interesting not only if it explored therapist *talk* about fathering, and alcohol problems but also allowed for some influence from the various contextual layers in which these talks occur. This would provide the distance I needed in order to be more aware of and perhaps even critical of familiar ways of seeing the world. Those who "do" therapy within the addiction treatment system belong to a number of different professional cultures. The dominating position is usually held by psychologists, but other professions are also represented, such as nurses, social workers and family therapists. By making provision for contextual influence, I hoped to address both the issue of a therapist's loyalty to her own culture of professional training and the question of her loyalty to addiction models at the clinic where she is employed. Of these two criteria the easier to address was representation of

the therapist's working context, - the local treatment culture created by the clinic where she was employed. If through my choice of research participants I could in a small way mirror possible diversity in both treatment models and treatment culture, this might extend the validity of my research. On the other hand, it seemed unlikely that any clinic would operate according to a rigid treatment model, since all clinics need to cater for some variety in problems to be addressed. Nevertheless, neither of these criteria played a crucial part in the sampling process. Although I travelled to new places, and although the clinics I visited made information available to me about their treatment ideology, I chose to limit the influence of any such information to the context of the interview. Where therapists have mentioned "their" clinic, this has been regarded as directly relevant. If they did not, the clinic context for therapy has been an implicit background interacting together with other criteria in the larger picture. I did not ask informants whether they thought that their professional allegiance had significance: however, I have discussed "professionalism" as a general issue in the analysis. Asay & Lambert claim (1999) that professional background and theoretical perspective are of little significance compared to other factors, such as the ability to bond well with the patient. Two therapists with two different professional backgrounds working at two different places with different ideologies may have more in common than two therapists with the same education working at the same treatment clinic. A final – but important criterion was the issue of free will. Above all, I wanted people to want to be interviewed. Although there is no doubt that all my informants both volunteered and consented to giving interviews, it was the clinic directors who steered the process of finding informants who would be willing to be interviewed. I return to this issue when discussing my role as researcher later in this chapter.

3.7 Choices when analysing data

I have approached the analysis of my research data in two separate ways. First, I did a simple content analysis. Next, I chose certain, limited gender-related themes from the content analysis and moved on to analyse these, applying principles from discourse analysis. The final analysis being presented in this report therefore encompasses two approaches, each representing a different level. Part One shows the workings of my data within the framework of a simple content analysis. This represents the level of our daily, cultural practices of interaction and language. Part Two represents a more distant level of discourse. Here, I have explored discursive aspects to my finding, both with reference to ideas of professionalism and in relation to the larger gender debate on fatherhood in Norway. This part of the analysis has a

Foucauldian perspective on discourse analysis. In the section that follows here I start by describing briefly the basic, broader characteristics of each method before moving on to specify how I narrowed my choices within each of these.

3.8 The content analysis in Part One

According to Patton, the term content analysis *"is used to refer to any qualitative data reduction and sense-making effort that takes a volume of qualitative material and attempts to identify core consistencies and meanings"* (2002: 453). He goes on to explain that this involves *"identifying, coding, categorizing, classifying and labelling the primary patterns in the data……analysing the core content of interviews and observations to determine what's significant"* (2002: 463). Research will often register these core meanings in the form of patterns; these can later also be grouped into various categories or themes. Patterns and/or themes are sometimes *discovered* in the data (a process called inductive analysis); at other times the data is analysed *according to a pre-existing framework* (a process called deductive analysis). I had started my research process with a desire to learn more about what therapists said, and how they described the process of addressing fatherhood. In that sense I was quite open for new data. Yet the pre-existing theoretical framework to my work had been decided in advance. The research theme had also been well integrated into my research guide (see Enclosure One) with its specific questions and list of key words to remind me of which topics I wanted to discuss. In that sense my process of looking for patterns, themes and coding categories *resembles* what Patton refers to as "*modified analytic induction*" (Patton 2002: 454-494). Here the researcher uses a preconceived framework of social science theory as a starting point of reference. From these she chooses certain "sensitizing" concepts, and uses these as a filter when doing her analysis. Using these, she examines and re-examines a cross section of cases; here she is testing both for her pre-conceived hypothesis and for ideas not originally taken into account. I justify my claim to this resemblance by referring to the fact that I was not totally open to all data when coding. I was limiting my choices by using key concepts from social constructionism as my framework of reference (cf. my research guide). In this respect I was especially interested in detecting patterns which mirrored my links to the culture of family therapy and to certain Foucauldian interpretations of discursive practices. I was also interested in drawing advantage from the fact that there was good comparative potential in my data. As is often the case for this method, I gained new insights; these are discussed in depth in the chapter on analysis. At the same time, the analytic process had many

"deductive" aspects to it, especially when I was interpreting data and when I was working on the discourse analysis.

3.9 The discourse analysis in Part Two

The term Discourse Analysis is used to describe a wide range of analytical methods; according to Stubbs (1983: 1) Discourse Analysis is used to study larger language units in conversation or written texts (in other words, the organisation of language beyond the level of sentences and clauses) and is concerned with placing these in social contexts. I have chosen to interpret Discourse Analysis within the specific theoretical framework of Foucauldian ideas and concepts. Foucauldian Discourse Analysis is currently being employed within a number of fields; however I am most familiar with versions developed by postmodern feminist researchers interested in demonstrating socio-cultural links between the construction of gendered identities and Foucauldian interpretations of discourse. With similar thoughts in mind I opened this report by delineating some of the larger contexts in which Norwegian therapists operate with regards to addiction treatment. I followed up by describing my theoretical preferences for social constructionist theory and for Foucauldian ways of understanding the world, as represented in therapy by White (1995: 115) and in research by a line of contemporary postmodern, feminist, gender researchers such as Butler (1990 and 2004) and Davies & Harré (1990). The analysis that follows in Part Two is based upon explanations given on page 13 in this report (theoretical framework). There I describe Foucauldian interpretations of discourse and explain how these see discursive practices as linked to the production of the self. In my Discourse Analysis I am interested in studying some of the effects the close links between power and knowledge have on how my informants are working with fathers. I am also interested in exploring some of the openings my informants made for seeing the "selves" of their patients who are fathers in ways that are sometimes subversive and disharmonic in relation to the many of the discourses that are popularly available on fatherhood. Davies & Harré maintain that during the discursive process, people are positioned or they position their selves in jointly produced story lines (1990). This process may be intentional or unintentional; the story line can be a fragment of a larger discursive whole. The fragment may also contain elements that are contradictory or inconsistent with the dominant discourse. Søndergaard (2000) has borrowed Davies & Harré's concept of story lines and has proposed that it be used in relation to research. Her main point is that a researcher can explore how such fragments in people's personal story lines can be

identified as similar to or conflicting with a range of categories of the larger discursive production of collective, cultural stories in society. This offers special opportunities for discovering any story lines which can be considered to be less conventional or more marginalized in relation to the dominant discourse. The Discourse Analysis presented in Part Two of this report examines the discourse concept in the light of such ideas.

3.10 Working through the analytic process

In this section I refer to the rather lengthy process of transcribing before moving on to describe my even more lengthy process of coding and deciding how to do the analysis.
Data upon which this analysis is based consists of transcriptions from these seven different interviews recorded with seven different informants (see above), together with text from emails from two of the informants. I give more details on the interview process later in this chapter; here it suffices to mention that transcription and interviews were done parallel to one another. Transcribing took a long time. I had some difficulties in catching words that had been said in local dialects, since Norwegian is not my mother tongue and Norwegian dialects are extremely diverse. With the help of good equipment and plenty of patience I was left with approx 150 pages of raw data with which I was now reasonably familiar. The next decision that had to be made was how to process this information. Here I do not give all the details of that process, but dwell especially on my initial steps up and until I had completed coding. All coding was done after transcription work had been completed. This is contrary to recommendations given by Miles & Huberman. They believe that coding should be done successively after each interview, and call "late" coding a serious mistake that "enfeebles" analysis (Miles & Huberman 1994: 65).
There were three main phases in coding, with smaller adjustments being made in between phases. During each phase I read through all the transcriptions and reflected on my research questions. The first coding was a rough analysis of patterns where categories of concepts were sorted so that they related to one another in a Foucauldian discursive tradition: seven categories linked the production of power and the production of knowledge together with disciplines of the self. This gave possible answers to questions on a meta-level of analysis. On reflection, I realized that these answers were appearing too early in the research process. I needed to describe my basic, first-level findings in order to illustrate how they formed a basis for later discursive, second-level findings. This led to my decision to start with a content analysis before moving on to some form of discourse analysis. After several attempts at

coding, I arrived at a relatively complex system with twenty-one codes and a number of sub-codes, each describing a theme or cluster of information that seemed relevant to my research questions. This system gave me an informal quantitative overview of the content in my data: I could see which theme had been touched on in relation to whom, and how often it had been mentioned during the interview. However when I started sorting my data into each code I realized that the large number of codes was leading the analysis off course. I wanted to find a system of coding that could help me show some of the dynamics and richness of meanings I had experienced when talking with my informants, while still remaining true to the epistemological basis for the research. After allowing the whole coding issue to rest for a few months, I read through all my interviews afresh, bearing in mind while I was reading what were the key "sensitizing concepts" in my research theme. The coding system which resulted from that work has been presented in Part One as my content analysis. It is not unlike the earlier system, but the codes are fewer and simpler. Themes that have been identified accentuate some of my links to social constructionistic cultures of family therapy. At the same time they have been labelled and organized so that the flow of discursive power between the therapist's local cultural arena and the larger cultural arena can more easily be demonstrated in Part Two of the analysis.

3.11 Meetings on many levels: some cultural tales

The following is a short detour into the multileveled and complex world that the research process opened for me. Elements of this process resemble some of the problems Fontana & Frey raise in connection with unstructured ethnographic interviewing (2000: 654-655). Here I describe how I got access to my informants, how I presented myself, and how I experienced some of the cultural meetings that took place between myself and my informants.

The question of access and presentation had to be included in the planning process, since the first barriers to access are those bodies whose task it is to examine ethical accountability of research. My plans were completed by the end of 2005. They were sent for approval first to my own supervisor at Diavett and shortly after that to Norwegian Social Science Data (NSD), the national ombudsman for privacy in research. Accompanying these plans was a letter of information that I had composed myself with the aim of getting access in an acceptable way to prospective informants. In the letter I presented myself and my main research theme, explaining that I hoped to get in touch with therapists who would allow me to interview them on tape about the issues in question. At the same time I described how I would be addressing

the issue of confidentiality both in relation to the informants themselves and any information they might want to give me about their patients (see Enclosure Two). Methods of access are also an issue for NSD. The NSD insists that researchers must avoid putting pressure on people to volunteer. In order to meet that criterion, I intended to send the letter to directors of clinics which I had selected as suitable for my samples, and ask them to pass on copies as they saw fit to therapists working with my target group (fathers to minors) at their clinic. NSD found my method acceptable and gave me their approval in early March 2006. After that came the relatively lengthy process of contacting, interviewing and transcribing. I did not contact clinics simultaneously, since I wanted to learn as much as possible from each interview and allow for minor adjustments as I went along. Most of the communication between myself and clinic directors or informants was done by e-mail, although in a few cases I also made follow-up phone calls. People were positive and cooperative: in the midst of their somewhat hectic lives directors and therapists gave support to my request so that I was able to limit my quest to the four first clinics that I had contacted. All initial contact was carried out as planned, through clinic directors. They passed on my letters to prospective informants and in due course returned to me with the names of people who were willing to be interviewed. After that I had direct contact with informants themselves. Before interviewing a research informant I tried out my questions and my guide on a working colleague without recording the responses. Since I seemed to be getting the information I was seeking and the timeframe was as expected (approximately one hour), I made no changes to the guide.

The story above says a little about some of the practicalities involved in connection with interaction between myself and my informants. Yet it was the cultural meetings we had that produced ethnographic richness on many levels. I devoted a whole day to every interview. This was because it always entailed some shorter or longer form of travel, and I needed to spend time before and after interviews to gather my thoughts. When I look back on pages written in my research diary after interviews I can see that these days had significance for my thoughts and actions with a scope far beyond the hours entailed. Wherever I came, people made me welcome. In some cases informants gave me books and brochures, showed me around a little and took me to lunch together with staff and patients. This helped me to step out of the routines of my own thoughts and practices. I found the contrasts stimulating and it made me more sensitive to differences and similarities in our various treatment cultures. What caught me a little unaware was how difficult I found it to regulate my input during some of the interviews. Being a therapist myself, I am used to talking to strangers in-depth, and my

personal style of conversation is relatively active. Although I am trying to make adjustments with that active style in my *clinical* work, never was it more difficult to moderate my own desire to agree and show enthusiasm than in the *research* talks I had with informants who shared ideological attitudes and my interest for working with fathers. So also with those whose ideological approach seemed far from my own: I found it difficult to avoid reacting to the differences in our ways of working. This factor needs to be considered as a possible disturbing element in relation to the data's reliability. One of my difficulties may have been caused by the fact that parallel to my research work I was exploring new terrain and harvesting new experiences in my own clinical work with fathers.[16] In the diary I kept during the whole of this research period I sometimes commented on my own reactions to the difference between my own experiences and what informants sometimes told about their own therapeutic practice. The interview process has been a reminder to me about how power is ever present during interaction. I do not see that as negative. For example, power can take mild and friendly forms, as it was during the sampling process when clinic directors took responsibility for recruiting possible research informants. Yet when power is accompanied by transparency, the openness in itself seems to beget trust. This may be why postmodern research underlines the value of openness in relation to the different elements in the research process. In this way, visibility becomes an issue not only for therapists, but also for researchers. In the interview excerpt that follows I try to take a middle way in relation to visibility – and that seems acceptable to my informant:

D: This is difficult stuff. Especially the bit about alcohol. Because it's so accepted in society, while at the same time it gets so obvious when you're out on the edge with what's accepted with regard to alcohol. And the consequences are quite drastic.
H: Mm. And you're diving right into things that I have experienced myself as a therapist and I notice that when I ask, it's about things that I've experienced myself as a therapist.
D: Ok.
H: And I'm not an objective researcher. You should know that. My own point of view and experiences do have a lot of influence on the questions I've asked you in the interview, and also how I ask them.
D: Well, ok, it's nice that you're honest about that.

[16] This was part of my Master's clinical practice project. In the course of the 16 months that project lasted I had worked quite intensively with 16 patients who were fathers, registering 95 conversations with couples, 17 with other adult family members, and eight with children during that period of time.

These were some of the ways in which my first cultural meetings with my informants took place. I realized when I was transcribing interviews that this was a way of meeting my informants for the second time. The recordings had all the advantages of any audio book; I could listen to them as many times as I wanted to. In addition, I could close my eyes and conjure up images from those meetings, giving texture to the words I was hearing. The tactic of staggering appointments so that there was time for transcribing between interviews proved fruitful. I could see from the first transcription that I was "occupying too much space" in the interview, so I decided to tone down my active style. Another change I made was done in order to structure myself better. For the last four interviews I gave informants a sheet of paper showing the questions I would be asking and asked them to read these before we started talking (cf. Enclosure Three). When we had finished discussing a theme, I marked that off on my own copy during the interview. To begin with, I was hesitant to make this slight change, fearing it might stress informants to see what I would be asking. However, the letter of information they had been given before we started had covered all my topics, so they were not surprised at any of the questions. On the contrary, this tactic of transparency seemed to put both me and informants at ease. One challenge that had to be met was deciding how much I would be willing to adjust for new information that arose during the research process. Since my research framework had been set beforehand, I tended to filter out openings for new information that came during interviews. I was prepared to hear about child care issues, but as it turned out it was issues relating to gender that became more and more interesting as the interview process progressed. These issues have therefore claimed more space than I originally anticipated, – in the interviews, in my theoretical framework and in the final analysis.

When I had finished transcribing, there was the challenge of deciding how to analyse. Trying to get an overview of possible choices and learning to understand the limitations and possibilities each choice might entail was an exciting but confusing process. All at the same time, I was busy in my clinical practice with fathers, thinking about what my informants had said about their own work, and reading a wide range of new literature that seemed relevant for the research. Just when I felt my thoughts were clearing, new ideas would start forming at points of intersection between practice, theory and research – often blurring the picture. For that reason the fact that it took me half a year to complete coding was probably advantageous. Talking to my Irish supervisor also provided a valuable "cultural crossover" that counteracted my own blindness to the over-familiar in Norwegian discourses of the day. Even translating texts and writing in English has been helpful in that respect. I recognise now another

similarity between research and therapy. As with therapy, I have needed to *practice* research in order to better learn how to do it. In discussing how to educate reflective practitioners, Schön uses the process of design as an example to explain how holistic skills cannot be taught, but should rather be practiced by reflection-in-action (Schön: 1987). This process has sometimes been lonely and I have often been uncertain; it was only towards the end that things started falling into place. I am like my patients: my greatest need has been for the encouragement I received and the *questions* my supervisor asked along the way. The answers have always acquired shape in my own hands.

3.12 Writing this report

In drawing up the report I have given consideration to Patton's three sides of triangulated reflexive inquiry: "*self-reflexivity, reflexivity about those studied and reflexivity about audience"* (Patton 2002: 495). To address the first of these I have chosen to position *myself* in this report, both as a person with my own lived experience, a thinker, a therapist and a researcher. I am part of the process of inquiry, and I have wanted that process to be presented in a fashion that is ethically tenable. By recounting some of my own personal thoughts and experiences I have uncovered some of the messier, less unified or perhaps even less attractive ways in which the research has taken place. For reasons of positioning of the self, I have mostly written in the first person. This emphasizes my part as an active, choosing agent who was implementing personal preferences within the framework of historical choices made by others. I could not avoid my own biases and preconceptions, but in this way they became visible and were given a voice. My decision to analyse data on two levels made it possible for informant talk to be situated within the larger context and I was able to be more reflexive about how informants said they were addressing the issue of fatherhood. By allowing room for my own person as a therapist, this also had the indirect effect of supporting some of the more marginalized voices expressed in the report (cf. the second side of Patton's triangulated reflexive self inquiry). With regard to making allowances for the need to consider whom I am writing for (cf. the third side of Patton's triangulated reflexive self-inquiry), I have given priority to the need to protect the identity of informants, who all practice in the field I am hoping to access through this study. I have used a pool of substitute names that are so common in Norway nowadays that there are probably many therapists working in the field with these names. When referring to informants in general I have gendered them all as women, – for practical reasons. In all other respects the informants' gender identity has not been changed. This is because gender identification has significance for the way the data has

been interpreted. For the three women I have used the names “Kristin” (K), “Elisabeth” (E) “Brit” (B), Anne (A), Ingun (I) and Vanja (V). The four men are presented as “David” (D), “John” (J), “Marius” (M), “Nils” (N), Fredrik (F), Olav (O), Petter (P) and Yngve (Y). Names have often been swapped around within the groups of men and women, in order to prevent any identification of individual informants. Whenever the letter H appears in quoted text, I am referring to myself, Hilary. Another aspect of my data which has not been swapped for purposes of non-identification is the cultural context of the treatment clinic where the informant works. In other words, when an informant has told me about general routines at their clinic, I have not made changes. Apart from these factors, I have done my best to remove characteristics which could lead to the identification of my informants. Informants consented to my request to be able to present excerpts from our conversation. Where that has been done, I have myself translated these from Norwegian to English.

3.13 Some limitations in my approach

This research is not part of the larger debate on which professional approach is best when addressing fatherhood within the context of alcohol treatment. Nor is alcohol treatment in any way a primary issue. Nevertheless two questions relating to both issues have arisen in the aftermath of the interviewing process. Were some or all of my informants representing the treatment clinic due to their key knowledge and experience with addressing fathering issues within addiction treatment contexts? If so, would the research have given totally different answers if I had spoken to other therapists? These questions remain unanswered.

4 Multiple fatherhoods on multiple levels

4.1 Introduction to my analysis

This chapter starts by describing my informants and their range of characteristics in relation to the sampling issue. All personal background information was gathered during the interview itself. I then move on to present by means of a content analysis what my informants actually said about how they address the issue of fatherhood within the context of treatment for alcohol problems. This section has been labelled Part One, and represents the local cultural level of speech and meaning-making on issues such as therapy, fatherhood and drinking problems – viewed from a social constructionist's perspective. Part Two follows directly afterwards, and is built upon the findings in Part One. There I expose a limited area of those findings to (Foucauldian) theories on discourse and discursive practice. I study some of the links between power and the knowledges which my informants put to use, explore their ways of portraying themselves and their patients as neutral and a-cultural persons or as gendered, constructed selves – and briefly discuss some possible ways of interpreting these findings.

4.2 About my informants

What is being presented in this research analysis is based upon information I gathered from doing seven semi-structured interviews with seven informants working at four different clinics. No two clinics are situated in the same town or city, but are relatively well geographically spread around Norway. Although I did interview three persons at one clinic, (one person volunteered when I arrived) I chose to transcribe and use data from no more that two informants there. This is because I was aiming for the best possible cultural spread of informants and chose therefore to limit representation at each clinic. As a result, the four clinics are represented by no more than two informants each. All four clinics have been operating in the treatment field for many years; they also all have long traditions and are well respected for their work. There is some variety in how treatment philosophies are represented. Two clinics only treat adults with alcohol problems. Of these two, one adheres to what I have earlier described as the "disease" model (c.f. note 4 on page 6), while the other is more in line with what I – for practical reasons – have earlier referred to in this report as the "research-based" model (c.f. page 17) [17]. The remaining two clinics have a number of similarities. Both

[17] This term is not used outright by people working in the treatment field. However, research findings on what worked or did not work in the past do significantly influence how future treatment practices are modelled.

treat generally for addiction, not specifically for alcohol problems. In addition, both have a family orientation and are orientated on the "research-based" model. However they differ in the way they organize their treatment, and in the emphasis they place on treatment methods. Three of my informants were women, four were men. I had little control regarding the distribution of gender, since these were the only informants who contacted me and consented to an interview. Although this does not represent the general gender distribution of therapists working in the field, it has been a useful variation with regard to addressing a possible assumption that men and women might see things similarly or differently, depending on their gender. I do not know whether lesbianism or homosexuality have been represented, since the sexuality of the informants was not discussed. All informants said they had been raised within the framework of Norwegian culture. Two informants described their childhood background as upper class, three felt they had a middle class upbringing, while two described their roots as working class.

Six of the seven had basic training either as nurses or psychologists - in fact one person had two basic professional trainings within the field of health and social affairs. All of these six had some form of additional postgraduate, clinical training, with family therapy, substance abuse and adult psychiatry all being represented. One person had previous personal experience as an "alcoholic" and had added to that competence by training as an addictologist[18]. Generally, the issue of experience was difficult to judge, since some informants were working at residential units. There, treatment is more intense than is the case for outpatient treatment. None were newly trained in their present professions, but the number of working years varied. Some had been therapists for five or six years, while others had practiced for up to twenty years. Their experience of working in addiction treatment centres where fathers with an alcohol problem were among the patients they met, also varied. All three women had been working with the target group for more than seven years, while that was only the case for one of the men. The remaining three men had more limited experience.

Interpretations used in what I have called the "research-based" model are also currently being merged with interpretations employed in the field of medicine. After the Norwegian Department of Health took over general responsibility for the treatment of all substance abuse, people receiving treatment for alcohol problems became "patients". As such, they needed a diagnosis which classified their alcohol problems according to accepted psychiatric models of research in Europe (the ICD diagnostic system) in order to be accepted for treatment (Epstein 2001: 55-58).

[18] This profession seems to be more commonly recognised in Sweden than in Norway. Addictologist training in Sweden follows the "disease" model of treatment for people with drinking problems and is usually based on the classic (AA) "twelve step" program.

Part One: How therapists positioned their selves

4.3 Introduction to Part One

In Part One it is the therapist who is in focus. I start by examining the knowledges my informants draw on, since these set the premises for each person's unique approach to the issue of fatherhood. Then I move on to demonstrate several ways in which my informants positioned their selves as therapists in relation to their patients' fatherhood practices. Later in the analysis (Part Two) I will both examine and discuss how this positioning is linked to ways of seeing patients who are fathers and their children.

4.4 Knowledges therapists drew on when addressing fatherhood

Professional knowledges: Those knowledges which enjoyed hegemony during the interviews were linked to my informants' professional selves. Here I am referring to those knowledges about children or parenting which are commonly acquired in the course of training within the health professions, based on theoretical foundations and re-asserted through exchanges with their peers. Informants also situated their professional selves within the treatment framework of the clinic where they worked: here they would mention how that clinic emphasized family matters, or give details on clinic routines to indicate the position the clinic took on fatherhood and topics related to child care. As a result, although informants seemed to have similar sources of knowledges, each of them contributed to the data material with her unique "mix" of professional expertise, skills and techniques. Two women and two men referred to their approaches of working as mainly "psycho-educative". They used these approaches in individual therapy and when teaching courses for patients about the consequences of adult addiction for family and children. Yet their individual interpretations of psycho-educative methods varied. John had originally trained as a psychologist and he leaned heavily on his supervisory role as a professional expert:

> *"I think when I sit in the therapy room I certainly use what I have learned in that role the whole way [...]. (Fathers) don't leave my therapy room without getting new, if not better competence on children in the same age group as their own kids."*

On the other hand, one of the men who defined his approach as psycho-educative supplemented that with the adjective "explorative". Explorative approaches to professional knowledges tend to collide with the professional "supervisor-expert" approach. One woman

and one other man described their way of working as *principally* “explorative”. Yet here again the professional approaches seemed to blur with one another. Three of the four men with the least experience mentioned their appreciation for knowledges they had recently gained from the field of family therapy. One man related a positive new experience he had in working with a reflecting team behind a mirror.[19] All three men had found it useful to draw the child’s mother into the therapy with the father, so that all sides of the parenting-and-alcohol issue could be explored and discussed openly. In that respect, the clinics where they worked had played an important part. David had started his working career at the clinic with a professional training that had a different focus; he had been influenced by the family focus at the clinic:

> *“There is a multidisciplinary community with many family therapists here, with long traditions in treating families with addiction problems. So in a way you get concerned about parenthood and fatherhood when you start working here.”*

The most experienced informants seemed themselves to be staking out paths with regard to knowledges about working with families. Two of these said they felt there was too little focus on families at their clinic.

Knowledges gained from own personal life experience: One of my informants differed significantly from the others. He was a reformed alcoholic, and although both his later professional training and the clinic’s approach were in accordance with the disease model, these knowledges first seemed to gain meaning when applied within the framework of his own life experiences. He said he felt comfortable about discussing his own previous fatherhood practices with his patients, since these were typical for active drinkers.[20] Feedback he had received about himself from his own children was also made available as a good example to others:

> *M: (I) use my own experience. Tell what my kids have told me. And they’re just like most kids.[...]*
>
> *H: What kind of reaction do you get?*

---

[19] Originally developed by Norwegian psychiatrist Tom Andersen (1988: 78), this method is based on social constructionistic ways of viewing the world, and is highly explorative. It also challenges the high-ranking status professionals often have in therapy (Hoffman 1992: 17).

[20] Roberts discusses some of the advantages and disadvantages of transparency and self-disclosure in family therapy in an article in Family Process (2005). There she refers to White’s general work with transparency (1995, 1997), and to the work of Diamond (2000), an addiction specialist who has written about narrative therapy and transparency issues with particular reference to treatment for alcohol problems.

M: Since I've been in the same situation myself I get through more easily.

Yet he was not the only informant to use knowledges gained from his own life experiences. All but one of my other informants referred to some form of personal knowledges which they employed when working with fathers. Sometimes these would just be private reflections about being a parent, or about the question of drinking in front of their own children. These thoughts would be in the back of their minds when they were talking to patients who were parents. Some informants would even articulate such thoughts in a discreet way. The problem was that the use of personal knowledges seemed to trigger doubts and difficulties on the part of informants. Kristin put it very succinctly:

(It's) simply because with alcohol, the transition from use, to misuse, to dependency is so slippery. It hits us right under the belt personally, so we would rather not relate to it personally.

On the other hand, when expressing some of these doubts and difficulties about their personal lives, informants seemed to be accessing alternative, less certain forms of knowledges. They were presenting their selves less as experts and more as culturally distinct individuals with their own moral values and preferences. Petter explained how his personal experience of being a father influenced his work with other fathers:

So, I have been a dad myself the whole time I have been working here (at the clinic). And as a result – for one thing - this stuff hits me harder. [...] I think that – being a father myself – I feel more strongly that fathers should be allowed to have access to their children. [...] And another effect is that I reflect in a different way round it all than I would have done if I didn't have children.

Petter had given great thought to fatherhood issues in his working context. He thought that his personal set of *values* with regard to alcohol and fathering had particular significance, since these emphasized the importance of not being judgemental.

Knowledges from practical experience: In short, it seemed that no one source of knowledge was sufficient. Although all my informants had some experience at working with fatherhood, it was those with the least experience who seemed to lean most on their professional training and who most appreciated the support they received from the clinic where they worked. Reflecting over knowledges gained from personal life experiences was also helpful. But

finding the appropriate mix of these knowledges seemed to have been done by means of the more "messy" trial and error process that practical, clinical work entails[21]. Anne was matter of fact about that:

> *Well, in this field you can learn **some** things from books, but mostly you learn by experience.*

None of the most experienced informants told me that they set aside fatherhood, while those with the least experience were also those who said to me that they sometimes had difficulties or expressed dissatisfaction with their own work. In contrast to this, experienced informants were spreading their integrated knowledges so that new patients and other therapists could share their own methods of success. Each had their own "recipe" of skills and techniques as to how to best approach fatherhood. Although such "recipes" seemed to work for the individual informant in question, I noticed that they differed slightly from one another in content – even in cases where informants were employed at the same clinic. The two examples that follow are excerpts from interviews with the two informants who had the most experience. In the first case I am talking to a man and in the second to a woman:

> *H: How would you characterize your way of working, then?*
> *J: Well, my line is pretty confrontational.*
> *H: Oh?*
> *J: Yeah. Because there are so many who – before they come here – have come up with all sorts of explanations and reasons for their actions. And I have sometimes said to patients: "I don't feel in the **least** sorry for you!"*

> *H: So what kind of discussion would you be aiming for here?*
> *E: Well, it's a pretty soft approach: I really do try to consider his (her patient's) feelings. Because I don't have any belief in a confrontational style, although I know that some people use **that** approach.*

Making knowledges public: Two men and two women said that they usually made their own positions clear when they addressed parenting issues. In this group of four were the three informants who had most experience at working with fatherhood in an addiction treatment

[21] In his study of how professionals think in action, Schön found (1983) that professionals tend to learn by fusing practical and theoretical knowledges in a complex process which he has termed "reflection-in-action".

context. Ingun had learned that by managing her professional knowledges with care, she could "go public" about almost anything:

You can raise almost any issue and talk about absolutely anything, it's just a matter of how you do it […]. You should not mince your words, you should be realistic, but at the same time you should respect (a father's) integrity, and you should lift the issue up to a solution-focused perspective.[…] My experience is that they become very humble and attentive to what therapists tell them as professional people.

The other three informants (two men and one woman) were more reticent. They seemed to fear that putting forward their own views could offend a group of patients that had more than enough to contend with. One man told me that he had experienced being criticised by patients for *not* using his therapist's prerogative for raising the fatherhood issue. As a result, he planned to be more persistent about asking uncomfortable questions in the future. Yet he still remained reticent about declaring his own point of view, and was more concerned with helping his *patients* to go public. For him, making his own position clear was more a *product* of the general process of building trust with his patients over time:

D: When they start trusting me and they notice that I see they can be a good father despite everything, [...] that I'm not trying to torpedo their fatherhood project as they have maybe experienced with others, that I am cooperating about this business about being a good and responsible dad, then it gets easier for them to talk about that (difficult) stuff.

Ethics as an active partner to knowledges: I explained in Chapter 3 how my data had been exposed to sensitizing concepts such as the context of the treatment culture, issues of gender and a social constructionist ideology, thus rendering value neutrality on knowledge impossible. I especially mentioned the workings of power in the therapeutic process, and proposed that ethics and knowledges needed to be active working partners. While my informants were talking to me it seemed that they were constantly taking an ethical stance on the issues at hand – sometimes in a conscious manner, and sometimes more as a matter of course. Since the context of our conversations was alcohol treatment, some of the ethical reflections on knowledges about therapy, alcohol and parenting were particularly poignant:

There are many fascinating sides to this business of alcohol. As opposed to illegal substances, alcohol hits you as a therapist and it hits the people your patient interacts with, – such as his family – in quite a different way. [...] My own daughter already

notices when I've had a beer, and she's only four. [...] She knows that her daddy works helping men and women who drink too much. And then she sees her own daddy drink, and asks why, when……

At such points, informants tended to adjust the way in which they were positioning their selves in relation to issues being discussed: Data findings then became complex, less clear and more difficult to interpret. The links to *personal* knowledges, however, were quite distinct.

4.5 Therapists' points of departure when addressing fatherhood

All my informants said they followed a basic principle which simply states that alcohol and children do not go together. They were also well aware of their positions in relation to Norwegian laws on children. Some informants had very active forms of cooperation with child care authorities, while others simply followed clinic routines with respect to focus on family and reporting cases of child abuse to child care authorities. In this section, however, I am referring neither to moral principles held by my informants, nor to the legal and administrative ways in which they addressed the fact that some male patients in treatment are fathers, *but rather to the way they positioned their selves when approaching fatherhood.*

Addressing fatherhood via the child: When analysing the interviews with two of the women and three of the men, it has seemed to me that their main therapeutic approach to fatherhood was via the child. To explain this more closely: when I asked these informants about how they addressed fatherhood, I seemed to be "pressing the start button" for a type of conversation that indicated it is customary in Norway to attribute high value to children. [22] In the following example, John seemed to be implying that if the child had no "need" for the father, he might not even raise the issue of fatherhood.

H: What do you think is important for therapists to keep in mind when they get to hear that their male patients have children (who are minors)?
J: Well, with regard to being fathers, we first need to know more about how important they are for their children.

[22] This is part of a nationwide approach to children, enshrined in legislation and general socio-cultural attitudes in the modern western world. According to Frønes (2001: 131) the child is considered to be the "last barricade" with regard to ideas of innocence in modern society.

Three informants told me that they liked working with the fatherhood issue because it had a preventative effect in relation to the next generation. They also appeared to value children of patients more than the patients themselves. I was told that when fathers living in residential units wanted to see their children, informants considered the "needs" of the child as having priority over the wish of the father. If children were to be invited to join their fathers in therapy sessions, the same rule of thumb would apply.

Therapists as experts on child care: While we were talking together all these five informants demonstrated their close links to and belief in the value of their knowledges as professional people. My findings also seem to suggest that the closer informants seemed to be cooperating with child care authorities, the more child-oriented their approach was to fatherhood. Informants who were cooperating very closely with child care seemed to be assuming a position of professional expertise on fatherhood that was more or less parallel to, or even superior to, that of child care authorities. In the example below, I show how these aspects are linked together in the case of Brit, who starts by telling me how she cooperates with child care authorities and then moves on to explain later in her interview how she organises the treatment:

> *And then it's always child care authorities that refer patients. So they are kind of standing on the sidelines and they have cooperative meetings with us regularly, to see how things are working out with regard to patients' ability to care adequately for their children.[...]*
>
> *B: Of course the focus is on interaction in the family and making sure that things are organized around children's needs [...].*
>
> *H: Can I just ask who takes the initiative for that? Do you wait for the fathers to do that, or do you do it yourself?[...]*
>
> *B: I have it as a theme throughout the treatment.*
>
> *H: So if you could put into words what your therapeutic style is, then, would you say it's kind of supervisory, building them up in a solution-focused manner?*
>
> *B: Absolutely, that's just what it is. And sometimes giving clear, direct advice. Because patients ask "What should I do? I don't know what people usually do!"*

My own practice experience supports these research findings. Although my approach to the fatherhood issue tends to be via the father, I find myself quickly slipping into the position of

an expert, judging appropriate fatherhood whenever I cooperate closely with child care authorities.

Starting directly with the father: However, one man and one woman did not employ a child-oriented approach. Although they both fully acknowledged a separate need to consider the child, their main therapeutic point of departure was via the father. These two informants were among those who had described their way of working as explorative: they were primarily concerned with helping patients to first express their own concerns. They did not emphasize the importance of their professional knowledges or give their opinions as experts, but wanted rather to try to understand how the father was experiencing his world and to not jump to conclusions too fast. As in the example following here, where David explains his basic point of departure, they shared my clinical experience of meeting motivated fathers

> *I don't think that having an alcohol problem is the same as being a bad father.[...] So I start by checking how important it (the fatherhood issue) is for him. [...] Because there is no point in me being taken up with it if he isn't. [...] (However) many (fathers) say "I feel like a better person, I feel valued, I feel proud". You get a lot of positive feelings connected to the father role, and that explains to me why it is so motivating for them.*

The stance demonstrated by these two informants on the situation for the children in question was down-to-earth and directed towards wellness:

> *B: And in a way, the children have grown up in what they have grown up in. And if they (the fathers) only make small changes, that can have a big effect!*

Destabilizing tendencies: One woman whose point of departure was very child-orientated declared that fatherhood was an important motivating factor. *Despite this, she indicated to me that fathers were not really keen on working at fatherhood before later on in the treatment.* Some informants felt that approaching the fatherhood issue was a matter of choice. This could be interpreted as an expression of respect for the patient's right to choose what is discussed during the therapy. Only one of these was in the group who approached the fatherhood issue via the father. The two others worked via the child. They usually started by addressing clinic routines that were not directed by criteria of choice, such as checking safety issues around the child. If the patient showed "resistance" and the child seemed safe enough they said they would most likely then set aside further discussions on fatherhood. *Yet both had previously*

declared how important fathers are for children. It should also be mentioned here that these two informants appeared dissatisfied with certain aspects of their own work and were among those with least experience at addressing fatherhood in an addiction treatment context. These are isolated examples of how informants tended to contradict in practice the beliefs they held. Such tendencies increased when we moved on to talk about gendered practices for men and women in the larger social context. In the section that follows I give more examples of how the same informant seems to set off in two opposing directions.

4.6 Therapist approaches to fatherhood seen with a gender filter

I think my informants understood in principle that I was positioning our conversation on fatherhood and alcohol within the larger cultural, socio-political context in Norway, -although some of them forgot that at times. When our talks touched on these points of intersection, issues relating to the general gender debate in Norway became especially relevant. In the section following here, I interpret gender as it is socially constructed within the Norwegian treatment system for men with alcohol problems.

Mother-oriented or equality-oriented positioning on fatherhood: I have created two concepts in order to describe how my informants positioned their local selves within the context of the larger gender debate in Norway on fatherhood issues. The first concept – "*mother-oriented positioning on fatherhood"* – describes a situation where the informant demonstrates cultural acceptance for traditional ways of understanding family constellations. Fathering is considered to be subordinate to mothering and the mother's definition of what is good fatherhood carries most weight. The second concept – "*equality–oriented positioning on fatherhood*" – describes a situation where the informant challenges prevailing cultural stereotypes and makes a conscious effort to promote the equal distribution of responsibility for the care of children between mothers and fathers. The implication of taking an equality-oriented position is that a father is as important to his child as the mother. With this equal responsibility equal rights would follow: among these would be the right for fathers to have an equal share in defining what good fatherhood is.

My findings indicate that when fatherhood issues were exposed to a gender filter, the data pointed in a number of contradictory directions. Five of the informants expressed equality-oriented ideologies. Yet it seemed that their reported practices often failed to harmonize with

these ideologies. There was a *tendency* for men and women to position their selves according to categories of gender in their practices, but not in their ideology. Sometimes there were contradictions between the ideologies expressed by one and the same person. In short, findings in categories of gendered criteria are characterized by disharmony and they tend to collide with and override other findings which might point in a unison direction. Nevertheless the data indicates some clear lines: for two male informants there was relative conformity during interviews between expressed equality-oriented ideology and reported practices. These two persons had adopted an equality-oriented position to fatherhood. They had mainly approached the subject of fatherhood via the father, and they called their main way of working "explorative".

Mother-oriented positioning dominated in practice: As mentioned above, many of the usual *practices* described by my informants can be defined within the framework of a mother-oriented position on fatherhood. Here I do not presume that mother-oriented positioning is automatically the equivalent of faulty positioning. Certain branches of the feminist movement might even regard such a stance as an appropriate balance to patriarchal systems which have all too long dominated society. However, my analysis indicated that cultural blindness to gender issues did have some drawbacks. Vanja was both honest and self critical about her own practices in that respect:

> *I think - for my own part – that as soon as a mother comes with a small child, there we are straight away! While if it's a father, you need…well, it seems we give in more easily. We – or at least **I** – am not so quick to raise the theme of fatherhood (as compared to the theme of motherhood).*

Rules and practices of cooperation with child care authorities that were mentioned during interviews seemed to support mother-oriented positioning on fatherhood. At one clinic, there were routines for regular cooperation with child care over mothers, but none at all for fathers. One of the informants working there took an equality-oriented position to fatherhood; yet she felt it was not her place to establish new clinic norms in that respect. At another clinic, some fathers could only get professional help with their fatherhood project after the mother had become a patient. At a third clinic where there was a large men's ward and many of the patients were fathers, they seemed reticent to contact child care authorities:

> *I: It is not so often we get into situations where we report our concerns to child care. That happens more often in the section for women (with an addiction problem).*

Brit commented on how structural discrimination was built into the treatment system. She thought that child care authorities were conspicuous by their absence in relation to fathers:

One thing that bothers me, but in fact it happens before patients get here, is that when a woman gets admitted to "detox", the case is automatically reported to child care authorities. And I think that should also be done if it is a man. There shouldn't be discrimination. [...] Because there are so many men that have responsibility for children [...] and it's important that they are aware of and take the consequences of that responsibility.

A noticeable disadvantage with mother-oriented positioning on fatherhood first became evident when I analysed the data. Informants whose position on fatherhood seems to be predominantly mother-oriented also seem to often have described their patients as "resistant" to discussing fatherhood issues. Here Marius – who had a clear mother-oriented position – is telling me how his patients typically react with "denial" when he introduces the issue of fatherhood:

M: When I ask my patients: [...]"Have you ever talked to your kids about what kind of impression you make on them (with the drinking)? they often say "the kids haven't noticed anything". [...] That comes early in treatment, that's standard.

In contrast to this, informants whose position on fatherhood seemed to be predominantly equality-oriented described their patients as very keen to raise their concerns:

B: I experience that they (the fathers) are good at taking the initiative themselves. [...] Since they have been drinking, the mothers can use that against them [...] So they are scared of losing touch and scared they won't be in a position to follow up.

Equality-oriented positioning promoted equality in the therapeutic relation: The example given above illustrates another aspect to the data: when a therapist adopted equality-oriented positioning on fatherhood, this seemed to promote greater equality in the therapeutic relationship with her patient. Therapy became more of a project where therapist and patient collaborated[23] to address concerns that were of shared interest, such as ensuring that the child was suffering as little as possible, or finding ways in which both parents could have access to

[23] White maintains that for therapists, the ethics of collaboration is an alternative which is far preferable to the ethic of control (1997: 195-199). Referring to therapists' sense of frustration, personal failure or even despair when they see how powerless their patients are, he points out that collaboration unburdens therapists and re-invigorates them in their work.

the child. Getting people together and creating space for them to voice their hopes, preferences and concerns was an important aspect of this collaboration for the therapist. The adoption of an equality-oriented position seemed to secure the therapeutic relation so thoroughly that other potential difficulties were overridden.

There were many ways in which equality-oriented positioning became apparent. One of the most straight forward representations was given by Nils:

> *A father's role is continuously changing. And responsibility for children has become more and more equal. [...] And I say straight out (to fathers) during treatment that you are just as responsible for the child, whether you are his mum or his dad. [...] Nowadays society expects fathers to go to PTA meetings, [...] accompany the child to the public health nurse and so on.*

Another way in which informants communicated attitudes on equality was when they were working with the family as a whole. The familiar picture communicated to me during interviews was one of tense or stressed relations between fathers with alcohol problems and their families. One theme which surfaced quickly – and which is also very familiar to me in my own practice – was the blocking of fathers' parental access to the child. Here it was either the mother or child care authorities who took action. Cases were also mentioned where older children had themselves actively rejected fathers. All my informants seemed to be working hard to try to reduce levels of family conflict. Three of the men had made it a permanent routine to invite or even put pressure on *both* parents to get together and discuss their differences in the therapy room. This is a method which I use myself, but none of the women who were informants mentioned this practice. The idea of insisting that mothers should come to joint sessions was reported to be somewhat unpopular with some fathers. Nevertheless, actions of such a kind do indicate to both fathers and mothers that men and women have equal responsibility for their children. Olav told me how he handled any protests:

> *H: So you just say to them, this is my way of doing therapy, I just have to talk to your wife. Huh! That's good.*
>
> *O: Yes, well… (he thinks a bit) I often think we shouldn't be so scared to do it. They (the patients who are fathers) aren't so scared either. Some protest a little, but then I say: "Look here, this is going to be really difficult for me. Here I am sitting here and talking to you about stuff that concerns others. And there are big conflicts here, and you tell me that she is resolute on* ***leaving*** *you. Well, so then she just has to come in here and talk about it." And there's only one case where I didn't manage to get her to come.*

Several informants told me that when they thought a father was ready for it, they also invited his children to join them in a therapy session. Children were reported to have used the opportunity to voice their anxieties and even complaints to fathers. Sessions of this kind were said to have been an eye-opener to the father and – in the long run – beneficial to everyone in the family.

Should men work with men: All informants thought their own gender was significant when working with fatherhood. In this matter, there was a general grouping of answers according to informants' own gender. All four men thought it made a difference, and three of them thought it was an advantage to be a man, especially if you were a father yourself. Here the value of personal life experience became evident. One man was uncertain. He feared that a male therapist could appear too successful in areas where the patient had failed. However, John was part of a network of other male therapists, and he said they all agreed that it was preferable for men to work with men. Here are some of advantages he mentioned:

> *H: Do you think that your gender communicates anything special to these men? [...]*
> *J: Mm. Several things. [...] I think that a therapist who is a man, running a group for men, creates an atmosphere that is different to that created by a therapist who is a woman. [...]We have a different way of talking. [...] Often we can use humour [...] to create breaks in the intense feelings that arise. I think men are more sensitive than women there.*

John raised another issue of particular relevance to the debate as to whether men should talk to men about fatherhood. He thought that women tended to employ an "identity" approach to parenthood, whereas men were more relaxed with a "task" approach to parenting. For that reason, he found it easier to talk to men than to women.

> *My experience so far both from group therapy and individual therapy with women and men who care for children is that it's easier to talk about parenting with men than with women. And that's because I find that mothers identify so strongly with mothering. If they don't get it right, then they are a bad mother and a bad person. A father sees it more as a task. I find he can more easily than the mother just talk about it as a job to be done, and discuss the various problems that arise in different situations.* [24]

[24] Carr has discussed this issue in an article about including fathers in family therapy (1998: 376). Pointing to research which indicates that men and women demonstrate those very differences in their styles of communicating and coping, he argues that therapists should make adjustments for that in their practice.

John told me that since the other male therapists in his network had similar experiences in their own practice, the group was planning to collect their knowledges and find better ways of working with men.

Women and the power issue: The three women were noticeably more concerned than the men with raising the power issue when approaching fatherhood. These women indicated in various ways that they thought that men receiving treatment for addiction problems had very low social status and were relatively lacking in power when compared to other groups. All my informants mentioned that changes in expectations during recent decades had contributed to difficulties fathers were having, but the women were especially concerned with what they felt were the consequences of these changes. Kristin had a small anecdote which illustrated what she felt was a common attitude in the helping professions:

> *In the treatment for women one is so concerned with guilt and shame and a mother that is failing and being stigmatized by society. Women with addiction problems more easily get defined as victims [...] while attitudes to men are tougher, more "morally reprehensible behaviour, this is what they have chosen". [...] We once sat at a meeting with a social worker, and then he said: "Yeah, you lot work with the* ***absolutely least*** *attractive patients!" Nowadays it's popular to do evaluations, and of course women have long been in focus [...] but adult males with alcohol problems – the largest group – are the least "interesting" in inverted commas. And that's who we fight for. And most of them – by far the majority – are fathers.*

The women's views seemed to influence the way they worked with their patients. All the women tended to have a compassionate approach. Here, Elisabeth explains:

> *The men's position is especially weakened. [...] That influences my way of talking. With extra care and empathy. Yes, because in many ways I can imagine what it must be like to [...] get prevented from seeing your children.[...] And if you look at the difference between myself as an authority, as a woman, as a mother, with a relatively well organized life, when compared with a father in that position, who maybe has lost contact with his kids, then…*

Elisabeth's gentleness was clearly motivated by her heightened awareness of the implicit imbalance of power in her therapeutic relationship with these fathers. [25]

4.7 Using stories to hold onto hope

Informants often illustrated their points with fragments of stories about family work with fathers. In that way they could explain things without accessing confidential information. I also specifically asked informants to recount to me an experience they had of a father who changed his parenting practices during the therapy process. My motive for this question was simply to generally enrich the content of data findings.

These small stories or even fragments of stories have had several functions. Firstly, they provided valuable examples of informants' practice experience on a local cultural level. Secondly, they were rich in discursive content and were therefore useful for my discourse analysis. Thirdly, they usually had a wellness profile and as such their value extended beyond that of content. This section presents findings relating to the wellness profile of these stories.

Fathers who change their fatherhood during therapy: In the course of interviews, all but one informant were able to tell me about fathers who changed. Some told me about small episodes of change while others had registered cases where a father had gradually changed over a longer treatment period. The only informant who could not recall a suitable record of change in fatherhood practices during therapy, was also the same person who demonstrated most hesitance when I asked what helped him to hold onto hope. *"I don't always manage to hope"* he had replied.

Yet the analysis showed that for my informants, it was not predominantly the content of these stories that held significance. Rather, it was the fact that *success stories got told and that they – as therapists – had heard them.* Hearing about success gave hope to the informant and strengthened her identity as a helpful therapist. The three informants with the most experience were especially aware of connections between their own hope as therapists, and the benefits of hearing patients' success stories after years of treatment and often initial failure:

[25] Building on Unger's discussions about imbalances of power in the therapeutic relationship (Unger 1989: 30), family therapist Jonella Bird suggests (2004) that therapists explore these questions quite openly with patients. Her experience is that open talks about power issues can have an empowering effect on the patients concerned.

K: Seeing all the patients who (finally) manage to make a change in their lives and in relation to their children, that's what helps me hold onto hope. [...] You know, getting to hear ***all the good stories*** *[...] makes me realize that what I'm doing does make a difference.*

A second significant factor about these stories is that they so strongly demonstrated an informant's position on moral issues; the moral of each tale being that working on fatherhood can produce "happy endings". Elisabeth explained to me at the end of her interview why that was so important:

Because, for those of us who have been working with substance abuse for a long time, well, you can imagine, you often feel pretty helpless. You know, when you look at the percentage of those who make the grade, well, you need to be able to disregard that and rather go in and meet every single patient "as if I believe you can do it". [...] I need that perspective to keep going. And the day I lose sight of that, I'm going to have to quit my job.

Elisabeth consciously used the hope that stories about the "re-storying"[26] of patients' lives generated in order to counteract any hopelessness which might threaten her in her work[27].

4.8 Conclusions from Part One

Conclusions regarding the way therapists positioned their selves on a local level in their therapy indicated that the majority of informants leaned heavily on their professional knowledges when addressing patients' fatherhood. They made their views clear to their patients, but styles varied. Psycho-educative modes of working were most popular, although explorative methods were also employed. This same majority (five of seven) used their professional knowledges to approach the patients' fatherhood via the child, taking an expert stance. During that process, children were ascribed higher ranking than the fathers. People in this group considered personal knowledges gained from own life experience to be useful, but (with one exception) only when accessed in a reticent, self-reflexive way. They demonstrated great sensitivity for ethical aspects about alcohol and fathering: Most of them felt the issue

---

[26] Here I am using the expression in accordance with the philosophy of narrative therapy. White claims that "it is the story of self-narrative that determines the shape of the expression of our lived experience (1995: 13).

[27] White maintains (1997) that what shapes the lives of patients also shapes the lives and work of their therapists. Furthermore, he claims, acknowledgment of that factor "serves to undermine the rigidity of the power relation of the therapeutic context (1997: 131).

affected them in personal ways that were difficult to manage. Those who had most experience found it altogether easiest to address the fatherhood issue.
Two of the seven informants deviated from this main group. They seemed to lean less on their professional knowledges. Their main way of working was explorative; they did not seem to be using psycho-educative methods at all. They addressed the issue of fatherhood via the father directly. Although they were willing to voice personal views if necessary, they were more concerned with helping patients to express their own views and concerns.

When I link what my informants said on the fatherhood issue to the larger gender debate in Norwegian society, this creates new groupings which clash with groups of findings described above. The majority of informants expressed themselves in such a way that I have defined them as subscribing to an equality-oriented *ideology* on the fatherhood issue. Yet judging by what they said they did, most of these informants *practiced* mother-oriented positioning, especially in matters regarding the involvement of child care authorities. Mother-oriented positioning seemed to be closely linked to cultural "blind spots", and there were many contradictions in my findings. However, finding from interviews with two men differed in that respect. These two both "preached" and "practiced" equality-oriented approaches when doing therapy with fathers. In addition, one of the women was heading away from mother-oriented positioning in the direction of equality-oriented practice. In sum, the main characteristic of my findings when exposed to a gender was a dynamic form of disharmony. Despite this, there were significant links between equality-oriented positioning, "explorative" ways of working and the existence of a collaborative therapeutic relationship where the father quickly came into direct focus during the therapy and was able to voice his views. Another characteristic of the findings was that when gender was raised as a *specific* issue, meanings expressed by the men and the women tended to fall into groups that could be categorized purely according to gender. The women tended to be more concerned with the power issue and the men tended to think that men should preferably work with men when addressing fatherhood.
When patients had managed to change their fatherhood practices it proved to be important for informants to get to *hear* these stories of success. Hearing specific stories about patients' success helped informants to believe that working on fatherhood could give positive results. As such, these stories also helped to generate the hope informants needed to continue with their work.

Part Two: When therapists positioned the selves of others

4.9 Introduction to Part Two

Part Two builds on my findings in the content analysis in Part One, but I focus more on links between what my informants said during interviews and cultures of discourse on a meta-level. I use Foucauldian theories to interpret meaning expressed by informants – specifically, I apply approaches developed by two groups of social constructionists who have explored the works of Foucault in similar but not identical ways.

When relating to ideas of power and therapy I have used White's interpretations of Foucault (White & Epston 1990; White 1995). Arguing that "*the vista of power has been much overlooked in the therapy literature generally, and especially in the benign view that we frequently take of our own practices"* White often explains his interest in Foucault as being grounded in his and Foucault's shared interest in studying power (White & Epston 1990: 18). Foucault was particularly interested in the close links between the production of power and the production of knowledges in a society (Foucault 1984: 51-75). At one point he illustrated these links by using examples from a field with which I am familiar – the field of psychiatry. He saw power as neither negative nor positive; rather it was constitutive in various dividing regimes of order which organize how people see the truth. As White explains: Foucault saw these "truths" as *"normalizing in the sense that they construct norms around which persons are incited to shape or constitute their lives. Therefore, these are "truths" that actually specify people's lives"* (White & Epston 1990: 19). Building on Foucauldian concepts, White has shown particular interest in how the *stories* that people tell tend to constitute the way they perceive their selves and the selves of others. This idea proves significant in relation to my findings.

When relating to ideas of positioning the fathers, I have used interpretations of Foucault by feminist researchers; in particular researchers Davies & Harré (1990) and Søndergaard (2000). They have developed the concept of storylines, based upon Foucauldian understandings of discourse (cf. page 13 in this report). With help from the storyline concept, I have explored how the individual informants are discursive participants in ideas which constitute their own lives and the lives of their patients seeking therapy. To that purpose, fragments of discursive meanings expressed during an interview have been seen as "lines" which demonstrate the informants' use of certain discourses. These discourses tend to clump together, forming the skeleton of two culturally collective stories operating on a meta-level in

society. By tracing paths of discourse it becomes possible to see how therapists are positioning their selves and the selves of others within these collective stories. We also learn more about certain aspects of these collective stories, as they are demonstrated by therapists doing therapy.

I have regarded these two perspectives on Foucauldian discourse as analytical tools which supplement one another and have helped me explore both the extent and nature of discursive concepts in my findings. Together, they have provided me with means to address both the theme of therapy and the concept of gender as social constructions.

4.10 The two stories: professional parenting and contemporary fatherhood

The analysis showed that there were two collective cultural stories circulating in the minds of my informants. Each of these stories represented cultural stereotyped beliefs as to what parenting entails and how fatherhood should ideally be done.

The first – and most dominating – story is the story of professional parenting[28]. I have mentioned earlier in this report that six of my seven informants had basic trainings within the health professions. Knowledges gained by training to such professions are generally held in high regard and it is also commonly believed that professional knowledges are the best sources of knowledge about parenting. I showed in Part One of this analysis that informants relied heavily on their professional knowledges when they were working with their patients' fatherhood. The story of professional parenting, therefore, does not imply that children should be removed from fathers and be put in the care of paid professional people, such as foster parenting or state homes for children. *Rather, it refers to the fact that informants' beliefs about "truths" in parenting were based upon professional knowledges – gained by training in their respective professions – and these beliefs were being used as guiding standards for how parenting should be understood.*

The second story is the story of contemporary fatherhood. This story is not as clear as the first story, but is more representative of the general state of confusion in Norwegian society at large with regards to what constitutes the contemporary ideal of fatherhood practice. The ideals I will be presenting here are based on the most recent research findings on fatherhood in Norway today (Aaseth 2007; Gullvåg Holter 2007b). The same ideals are also

[28] One of those who have explored certain aspects of the collective cultural stories in society is sociologist Frønes (2001: 115-137). He points out that those collective stories which dominate often represent a cultural lag.

being presented by the media and by political authorities as the preferred norm for "doing fatherhood". The research indicates that it is middle class couples – where both parents are well educated and are in full time employment – who are both living up to and helping to shape the cultural ideals of fatherhood (Brandth and Kvande 2003: 78, Aaseth 2007: 121). Here I remind the reader that five of my seven informants said they had middle class or upper class upbringing, while six of the seven could be described as highly educated. They can therefore be regarded as typical representatives of the cultural elite who are promoting these ideals.

According to these ideals, contemporary fatherhood is about the search for meaning and self-realisation and the re-shaping of identities in the family and at work. Gendered practices are being un-sexed. The tasks both at work and in the family are being regarded as projects, one of the most important of which is having and rearing children. The story of contemporary fatherhood also entails rejecting traditional ideals of what is considered to be masculine in favour of a non-traditional "new" masculinity. Recent research findings indicate that today's men play down the importance of friendship with other men and give greater priority to family life, children and tasks related to care-giving (Gullvåg Holter 2007b: 236).

The analysis that follows indicates that it is with allegiance to these stories that my informants approached the issue of fatherhood with their male patients.

4.11 The professional parenting story

In this section I will be presenting findings which can be linked with the values, knowledges, and approaches championed in the story of professional parenting. These findings show that when talk was part of the professional parenting story, the content became predominantly problem-oriented and *children* were usually in focus.

Dominating discourses about parenting: When conversation moved to the subject of parenting during the research interview, I seemed to be hearing several discourses. Discourse on professionalism dominated and was evident in six of the seven interviews. Here I interpret the concept of professionalism as simply emphasizing the fact that the informant had long training and had gained specialized knowledges within a certain "profession". Discourse on professionalism occurred most often when informants were positioning their selves as experts on parenting and child care. When informants spoke, they usually replicated knowledges and

descriptions categorized within the field of psychology, commonly referred to as "psy" discourse. Children were seen to have psychological "needs" which should be acknowledged and fulfilled by parents.[29] When John spoke, "psy" discourse and discourse on professionalism seemed to be almost interchangeable:

> *J: I try to be clear – professionally clear – about what I mean in relation to parenthood.*
> *H: Professionally clear. Could you tell me how you separate out the concept "professionally"?*
> *J: (laughs) One is being professional all the time. Well, I think I would have used some time on explaining the developmental phases of children and say more about how children might interpret experiences.*

If the subject of conversation was *children of fathers with alcohol problems* – and the talk was *general* as opposed to *specific* – then that dominating discourse became exclusively problem-oriented. The children were portrayed as suffering from guilt, confusion, and anxiety, while their fathers were depicted as emotionally damaged. In the example below, Elisabeth describes behaviour which is typical for children whose father *and* mother are "lacking in rescourses":

> *The children play out their symptoms to show they need help. You can tell by the way they're sitting on their chair, their gaze, and by the way they are frightened to say anything to offend their parents. They are extremely wary and sensitive and have little self agency.*

Elisabeth had frequent contact with children. On the whole, however, I could not establish whether informants were giving me a "true" picture of these children, or whether they were simply accessing the dominant problem-oriented discourse on "children of alcoholics" which circulates in the treatment field and in literature from the field of substance abuse (cf. p 6-8 in this report). Only two of the seven informants had frequent contact with children as part of their work. The other five had contact either occasionally, seldom or not at all. Consequently, much of what they knew about these children had been related to them by fathers during therapy sessions.

[29] According to White (2000: 13-14), structuralistic understandings of such a kind are relatively new in Western society.

One difficulty I observed with regard to this problem-oriented discourse was that knowledges about what could protect and help fathers and their children were being marginalized. This aspect will be examined under the heading "specific tales of wellness".

Assessing risks around children during therapy with fathers: Therapists are required by law to contact child care authorities if they are seriously concerned about the welfare of children that they meet or hear about during therapy with adults.[30] When informants were telling me about their concerns about the safety of patients' children, their choice of words and the views they expressed can be defined as belonging to the discursive category of risk assessment. My findings indicate that the four of the five informants who addressed their patients' fatherhood via the child frequently *started up* their work with fathers by asking about situations where they believed the child might be at risk. In the lines below, John is explaining how he starts working with fathers:

> *J: And we go in and use quite a bit of energy inquiring pretty early in the whole process [...] about the children's safety. [...] I kind of check out or cross off or inquire as to whether [...] they are exposed to drinking when parents are intoxicated. You know, elements of obvious danger.[...] So I ask about that pretty directly.*

When treating for substance abuse, therapists are required to fill out a form together with their patients – commonly named the KK form – asking for statistical information. Here it will be established whether a patient has children. Some of the questions on that form are of a sensitive nature and are directly related to the assessment of risks.[31] In that way, clinic routines also contribute to therapists' use of "risk assessment" discourse. All these four informants fell comfortably into risk assessment discourse when telling me about their routines and did not seem to question their roles as extended arms of the state on behalf of child care authorities. For them, risk assessment during therapy seemed to be more a fact of life rather than a point of discussion. Only two informants questioned checking-and-controlling practices in general; they were the same two who had approached fatherhood in an explorative manner, via the father directly. However, these informants had methodological

---

[30] Norwegian laws have given child care authorities powers to evaluate what is good enough parenting. This is one of the ways in which the state carries out its role as gatekeeper with regard to fulfilling the "needs" and "rights" of children and maintaining approved norms of parenting. However, recent research on child welfare practices in the Western world as a whole indicates that state authorities no longer focus on meeting the needs of children, but rather on assessing and managing risk (Parton 1999: 101). In this respect, child care authorities often depend on *other* professionals – among them, therapists – to assess risky situations in relation to children.

[31] E.g. one of the questions is: Have you in the past four weeks had serious thoughts about taking your own life?

rather than ethical doubts. Generally, clinic staff are well accustomed to assessing problems and risks. Psychologists are particularly accustomed to using "psy" discourse in combination with risk assessment discourse when testing, evaluating, filling out medical records and writing reports on their patients. The remaining three informants spoke in a different way about children and either mentioned risk assessment fleetingly, or not at all. One of these three was a man who approached the issue of fatherhood via the child. *He relied heavily on personal knowledges while we spoke together and did not mention risk assessment in any way.* The other two informants – one man and one woman – were those who had addressed fatherhood directly via the father. Their way of speaking about fatherhood was essentially collaborative – an aspect which will be illustrated later in this section.

Destabilizing tendencies: In sum, discourses that dominated interviews were discourse on professionalism, risk assessment discourse, "psy" discourse and problem-oriented talk. There were close links between these discourses and they tended to mutually underpin one another. It seems that by using these discourses, informants were furthering traditional understandings of the professional parenting story. Yet informants did not *always* speak in such ways. There were moments in *every* interview where an informant would "double back" on her self and qualify or adjust what she had just said. Perhaps she would tell me about a practice which did not seem to be in accordance with an ideology she had expressed earlier. Or she might discover in the course of our conversation that she was not always practicing in accordance with her preferred ideology. When meanings became destabilized in this way, this often produced the type of data I was especially interested in obtaining for this research. Such forms of destabilizing talk had consequences for how the selves of fathers and their children were being positioned and constructed in our conversation. There was a greater focus on wellness. Structuralistic descriptions were generally set aside. Instead, informants practiced ways of thinking and talking where uncertainty and the possibility of choosing among many alternatives came to the foreground.

Wellness oriented discourse occurred together with specific stories of children: Helmen Borge points out that *"children are decision-makers – they make choices and have the opportunity to succeed and gain self confidence in many situations*" (2003: 26, my translation). I wanted to learn more from my informants about situations where children had been able to practice self agency. Telling *specific* stories about children of patients required a more personal form of talk where the informant needed to reflect on experience with a

particular child. Some of the more experienced informants chose of their own accord to relate at least one small episode about a patient's child. At one point in each interview I actively elicited accounts of informants' specific experiences with children in that respect (cf. my interview guide). The task of relating to concrete experiences seemed to require informants to challenge their own ways of thinking and talking about patients and patients' children. In these very short narratives, children were described as demonstrating autonomy and self-agency – which is a preferred form of behaviour for children in Norway. The prevailing discourse was no longer problem-oriented. On the contrary, discourse focused on wellness. I heard about children who made choices and expressed self-agency either in words or deeds – as one informant recounted to me here:

> *Some kids even block their fathers from coming home. Not so long ago I sat with a chap whose kid had said: "It's daddy or me! If he comes home, I'm moving out – and I'm not old enough to move!"*

It was the most experienced informants who seemed most reluctant to surrender their problem-oriented discourse on children in favour of more wellness-oriented accounts. The excerpts that follow below demonstrate how one informant first needed to explain to me the pattern of general dysfunction in families where an adult has alcohol problems, before he was finally able to access a specific incident which he had most likely experienced at close hand, where a child indicated what made it feel safe:

> *H: **(I am reading a question from my interview guide**) We know that some children indicate to their parents what kind of parenting they want…what makes them safe, [...] What experience do you have with that? [...]*
> *J: Children don't! (indicate what kind of parenting makes them feel safe).*
> *H: They don't? Because just now you gave me an example of a child that did….?**(I am referring to a little story he had just told me of his own accord)***
> *J: Children are so loyal. They make excuses all the time.*
> *H: But do you know about any more exceptions?*

J: Well…… It could happen. You could say that the family is an arena, and in that arena we all have our roles, and the children go in and take over some of those roles. ***(The informant first replicates some general storylines which the disease model proposes about children of "alcoholics". He then moves on to tell me about an incident that he could obviously access directly.)*** *Like, if the father has a drinking problem, the kids might say: Mum, can't* ***you*** *drive us to training today? That's a pretty clear message that they won't ask their father…*

This informant adopted mother-oriented positioning to patients' fatherhood during much of the interview. He approached the fatherhood issue via the child, with an ideology that warns of the dangers of damaging children. By requesting a specific story about the wellness of patients' children, I was asking him to break with the way he habitually organized his way of thinking. In order to answer me, he would have to defy his own professional ways of regarding children, together with the ideology proposed by that clinic's treatment model. It proved that by telling a few story lines about a specific incident – where he may even have had specific people in mind – he was more easily able to access the exception rather than the stereotype.[32] At the same time, discourse changed to more personal forms of talk.
In sum, narrating small tales about specific children enabled informants to focus less on problem-oriented aspects of the professional parenting story and more on personal aspects which highlighted knowledges about wellness.

4.12 The contemporary fatherhood story

In this section I present findings which describe the fathers with alcohol problems: here I am particularly interested in examining how they are being portrayed as gendered beings in their fatherhood practices. Most informants seemed to take for granted the idea that the ideals of contemporary fatherhood story as presented on page 54 in this report were the preferred norm for society at large. With these ideals as their preferred norm, they were collaborating with patients to negotiate new meanings about fatherhood and the drinking of alcohol.

[32] Theory and practice from the field of narrative therapy supports the idea that the "storying" of experience enables people to negotiate preferred identities (Freedman & Combs 1996; White 2000).

I explained in Part One that there was little harmony in findings with regard to gender-related issues. The analysis of informants' discourse about fathers as gendered beings seems to show the same tendency. For example, informants indicated that appropriate fatherhood could be anything along a time axis of "*not trying to make up for lost time by smothering the child with unwanted attention*" – a quote from my interview with one of the male informants who had plenty of personal experience, to *"spending (more) quality time together (with children)"* – a quote from an interview with one of the women whose professional experience was extensive. Some of the discourse being employed was of a categorical nature: it seemed that informants were very sure of their views. At other times it seemed there was room for negotiating with patients as to how fatherhood could be interpreted and practiced.

Patients as men and fathers in role conflict: All my informants portrayed patients who were fathers as struggling to fulfil the many conflicting expectations to Norwegian men with children. There was frequent use of "role conflict" discourse. Talk of this kind is based on a social theory that men and women behave differently in social situations and take different roles, due to expectations that society imposes on them. Role conflict refers to situations where a person is expected to play two incompatible roles. Role theory is a traditional way of describing how ideals of masculinity – and femininity – function in society and is not so well adapted to illustrating fluidity when interpreting what is gender appropriate behaviour in a rapidly changing society. Nevertheless, the analysis showed that informants were increasingly aware of gender issues in their work with men. Anne was one of the informants who especially mentioned the challenges her patients encountered as men. Her clinic was making adjustments in order to better help male patients adapt to changing concepts of masculinity in society at large. She was well informed about current research on fatherhood issues, and was especially concerned about the difficulties fathers with alcohol problems were having in "mastering their roles" as men. She pointed out that patients were often led to believe that they were not living up to expectations that *any* "normal" father should be able to fulfil, namely taking active responsibility for his child. In her opinion, this was harsh judgement, since research on families has consistently shown that active fatherhood and shared parenting is not in fact the dominant practice among Norwegian men at large (c.f. page 10 in this report). Ann felt that therapists needed to be sensitive to the newer, conflicting demands being made on male patients with alcohol problems:

> *A: It's a bit in the starting phase – seeing these men more as men rather than as patients – because for the last thirty years we've been to a great degree just thinking*

about them as patients. Now we are much more conscious of thinking about them as men, and then of course as fathers and employees and brothers and so on.[...] And all these roles, they crash completely! Even without having an addiction problem, men are the losing party in child custody cases. The position of these men (referring to fathers with alcohol problem) is even more shaky, they have lost all power and are really vulnerable.

Current research supports Anne's comment about the men's powerlessness and vulnerability. The largest group of men who seek treatment for alcohol problems are 40-50 years old, divorced, without work and are homeless (Fekjær 2004). All these factors contribute to lowering their social status. The loss of work and separation from family members also effectively blocks their access to those arenas which – *according to ideals of contemporary fatherhood* – are the greatest sources of meaning and identity. Some fathers are even unable to maintain visiting arrangements for their children, because they are homeless. All the above implies that they have become highly un-masculine – in their own view and in the eyes of family and society at large.

Negotiating stories of gender-appropriate fatherhood practices: In the section that follows I will explore lines from two short stories told to me by male informants, about fathers who changed while they were in therapy. These are examples of moral stories which communicate hope and "happy endings". I am especially interested in exploring what kind of hope they communicate with respect to fulfilling the ideals of contemporary fatherhood. I have regarded the "before" portrayals of fathers as implicitly exemplifying what was thought to be un-masculine, inappropriate fatherhood as measured in relation to the ideals proposed in the contemporary fatherhood story. Following the same train of thought, I see the "after" descriptions as implicitly illustrating what is considered to be appropriate fatherhood, when measured against the "new" ideals of (masculine) contemporary fatherhood. On this basis, I examine how implicit ideas of what is masculine or un-masculine influence the ways in which male patients are choosing to do their fatherhood.

The first example I give is a little story told to me by an informant who did not underline his expertise. He had approached the issue of fatherhood from an equality-oriented point of view, working directly via the father,[33] using democratic principles such as the valuing of

[33] Here I am referring to concepts I proposed for the purpose of this research in the Content analysis (c.f. pp 41-43 in this report).

personal choice and the practicing of non-coercion as his means to therapeutic ends. The starting point for the story was a situation where the public and the private myth about my informant's patient had defined him as a bad father. The mother had taken action so that the child's father had lost visiting rights to his child. The father felt victimized because he had been steered by the choices of others, particularly the mother. During the long process of therapy, he came to feel that he had taken control over his own choices and he decided to change of his own accord. The idea of "taking responsibility" for his child had become so appealing that he was willing to discipline his self and stop drinking.

> *D: **(Describing a father before change)** He came more as a victim who had been stopped (by the mother) from seeing his child because of alcohol [...] ...In a way she had "passed judgement" on him [...] And we talked about this a lot.*
>
> *D: **(Describing the same father after change)** Then there was (gradually) a change whereby he in a way dismissed the whole debate and thought: "I have to do these things not for her sake, but for my own sake, and for the sake of my son. You see, there was a difference between doing it for her sake and doing it for his son. Doing it for his son was more legitimate. You know, taking responsibility for the child…he could talk about that with pride.[...]*
>
> *H: What can you tell me that you think you did that contributed to the change and that I can pass on to readers of this research?*
>
> *D: About the same as what I do in all my cases: I gave him feedback about all the good qualities he had despite the alcohol problems. [...]And he had in fact taken responsibility and made positive changes (with regard to the alcohol) [...] You see, these men get really sensitive when they start treatment: they more or less expect to be damned. And if they notice that doesn't happen, that in itself has a positive effect.*[34]

The dominant discourse throughout the telling of this story was collaborative and wellness-orientated. This male informant also took the opportunity to convey a moral tale of hope: wellness talk helps motivate fathers to take more active responsibility for their children.

[34] In a newly published article on the value acknowledgement has for well-being, family therapists Tomm & Govier wrote (2007: 149): "*One of the most therapeutic effects in our activity as therapists is to implicitly convey the kind of acknowledgements that are missing in the lives of our clients*".

The second small story below tells of a father who has been “smothering” his child with too much love and prevented it from developing its motor skills. During treatment, the father learns to recognize “psychological stages of development” in children. This helps him to relax more about his child and give it greater physical freedom:

> *O: **(Describing a father before he changed)** He smothered the child with his caring in the sense that he never let it out of his sight. There he was, all the time, making sure everything was safe, steering much of the play, making sure the child didn’t hurt itself, laying down together with the child…*
>
> *O: **(Describing the same father after change)** In a very noticeable way, we saw a father who to a much greater degree was able to adjust for his child’s developmental process. He could see that his child had stages of development, that he had a physically active child. If you asked him what his child was like, he could answer that well: his son was very physically testing and had good motor skills. (The child) liked climbing trees. But then again - if you climb trees - you might fall down.*

Discourse in this second story starts on a very personal note. However in the “after change” description my informant’s talk *destabilizes* and reverts to predominantly “psy” discourse. I have interpreted this on two levels. The interpretation should be taken at face value, since we cannot tell from the story whether the informant would have evaluated a mother’s behaviour in the same way. Nor can we know if the father would have been judged differently if the informant had been a woman. The explicit meanings expressed by my informant tell me what he felt this specific patient was doing wrong. If I as a listener also step up onto a more general level and allow for the play of cultural and gender-sensitized forces, then what I am hearing being described is my male informant’s interpretation of gender-inappropriate love on the part of any father. In the same way, I have interpreted the descriptions of the father after change as more than just an account of approved changes made by this specific father. Seen on a more general level, I find I am learning about what my male informant believes is a more gender-appropriate way for men to love their children. The fact that this father seems to be expected to present a strong face (as a man) could at first glance be viewed as typical of traditional ways of understanding masculinity. On the other hand, this story also illustrates – implicitly – a new way of understanding masculinity in fathers. This man had gained a type of competence about his child previously unheard of for the average man: he could apply his knowledges in ways that are approved of in the story of professional parenting. When these

knowledges became available to him in his daily life practices with the child, it was seen as a demonstration of appropriate child care on the part of the father.

Child psychologist and feminist researcher Hanne Haavind has recently pointed out that traditional theories of psychology "*usually support the continuation of traditional understandings of gender roles in the family"* (Haavind 2006: 684, my translation). Yet in this small tale of change, beliefs about professional parenting and ideals of contemporary fatherhood seem to blend and blur in the mind of my informant. In this way he represents those professionals who are flaunting such traditional ideas and setting new trends as to what is an appropriate, masculine way of doing fatherhood. The contrast between, on the one hand, my informant as a pioneer of new social ideology, and on the other hand, his patient who is a straggler in the game, is likely to have been large. That contrast may have led to unintentional consequences, although we do not learn from the story what these might have been.

When collaborative discourse dominated interviews: As I have shown in the Content Analysis in Part One, there were two informants who tended to think differently about my research issues, when compared with the majority of informants. These were the same two persons who had approached the fatherhood issue via the father directly. Findings suggest that both tended to view fathers as being somewhat discursively oppressed by the dominating story about their inadequacies. Neither of these informants mentioned their own professional expertise, but tended rather to focus on their patient's competence. They seemed to predominantly be applying a collaborative discourse when doing therapy with fathers, emphasizing the importance of patients' views and playing down the importance of their own opinions. [35]
In the example below, my informant indicates that she prefers to seek ways of enhancing her patient's own knowledges so that he can choose solutions which fit with his unique life situation. She seems to be prepared to negotiate alternative ways for her patient to understand fatherhood. – and she wants to hear his views. She has not ranked the father's competence with children below her own, or that of the mother or even child care authorities. However, by questioning how the patient believes fatherhood should be done, what is taken for granted has become an issue for open debate in therapy:

[35] Feminist family therapist Hare Mustin points out (1994) that structural inequalities between therapists and their patients often tend to strengthen the dominating stories about patients and steer what is being said in the therapeutic conversation. In order to counteract the discursive effect of these dominant stories, she suggests that therapists develop reflexive awareness and seek alternative meanings to the issues being discussed.

*V: **(Referring to ways of approaching fatherhood)** I think I try to help them find out things for themselves, and see how that fits into their lives. [...] I believe that what they (the fathers) think is more important than what I think. You know, when they themselves start wondering "How should I do this? Should I go on doing what I have always done before, or are there alternatives?" then they become more expansive in the way they think.*

The discourse illustrated in the example above is typical for therapists who work with groups; it proves also that this informant often works with groups, and that group approaches to treatment are valued at her clinic. Promoting patient "voice" and patient "choice" is also generally becoming more important in treatment now than it has been previously. National legal and socio-political trends in the field of specialized medicine[36] since the turn of the 20th century [37] encourage all health workers today – including therapists – to make adjustments for the fact that patient satisfaction is increasingly important.

Neither of these two informants were family therapists, yet their way of speaking is typical of social constructionist discourse on therapy, especially social constructionist talk in family therapy. Family thinking was an important focus at the clinics where these two informants were employed. That was evident in Petter's "talk":

*P: (**referring to solution-focused family therapy theory**) I find this way of thinking about families helps me, because I (as a therapist) am not so important. I'm more like a catalyst in my work: it's not my responsibility to "fix" this man. [...], or "save" this family. [...] And then I relax a lot more in my role.*

Collaborative discourse is often sourced in the work and writings of a discursive trend-setter in social constructionist family therapy theory – Harlene Anderson (e.g. in 1997 and 2005). She maintained that a therapist should adopt a tentative posture to "truth" and rather use her expertise to be "*a creator and facilitator of dialogic space and process*" (1997: 95). These ideas have been further pursued by therapists who are particularly interested in discursive aspects of talk – such as Peter Rober (e.g. in 1994 and 2004) or Strong & Paré (2004).

[36] Now responsible for all treatment for substance abuse.

[37] The new Act on rights for patients passed in 1999 generally strengthened patients' rights to feel they "owned" solutions suggested to them in treatment. At about the same time, the market principle was introduced to the health sector in Norway. People who seek treatment for alcohol problems can now choose between several clinics which compete to offer treatment for substance abuse. This means that therapists and clinics alike are constantly being evaluated with regard to patient satisfaction.

4.13 Conclusions from Part Two

The discourse analysis showed that two collective cultural stories seemed to be operating on a meta-level. I identified these stories as the story of professional parenting – which represents the cultural stereotyped belief for how parenting should be *understood*, and the story of contemporary fatherhood – which represents the cultural stereotyped ideal for how fatherhood should be *practiced*. Informants approached the issue of their patients' fatherhood with discursive allegiance to beliefs and ideals proposed in these stories. Discursive allegiance was an indication of *how therapists were positioning the selves of others*.

It was concepts associated with professionalism which enjoyed discursive hegemony in the story of professional parenting. When informants spoke in *general* terms, they usually displayed structural understandings of what was "true" about fathers and children, replicating knowledges and descriptions categorized within the field of psychology and commonly referred to as "psy" discourse. Those who addressed fatherhood via the child tended to make frequent use of risk assessment discourse and much of their talk focused on problems. Of these, the man who had predominantly used personal knowledges differed in the sense that he employed neither psy discourse nor risk assessment discourse. Nevertheless, his talk also focused on problems. In sum, beliefs which dominated in story lines on professional parenting tended to continue nourishing the type of discourse which gave data on problematic aspects about fathers with alcohol problems. Talk about the father's children emphasized their lack of self-agency and the risks to which they were being exposed and it proved difficult to learn more about what could protect and help fathers and their children. At the same time, the use of such discourses was furthering traditional understandings of the collective cultural story of professional parenting.

However, even in these interviews there were moments when informants seemed to rebel against discourse which had dominated up to that point and expressed meanings which communicated hope for all parties concerned. There was also a small minority of informants who hardly mentioned risk assessment and who spoke little about problems. It proved that especially when recounting small, *specific* episodes around children, informants adjusted their talk. Professional discourse was set aside in favour of talk of a more personal nature. At these times there was a greater focus on wellness. Children were portrayed as autonomous, subjects who exercised choice and acted with self-agency.

The analysis of discourse about *fathers as gendered beings* indicated that informants tended to have strong views on the subject and these views varied from person to person. Nevertheless, the majority of informants seemed to presume that values proposed in the ideals of contemporary fatherhood story were the preferred values of society. Informants used role conflict discourse to explain how patients who were fathers struggled to meet social expectations implicit in those ideals. Some thought their own views were less important and preferred to emphasize the importance of patients' views and the value of patients' choices. These informants used discourse that could be characterized as collaborative and wellness-oriented. Analysis of two moral tales of changed fatherhood showed that one informant believed that fathers find it easier to *want to* take more responsibility for their children if the therapy focused on wellness. A second informant seemed to believe that when fathers can apply knowledges that are associated with the professional parenting story in his fathering practises, then ideals of contemporary fatherhood are being fulfilled. I see this second story as an example of a new trend where therapists integrate beliefs proposed in the story of professional parenting with ideals preferred in the story of contemporary fatherhood. Interpretations of this kind do not only challenge traditional theory from the field of psychology, proposing how fathers in general should behave. They also challenge each individual patient, whose daily fathering practices are being measured against the ideals of the cultural elite.

5 A researcher re-positions her self

I started this research project in search of knowledges which could add to practice skills in an area where little work had been done: I wanted to learn more about how therapists could address fatherhood within a treatment context for alcohol problems. I particularly had in mind knowledges which could stimulate reflexive processes and add to what we know about wellness and win-win situations for fathers and their families. My quest led me to a group of persons who all worked actively with fatherhood and who can therefore be seen as key holders of knowledges in that respect. I learned that – like me – these informants found fatherhood issues to be complex, multifaceted and difficult to address. The research data is rich in findings with regard to knowledges which already circulate in the dominating discourse about parenting for people with alcohol problems. However, I chose to give a disproportionate amount of emphasis to those findings which seemed most beneficial with regard to the main purposes of the research. In closing this report, it seems timely to return to my starting point and reflect on what I have learned. Here I am particularly concerned with ways in which the research has challenged or changed my own understandings. How would I now re-position my research question and how will I in the future position my self as a practitioner?

Perhaps those questions are best answered indirectly. Doing the analysis illustrated in practice what Linley & Joseph point out with regard to practising positive psychology in clinical work (2004: 330): that talk about hope and wellness requires using a different type of language to that required when talking about problems or, for that matter, talking about solutions. In this research project, talk about hope and wellness required informants to focus more on personal and less on professional aspects of the issues at hand. And so it has happened that this report has become a story about personal stories positioning fatherhood in therapy. Stories recounted by informants have convinced me that some fathers who struggle can and do find ways of changing their fatherhood practices during therapy. In the same spirit, stories about children have confirmed that some children manage some times to demonstrate wellness and self agency. Finally – and perhaps most importantly for the purposes of this research – it proves that stories are of particular value to *therapists* who work with positioning fatherhood in treatment contexts where the prognosis for patients is not always good.

My findings are backed by a variety of clinicians working with socio-cultural and social constructionist approaches to therapy. White has emphasized the "life-shaping effect" the telling of stories has for how people interpret their own identities (2000: 68). He has also pointed out that this is an important reason to why the AA model is helpful for so many people (2000: 31). Lowe proposes (1990) that family therapists in particular are important narrators and creators of cultural, social and psychological tales. It becomes pertinent for such therapists to then ask themselves what stories they develop together with their patients. In his book about the socio-cultural framework for children's development, cultural psychologist Hundeide argues that by interpreting and describing children's care-givers as having certain *characteristics*, we tend to create self-fulfilling prophecies (Hundeide 2003: 34). Bearing this in mind, it seems appropriate to follow the advice of Postman, who suggested that the purpose of family therapy should be to put forward *"metaphors, images and ideas that can help people live with some measure of understanding and dignity"* (Postman 1989). Judging from my findings, it seems that images of such a kind are more readily available from our repertoire of personal, specific experience rather than the general, professional discourse. Family therapist Weingarten has written about the healing power of "witnessing", or "giving a voice" to painful experiences with the help of personal stories (2000). She believes that hope is a relational concept and argues that therapists should "do" hope together with their patients in therapy. When I link her idea to my research findings, it would seem that informants practiced "doing" hope more in relation to the selves of others than in relation to their own selves. Only the most experienced understood how meaningful hope was for therapists who work with substance abuse. I believe it would be helpful if fathers who have succeeded in changing could "do" hope together with their therapists, by telling their personal stories of how treatment helped. If I were now to re-formulate my main research question, I would be more in search of stories and perhaps more concerned with the needs of therapists. The revised version would perhaps be: What stories do therapists tell about their patients' fatherhood, when the main issue for therapy is his problems with alcohol? And what stories do fathers tell therapists at the end of the treatment process, with regard to their own process of change? I believe the answers to this would provide even richer data on win-win situations for fathers and their families.

My own process has also been one of change. Reading more and new secondary literature has driven me onto new ground. The studies of the politics of parenting in Norway enlightened me as to how powerful discursive forces shaping the culture of fatherhood in Norway have

become: these are far beyond the control of individual fathers or their families. Ellingsæter points out (2006: 132) that the "*childcare gap*" in Norway is huge – a factor which is the cause of much parental frustration. Understanding the stress of people's lives as part of general and political rather than individual and personal phenomena may offer less oppressive ways of interpreting patients' difficulties. Exploring literature on fatherhood and childhood from a social constructionist perspective has also enhanced my state of awareness. My introduction to gender research on men has prodded me into examining and reconsidering my own pre-assumptions about fathers as gendered beings in my practical work with patients. At the same time, new "blind spots" are surely being created. Whether fathers are to be seen as victims of mothers' harassment, failing partners to mothers' expectations of contemporary parenting or successful examples of the "new" masculinity: all seem to be temporary discourses in a world which at any time may require new constructions or concepts. The challenges are even greater with regard to these fathers' children. Dencik contends that "*our perspectives on children often have a chronocentric starting point – both in upbringing and research. In the process of socialization one tends to prepare them for a society they will never be living in – simply because those cultural and living patterns will no longer exist when the children have grown up into the post-modern society which they are **in fact** delegated to live in."* For that reason, Dencik argues*, "there is a tendency to look at children in child research with the use of theories where the basis for reality is melting away.*" (1999: 41, my translation)

For my part, the findings on therapist positioning have both challenged and helped me to appreciate the value of staying "uncertain" about what appropriate fatherhood practice is. These findings seem to suggest that when working with fatherhood, therapists can also more readily move from the sphere of what is personal and specific for their patients over to what is personal and specific with regard to their own selves as therapists.[38] Ideas of this kind appear to be incompatible with certain cultures of professionalism and could be the cause of intuitive discomfort for some. Yet this very discomfort could also help to push the therapeutic relationship in an egalitarian direction. I believe that would benefit fathers in therapy.

---

[38] Whites' adaptation of the reflecting team approach to therapy – where therapists take a de-centred position and become "outsider witnesses" to stories of peoples' lives (1997: 101, 2000: 67) – is based on the idea of using therapists' personal and specific knowledges to the benefit of their patients. However White himself points out that the discursive effects of therapy on the therapist's own person is a theme which has been little explored (1997: 124). In Norway, professor and family therapist Per Jensen is presently researching patterns which connect therapists' personal and private lives to their clinical practice.

6 References and sources

Aarseth, Helene. (1994) *Mellom likegjøring og det andre: Mannen som innfallsport til forståelse av det kvinnelige.* Thesis for a master's degree in sociology.

Aarseth, Helene. (2007) Nye fedre 1990 – 2005: Fra fascinasjon og romantisering til kjønnsnøytrale livsstilsprosjekter i familien. In: *Män i rörelse: Jäställdhet, förandring och social innovation i Norden*. Gidlunds Forlag, 118-145

Allen, JoAnn & Laird, Joan. (1991) Men and Story: Constructing New Narratives in Therapy. In: Michele Bograd (Ed)*, Feminist Approaches for Men in Family Therapy.* New York, Harrington Park Press, 75-100

Andersen, Arnfinn J. (2003) *Menn skaper rom for forelderskap og familie. Faderskapets betingelser i en heteronormativ kultur.* PhD Thesis NTNU 2003.

Andersen, Tom. (1988) Forandring kjenner sin egen tid og sine egne veier. In: Håkon Hårtveit, Astrid Johnsen & Solrun Tømmerås. (Eds), *Gjennom speilet og tilbake. Refleksjoner over systemer i behandling, behandlingssystemer og systemisk behandling*. Tano, 69-84

Anderson, Harlene. (1993) On a Roller Coaster: A collaborative Language Systems Approach to Therapy. In: Steven Friedman (Ed), *The New Language of Change. Constructive Collaboration in Psychotherapy.* New York. Guildford Press, 323-344

Anderson, Harlene. (1997) *Conversation, Language and Possibilities. A Postmodern Approach to Therapy*. Basic Books.

Anderson, Harlene. (2005) Myths about "Not-Knowing". In *Family Process.* Vol. 44, No. 4, 495-504

Asay, Ted P. & Lambert, Michael J.: (1999) The empirical case for the common factors in Therapy: Quantitative findings. In: Mark A. Hubble, Barry L. Duncan and Scott D. Millar. (Eds), *The heart and soul of change: What works in therapy.* American Psychological Association Press, Washington DC, 23-56

Babor, Thomas. et al. (2003) *Alcohol: No ordinary commodity. Research and public policy.* Oxford University Press.

Barnard, Marina. (2005) Discomforting research: colliding moralities and looking for ”truth” in a study of parental drug problems. In: *Sociology of Health and Illness* Vol. 27. No. 1, 1-19

Barnes, Grace M. & Augustino, Diane K. (1987) *Alcohol and the Family. A comprehensive Bibliography*. New York. Greenwood Press.

Baruch, G. (1982) Moral tales. Interviewing parents of congenitally ill children. Unpublished PhD thesis, University of London. In: David Silverman, (2001): *Interpreting Qualitative Data. Methods for Analysing Talk, Text and Interaction.* 2nd Edition, London. Sage Publications.

Berg, Insoo Kim. (1992) *Working With the Problem Drinker. A solution-Focused approach.* Norton & Company.

Berg, Insoo Kim & de Shazer, Steve. (1993) Making Numbers Talk: Language in Therapy. In: Steven Friedman (Ed), *The New Language of Change. Constructive Collaboration in Psychotherapy.* New York: Guildford Press, 5-24

Berg, John E. (1994) *Ressursorientert (re)habilitering av rusmiddelmisbrukere*. Universitetsforlaget.

Bergman, Helena & Hobson, Barbara. (2002) Compulsory Fatherhood: the coding of fatherhood in the Swedish welfare state. In: Barbara Hobson (Ed) *Making Men into Fathers. Men, Masculinities and the Social Politics of Fatherhood.* Cambridge University Press.

Bird, Jonella (With Conversational Partner Catherine Cook). (2004) Narrating the Difference. In: Tom Strong & David Paré (Eds), *Futhering Talk. Advances in the Discursive Therapies*. New York, Kluwer Academic/Plenum Publishers, 53-72

Brandth, Berit & Kvande, Elin. (2003) *Fleksible fedre: Maskulinitet, arbeid, velferdsstat*. Oslo. Universitetsforlaget.

Brown, Stephanie. (1988) *Treating Adult Children of Alcoholics. A developmental perspective*. Wiley & Sons, New York.

Brown, Janice M. (2001) The Effectiveness of Treatment. In: Nick Heather, Timothy J. Peters & Tim Stockwell (Eds), *International Handbook of Alcohol Dependence and Problems*. Wiley & Sons, 497-508

Butler, Judith. (1990). *Gender Trouble.* New York: Routledge.

Butler, Judith. (2004). *Undoing Gender.* New York: Routledge.

Carr, Alan. (1998) The inclusion of fathers in family therapy: A research based perspective. In: *Contemporary Family Therapy*. Vol. 20, No.3, September 1998, 371-383

Chambron, Adrienne. (1999) Foucault's Approach: Making the Familiar Visible. In: Chambron et al. (Eds), *Reading Foucault for Social Work*. Columbia University Press, 51-82

Chang, Jeff & Phillips, Michele. (1993) Michael White and Steve de Shazer: New Directions in Family Therapy. In: Stephen Gilligan and Reese Price (Eds), *Therapeutic Conversations*. New York, Norton & Company, 95-111

Davies, Bronwyn & Harré, Rom. (1990) Positioning: The discursive production of selves. In: *Journal for the Theory of Social Behaviour.* Vol. No. 20, 43-63

Dencik, Lars. (1999) Fremtidens born – om postmodernisering og socialisering. In: Lars Dencik & Per Schultz Jørgensen (Eds), *Børn og familie i det postmoderne samfund.* Hans Reitzels Forlag, 19-44

Diamond, Jonathan. (2000) *Narrative means to sober ends: Treating addiction and its aftermath*. New York, Guildford Press.

Doherty, William, Edward F. Kouneski & Martha F. Erickson. (1998) Responsible Fathering: An Overview and Conceptual Framework. In: *Journal of Marriage and the Family.* Vol. 60, No.2, 277-292

Duckert, Fanny. (2003) *Alcohol og Livvstil. Strategier for moderasjon.* Seriti Forlag.

Ekenstam, Claes. (2006) Mãn, manlighet och omanlighet I historien. In: Jørgen Lorentzen & Claes Ekenstam (Eds), *Mãn i Norden. Manlighet och modernitet 1840-1940*. Gidlunds Förlag, 13-47

Ellingsæter, Anne Lise & Leira, Arnlaug. (Eds) (2004) *Velferdsstaten og familien. Utfordringer og dilemmaer*. Gyldendal Akademisk.

Ellingsæter, Anne Lise. (2006) The Norwegian childcare regime and its paradoxes. In: Anne Lise Ellingsæter & Arnlaug Leira (Eds) *Politicising parenthood in Scandinavia. Gender relations in welfare states.* Policy Press, Bristol.

Epstein, Elisabeth. (2001) Classification of Alcohol-Related Problems and Dependence. In: Nick Heather, Timothy J. Peters & Tim Stockwell (Eds) *International Handbook of Alcohol Dependence and Problems*. Wiley & Sons, 47-70

Fekjær, Hans Olav. (1996) Hvor mange alkoholikere har vi? Alkoholproblemer i Oslo. In: *Norsk Epidemiologi* 1996, Vol. No. 6. No. 1., 23-28

Fekjær, Hans Olav. (2004) *Rus. Bruk, motiver, skader, behandling, forebygging, historikk.* Gyldendal Akademisk.

Fjeldstad, Tor. (2005) Samtaler med fedre – Hvilken betydning har kjønn for fedres møte med psykisk helsevern for barn og unge? In: *Fokus på familien* 2005 No. 2, 84-100

Fontana, Andrea. & Frey, James H. (2000) The interview: From Structured Questions to Negotiated Text. In: Norman K. Denzin & Yvonna S. Lincoln (Eds), *Handbook of Qualitative Research.* Sage Publications, 645-672

Foucault, Michel. (1977) What is an author? In: D.F. Bouchard.: D.F. Bouchard & Sherry Simon, (Eds) (translated from page 199). Language, countermemory, practice: Selected essays and interviews.: 115-138, Ithaca, New York, Cornell University Press. In: Adrienne Chambron (1999) Foucault's Approach: Making the Familiar Visible. In: Adrienne Chambron et al. (Eds) (page 57) *Reading Foucault for Social Work.* Columbia University Press.

Foucault, Michel. (1984) Truth and Power. (From Power/Knowledge): An interview with Michel Foucault conducted by Alessandro Fontana and Pasquale Pasquino. In: Paul Rabinow (Ed), *The Foucault Reader*. New York, Pantheon Books.

Fraser, Nancy. (1989) *Unruly practices: Power, discourse, and gender in contemporary social theory*. University of Minnesota Press.

Freedman, Jill & Combs, Gene. (1996) *Narrative Therapy. The Social Construction of Preferred Realities*. New York, Norton & Company.

Frønes, Ivar. (2001) *Handling, kultur og mening.* Fagbokforlaget.

Gergen, Kenneth J. & Kaye, John. (1992) Beyond Narrative in the Negotiation of Therapeutic Meaning. In: Sheila McNamee & Kenneth J. Gergen (Eds), *Therapy as a Social Construction*. Sage Publications, 166-185

Gergen, Kenneth J. & Kaye, John. (1994) *Realities and relationships: Soundings in social construction.* Cambridge MA. Harvard University Press.

Gullvåg Holter, Øystein. (1989) *Menn*. Oslo. Aschehoug & Co.

Gullvåg Holter, Øystein & Aarseth, Helene. (1993) *Menns livssammenheng.* Ad Notam Gyldendahl, Oslo.

Gullvåg Holter, Øystein. (2003a) *Can men do it? Men and gender equality – The Nordic Experience.* København, Nordic Council of Ministers, Serie Tema Nord: No. 510, 2003

Gullvåg Holter, Øystein. (2003b) Social Theories for Researching Men and Masculinities: Direct Gender Hierarchy and Structural Inequality. In: Michael S. Kimmel & Jeff Hearn & R.W. Connell (Eds), (pages 15-34) *Handbook of studies on men and masculinities,* Sage Publications.

Gullvåg Holter, Øystein. (Ed) (2007a) *Män i rörelse. Jämställhet, förändring och social innovation i Norden.* Gidlunds Förlag.

Gullvåg Holter, Øystein. (2007b) Sosial innovasjon, velferd og ny maskulinitet. In: Øystein Gullvåg Holter (Ed), *Män i rörelse. Jämställhet, förändring och social innovation i Norden.* Gidlunds Förlag, 225-271

Haaland, Thomas, Clausen, Sten-Erik & Schei, Berit. (2005) Vold i parforhold – ulike perspektiver. Resultater fra den første landsdekkende undersøkelse i Norge. In: *Kommentarutgave til NIBR-rapport 12.05.05: 2005: 3*

Haavind, Hanne. (Ed), (2000) *Kjønn som fortolkende metode. Metodiske muligheter i kvalitative forskning*. Gyldendahl Akademisk.

Haavind, Hanne. (2006) Midt i tredje akt? Fedres deltagelse i det omsorgsfulle foreldreskap. In: *Tidskrift for Norsk Psykologforening.* Vol. No. 43, 683-693

Hammersley, Martyn. (2000) *Taking sides in social research*. *Essays on Partisanship and bias*. Routledge, London.

Hansen, Frid. (1990) Rusmisbruk i et familieperspektiv. In: *Tidsskrift for Norsk Psykologforening* Vol. 27, No.10, 737-746

Hansen, Frid. (1992) Fra avmakt til handlekraft. In: *Tidsskrift for Norsk Psykologforening***,** Vol. 29, No. 7, 599-610

Hare-Mustin, Rachel. (1994) Discourses in the Mirrored Room: A Postmodern Analysis of Therapy. In: *Family Process* Vol. 33 No. 1, 19 -35

Heather, Nick (Ed) (2001) PART V: TREATMENT AND RECOVERY. In: Nick Heather, Timothy J. Peters & Tim Stockwell. (Eds), *International Handbook of Alcohol Dependence and Problems*. Wiley & Sons.

Helmen Borge, Anne Inger. (2003) *Resiliens. Risiko og sunn utvikling.* Gyldendal Norsk Forlag.

Hennum, Nicole. (2002) *Kjærlighetens og autoritetens kulturelle koder.* Norsk institutt for forskning om oppvekst, velferd og aldring (NOVA): Rapport 19 / 02.

Hester, Reid K. & William R. Miller. (1989) *Handbook of Alcohol Treatment Approaches*. New York. Pergamon Press.

Hoffman, Lynn. (1990) Constructing Realities. An Art of Lenses. In: *Family Process,* Vol. No.29, 1-12.

Hoffman, Lynn. (1992) A Reflexive Stance for Family Therapy. In: Sheila McNamee & Kenneth J. Gergen (Eds), *Therapy as Social Construction*. Sage Publications, 7-24

Holstein, James A. & Gubrium, Jaber F. (2004) The active interview. In: David Silverman. (Ed), *Qualitative Research. Theory, Method and Practice.* London. Sage Publications, 140-161

Hundeide, Karsten. (2003) *Barns Livsverden. Sosiokulturelle rammer for barns utvikling.* Oslo. Cappelens Akademisk Forlag.

Institute of Medicine, Division of Mental Health and Behavioural Medicine. (1990) *Broadening the Base of Treatment for Alcohol Problems.* Washington. National Academy Press.

Juhnke, Gerald & Hagedorn, W. Bryce. (2006) *Counceling Addicted Families. An integrated Assessment and Treatment Model.* Routledge.

Kaufman, Pauline & Kaufman, Edward. (1979) *Family Therapy of Drug and Alcohol Abuse.* New York. Gardner Press.

Killen, Kari. (1991) *Sveket. Omsorgssvikt er alles ansvar*. Kommuneforlaget.

Klingemann, Harald K.H. (2001) Natural Recovery from Alcohol Problems. In: Nick Heather, Timothy J. Peters & Tim Stockwell (Eds), *International Handbook of Alcohol Dependence and Problems*. Wiley & Sons, 649-662

Lincoln, Yvonna S. & Guba, Egon G. (2000) Paradigmatic controversies, contradictions, and emerging confluences. In: Norman K. Denzin & Yvonna S. Lincoln (Eds), *Handbook of Qualitative research.* 2nd edition, Sage Publications, 163-188

Linley, P. Alex & Joseph, Stephen. (2004) *Positive Psychology in Practice.* Wiley and Sons.

Lorentzen, Jørgen. (2006a) Forskning på menn og maskuliniteter. In: Jørgen Lorentzen & Wenche Mühleisen. (Eds), *Kjønnsforskning. En grunnbok*. Universitetsforlaget 2006, 121-135

Lorentzen, Jørgen & Ekenstam, Claes. (Ed) (2006b) *Män i Norden. Manlighet och modernitet 1840-1940*. Gidlunds Förlag.

Lowe, Roger. (1990) Re-imagining family therapy: Choosing the metaphors we live by. In: *Australian & New Zealand Journal of Family Therapy* No. 11, 1-9

Lupton, Deborah & Barclay, Lesley. (1997) *Constructing Fatherhood. Discourses and Experiences.* Sage Publications.

Løkke, Per Are. (2000) *Farsrevolusjonen: Fedre og maskulinitet i en ny tid.* Oslo. Universitetsforlaget.

Mac an Ghaill, Màirtín & Haywood, Chris.: (2007) *Gender, culture and society. Contemporary femininities and masculinities.* Palgrave Macmillan.

Malterud, Kirsti. (2003) *Kvalitative Metoder i Medisinsk Forskning*. 2nd edition, Universitetsforlaget.

Miles, Mathew B. & Huberman, A. Michael. (1994) *Qualitative Data Analysis*. London. Sage Publications.

Moe, Vibeke. (2004) *A prospective, longitudinell study of children prenatally exposed to drugs.* PhD Thesis, Aline poliklinikk og spebarnssenter og Psykologi institutt, UiO.

Moore, David. (2001) The Anthropology of Drinking. In: Nick Heather, Timothy J. Peters & Tim Stockwell. (Eds), *International Handbook of Alcohol Dependence and Problems*. Wiley & Sons, 471-489

Noack, Turid. (2004) Familien i velferdsstaten: Fra støttespiller til trojansk hest? In: Anne Lise Ellingsæter & Arnlaug Leira. (Eds), *Velferdsstaten og familien: Utfordringer og dilemma.* Gyldendahl Akademisk, 39-66

NOU Norges offentlige utredninger. (2003: 4) *Forskning på rusmiddelfeltet. En oppsummering av kunnskap om effekt av tiltak*. Oslo. Statens forvaltningstjeneste Informasjonsforvaltning.

Oftung, Knut. (2000) Men and gender equalities in the nordic countries. In: Connell et al. (Eds), *Male roles, masculinities and violence. A culture of peace perspective*. UNESCO 2000.

Oftung, Knut. (2005) Mannen mellom myte og modernitet. In: *Tidsskrift for ungdomsforskning* No.1, 2005

Olesen, Virginia L. (2000) Feminism and qualitative research at and into the millennium. In: Norman K. Denzin & Yvonna S. Lincoln (Eds), *Handbook of Qualitative research.* 2nd edition. Sage Publications, 215-256

Parton, Nigel. (1999) Reconfiguring Child Welfare Practices: Risk, Advanced Liberalism and the Government of Freedom. In: Adrienne S. Chambron, Allan Irving & Laura Epstein. (Eds), *Reading Foucault for Social Work*. Columbia University Press.

Patton, Michael Quinn. (2002) *Qualitative Research and Evaluation Methods*. 3rd edition. Sage Publications.

Pedersen, Willy. (1998) *Bittersøtt. Ungdom / sosialisering / rusmidler*. Universitetsforlaget.

Peele, Stanton. (1985) *The Meaning of Addiction. Compulsive Experience and its Interpretation.* Lexington Books.

Postman, Niel. (1989) Conscientious objections: Stirring up trouble about language, technology and education. London, Heineman, (page 18). In: Peter Rober. The Therapist's Inner Conversation in Family Therapy Practice: Some Ideas About the Self of the Therapist, Therapeutic Impasse, and the Process of Reflection, (page 212). In: *Family Process,* Vol. 38, No. 2, 1999, 209-228

Regjeringens handlingsplan mot rusmiddelproblemer 2006-2008, Arbeids og sosialdepartementet. Oslo. Statens forvaltningstjeneste.

Roberts, Janine. (2005) Transparency and Self-Disclosure in Family Therapy: Dangers and Possibilities. In: *Family Process,* Vol. 44, No. 1, 45-61

Rober, Peter. (1999) The Therapist's Inner Conversation in Family Therapy Practice: Some Ideas About the Self of the Therapist, Therapeutic Impasse, and the Process of Reflection. In: *Family Process,* Vol. 38, No. 2, 209-227

Rober, Peter. (With Conversational Partners Glenn Larner and David Paré) (2004) The Client's Nonverbal Utterances, Creative Understanding & The Therapist's Inner Conversation. In: Tom Strong & David Paré (Eds) *Furthering Talk. Advances in the Discursive Therapies*. New York, Kluwer Academic/Plenum Publishers, 109-124

Robinson, Bryan E. (1989) *Working with Children of Alcoholics. The practitioner handbook*. Lexington Books.

Room, Robin. (2001) Governing images in public discourse about problematic drinking. In: Nick Heather, Timothy J. Peters & Tim Stockwell. (Eds), *International Handbook of Alcohol Dependence and Problems*. Wiley & Sons, 33-46

Schwandt, Thomas A. (2000) Three epistemological stances for qualitative enquiry. In: Norman K. Denzin & Yvonna S. Lincoln (Eds), *Handbook of Qualitative research.* 2nd edition, Sage Publications, 189-214

Schön, Donald A. (1983) *The Reflective Practitioner. How Professionals Think in Action.* Basic Books.

Schön, Donald A. (1987) *Educating the reflective practitioner.* Jossey-Bass.

Seligman, Martin.E. P & Czikszentmihalyi, Mihály. (2000) Positive psychology: an introduction. In: *American psychologist,* No. 55, 5-14

Silverman, David. (2001) *Interpreting Qualitative Data. Methods for Analysing Talk, Text and Interaction.* 2nd edition, London. Sage Publications.

Storm Mowatt Haugland, Bente.: (2004) *Fedres alkoholmisbruk – konsekvenser for familien og barna*. PhD Thesis, UiB.

Strong, Tom & Paré, David. (2004) Striving for Perspicuity: Talking our Way Forward. In: Tom Strong & David Paré. (Eds), *Furthering Talk. Advances in the Discursive Therapies*. New York, Kluwer Academic/Plenum Publishers, 1-14

Stubbs, Michael. (1983) *Discourse Analysis. The Sociolinguistic Analysis of Natural Language.* Oxford, Basil Blackwell

Sundfær, Aase. (1992) *Ung og lovende: barna til 31 mødre med rusproblemer i svangerskapet er blitt ungdommer: tredje gangs etterundersøkelse med fokus på utvikling og mestring i familien, skole og fritid.* Oslo kommune, Barne- og familieetaten og Rusmiddeldirektoratet.

Sundfær, Aase.: (2004) *Barna til 31 kvinner med rusproblemer er blitt 20 år.* Nydalen senter for barne- og ungdomspsykiatri.

Søndergaard, Dorte Marie. (2000) Destabiliserende diskursanalyse: veje ind i poststrukturalistisk inspirert empirisk forskning. In: Hanne Haavind (Ed), *Kjønn og fortolkende metode***.** Gyldendal Norsk Forlag, 60-104

Thagaard, Tove. (2003) Systematikk og innlevelse: en innføring i kvalitativ metode. 2nd edition, Fagbokforlaget.

Tjeder, David. (2006) Borgerlighetens sköra manlighet. In: Jørgen Lorentzen & Claes Ekenstam (Eds) *Män i Norden. Manlighet och modernitet 1840-1940*. Gidlunds Förlag, 48-76

Tomm, Karl & Govier, Trudy. (2007) Acknowledgement: its significance for reconciliation and well-being. In: Carmel Flaskas, Imelda McCarthy & Jim Sheehan (Eds), *Hope and Despair in Narrative and Family Therapy. Adversity, forgiveness and reconciliation.* London. Routledge.

Treadway, David C. (1989) *Working with Substance Abuse in the Family*. New York. Norten & Co.

Unger, Rhoda K. (1989) In: Mary Crawford & Margaret Gentry (Eds), *Sex, gender and epistemology in gender and thought: Psychological perspectives.* New York. Stringer-Verlog.

Waal, Helge & Duckert, Fanny. (Ed) (1996) *Behandling av rusproblemer – nytter det, og hva koster det? Metoder og muligheter i kostnad-nytteforskning*. Rusmiddeldirektoratet og Statens institutt for alkohol- og narkotikaforskning, Temaserie 1996, No. 2.

Weakland, John. (1993) Conversation – But What Kind? In: Stephen Gilligan & Reese Price. (Eds), *Therapeutic Conversations*. New York: Norton & Company, 136-145

Weingarten, Kathy. (2000) Witnessing, Wonder and Hope. In: *Family Process,* Vol. 39, No. 4., 389-402

White, Michael, & Epston, David: (1990) *Narrative Means to Therapeutic Ends.* New York. Norton and Company.

White, Michael. (1995) *Re-Authoring Lives: Interviews and Essays.* Adelaide, Australia. Dulwich Centre Publications.

White, Michael. (1997) *Narratives of therapists lives.* Adelaide, Australia. Dulwich Centre Publications.

White, Michael. (2000) *Reflections on Narrative Practice.* Adelaide, Australia. Dulwich Centre Publications.

Willig, Carla. (2001) *Introducing Qualitative Research in Psychology*: *Adventures in theory and method*. New York. Open University Press.

Windle, Michael & Searles, John S. (1990) (Ed): *Children of Alcoholics. Critical Perspectives*. New York. Guildford Press.

Appendice One: research guide

<table>
<tr><td colspan="2"><u>Main research question:</u>
What do therapists say about how they address the issue of their male patient's parenthood, seen in relation to the treatment for alcohol abuse?</td></tr>
<tr><td>RESEARCH THEME</td><td>RESEARCH QUESTIONS</td></tr>
<tr><td>One consequence of social constructionism is that therapists need to state where they stand / what they think (how they view reality)</td><td>Does the therapist come out into the open with her own points of view on their patients' parenthood?</td></tr>
<tr><td>This project has ideas:
- about reflexivity

- about discourses

- about power</td><td>Does the therapist change levels from macro to micro and vice versa, reflecting together with her patients?

Are there discourses about parenthood?

Are there discourses about child care?

Are there discourses about how people express their gender while parenting?

How about changes in how society thinks fatherhood, or child care or gender should be exercised? Is this taken into account?

What or who has power in these issues?</td></tr>
<tr><td>"Normal" fatherhood, seen in a dynamic perspective. Note any changes in what Norwegian society and Norwegian mothers and fathers expect from fathers.</td><td>Does "flaws and defects" model on alcohol abusing fatherhood get priority? How?

Does this "flaws and defects" model get challenged at any point? How?</td></tr>
<tr><td>Tracking decisive moments of change</td><td>Any practical tips to pass on regarding decision moments of change?</td></tr>
<tr><td>Resilience. Children can contribute to forming their parents' concept of what "good" parenthood is.</td><td>Do the therapists ever talk with their patients, or do their patients ever relate stories about how children can contribute to forming their parents' concept of what "good" parenthood is (White's mapping)?
Key word: resilience</td></tr>
</table>

<table>
<tr><th colspan="2"><u>Main research question:</u>
What do therapists say about how they address the issue of their male patients' parenthood, seen in relation to the treatment for alcohol abuse?</th></tr>
<tr><th>RESEARCH QUESTIONS</th><th>INTERVIEW QUESTIONS</th></tr>
<tr><td>Does the therapist change levels from macro to micro and vice versa, reflecting together with her patients?

Are there discourses about parenthood?

Are there discourses about child care?

Are there discourses about how people express their gender while parenting?

How about changes in how society thinks fatherhood, or child care or gender should be exercised? Is this taken into account?</td><td>I know that this treatment centre sometimes takes in male patients who are fathers. When you hear that a patient of yours is a father, how would you go about finding out more about this?
Follow up question: What kind of discussion would you be aiming for with this patient?

Key words: parenthood, fatherhood, child care, gender issues, changing society

How much emphasis would you give to discussing these issues in the light of general changes happening in society?</td></tr>
<tr><td>Does "flaws and defects" model on alcohol abusing fatherhood get priority? How?

Does this "flaws and defects" model get challenged at any point? How?

Does the therapist come out into the open with her own points of view on their patient's parenthood?</td><td>What do you think is important for therapists working in the system of alcohol treatment to bear in mind when they get to hear that their male patients have children?

How do you let patients know where you yourself stand with regard to their parenting role?</td></tr>
<tr><td>Any practical tips to pass on regarding decision moments of change?</td><td>Can you give me an example of any "parenting" change that you have noticed while you have been a therapist for one of your male patients who was a father?</td></tr>
<tr><td>Do the therapists ever talk with their patients, or do their patients ever relate stories about how children can contribute to forming their parent's concept of what "good" parenthood is (White's mapping)?
Key word: resilience</td><td>We know that some children tell their parents pretty clearly what kind of parenting they feel safe with. What experience do you have of that in your therapeutic practise?
Key word: resilience</td></tr>
</table>

Main research question: What do therapists say about how they address the issue of their male patients' parenthood, seen in relation to the treatment for alcohol abuse?	
WHAT THE INTERVIEWER SHOULD REMEMBER	**INTERVIEW QUESTIONS COMPLETE**
Introductory question: ***Follow up question:*** ***Key words: parenthood, fatherhood, child care, gender issues, changing society***	I know that this treatment centre sometimes takes male patients who are fathers. When you hear that a patient of yours is a father, how would you go about finding out more about this? What kind of discussion would you be aiming for with this patient? How much emphasis would you give to discussing these issues in the light of general changes happening in society?
Identify "flaws and defects" model or other model that could challenge this ***Therapist's point of view visible***	What do you think is important for therapists working in the system of alcohol treatment to bear in mind when they get to hear that their male patients have children? How do you let patients know where you yourself stand with regard to their parenting role?
Identify any significant moments of change	Can you give me an example of any "parenting" change that you have noticed while you have been a therapist for one of your male patients who was a father?
Key word: resilience	We know that some children tell their parents pretty clearly what kind of parenting they feel safe with. What experience do you have of that in your therapeutic practise?
Closing question:	What helps you to hold onto hope when you are doing therapy with this group of patients?

Appendice Two: letter of information to prospective informants

Forespørsel om å delta i intervju

Jeg er en Trinn C student ved Mastergradstudium i familieterapi og systemisk praksis ved Diakonhjemmet Høgskole, avdeling for etter- og videreutdanning, og holder nå på med det avsluttende forskningsprosjekt. Tittelen for prosjektet er "Forelderskap som tema i terapi med alkoholmisbrukende fedre: Terapeuters perspektiv". Jeg skal undersøke hva terapeuter sier om hvordan de forholder seg til sine mannelige pasienters forelderskap, sett i sammenheng med deres behandling for alkoholmisbruk. Hovedhensikten bak prosjektet er å gi et lite bidrag til utvikling av kunnskaper som kan utvide terapeuters praksis repertoire innenfor rusbehandling, særlig innenfor behandlingsfeltet for fedre med alkoholproblemer der hvor mindreårige barn er i bildet.

For å vite mer om temaet, ønsker jeg å intervjue mellom 5 – 7 personer som arbeider som terapeuter på behandlingssteder hvor det tilbys terapeutisk behandling for alkoholproblemer og der voksne menn (fedre) med mindreårige barn er blant den aktuelle målgruppen for behandling. I denne omgang henvender jeg meg til din klinikk, men for å sikre bredde og anonymitet i undersøkelsen har jeg tenkte å kontakte et utvalg av klinikker rundt omkring i Norge, uten å opplyse hvilke klinikker som er blitt valgt.

Under intervjuet vil jeg stille åpne spørsmål om meninger og ståsteder terapeuter har om deres mannelige pasienters forelderskap. Spørsmålene vil handle om hvordan de tilnærmer seg temaet og hva de vektlegger underveis i terapien. Jeg er også interessert i å høre om de har merket at små ting de har sagt eller gjort i den forbindelse kan knyttes til betydningsfulle endringer underveis i terapien. Samtidig vil jeg understreke at jeg ikke kommer til å spørre om eller ønske å få tilgang til opplysninger om enkelte pasienter eller andre forhold som er taushetsbelagt ved din arbeidsplass.

Jeg vil bruke båndopptaker og ta notater på en liten flip-over mens vi snakker sammen. Intervjuet vil ta omtrent en time, og vil kunne arrangeres i løpet av våren / sommeren 2006 enten på din arbeidsplass eller et annet sted som vi bli enige om.

Det er frivillig å være med og du har mulighet til å trekke deg når som helst underveis, uten å måtte begrunne dette nærmere. Dersom du trekker deg vil alle innsamlede data om deg bli slettet.

Opplysningene som samles under intervjuet vil bli behandlet konfidensielt, og det er kun jeg som student og min veileder som har tilgang til datamaterialet. I den endelige oppgaven/rapporten vil det ikke være mulig å gjenkjenne deg og de opplysninger du har gitt. Det vil heller ikke gå fram i forskningsrapporten hvilke klinikker som er blitt brukt som kilder, eller hvem jeg har snakket med. Ved prosjektslutt 30.06.2007 vil datamaterialet anonymiseres ved at direkte og indirekte personidentifiserende opplysninger slettes eller omkodes, båndopptakene slettes.

Resultatene av studien vil bli publisert som en forskningsrapport eller en artikkel som publiseres i et anerkjent tidsskrift innenfor feltet.

Dersom du har lyst til å være med på intervjuet, er det fint om du skriver under på den vedlagte samtykkeerklæringen og sender den til meg.

Hvis det er noe du lurer på, kan du ta kontakt med meg på et av disse telefonnumrene: 23265000 (jobben på dagtid), 22563591 (privat, kvelder og helgene) eller 47884522 (mobil). Om du foretrekker e-post har jeg to adresser: hilary.wongraven@online.no (privat) og hilary.wongraven@skbo.no (jobb). Du kan også kontakte studieleder ved Diakonhjemmet Høgskole, Håkon Hårtveit telefonnr 22451945 eller skrive på engelsk til min prosjektveileder Professor Jim Sheehan på følgende e-post adresse: jsheehan@mater.ie

Prosjektet er meldt til og godkjent av Personvernombudet for forskning, Norsk samfunnsvitenskapelig datatjeneste AS.

Med vennlig hilsen,

Hilary Wongraven
Arnstein Arnebergsvei 7,
0274 Oslo.

……………………………………………………………………………………….

Klippes eller rives av her og sendes til:
Hilary Wongraven, Arnstein Arnebergsvei 7, 0274 Oslo
(Se vedlagt konvolutt med adresse og frimerke).

Samtykkeerklæring:

Jeg har mottatt informasjon om studiet av "Forelderskap som tema i terapi med alkoholmisbrukende fedre: Terapeuters perspektiv" og ønsker å stille til intervju.

Jeg forstår at forskeren ikke ønsker og ikke kan få tilgang til lovmessige taushetsbelagte opplysninger.

Signatur …………………………………………………………………………………

Telefonnr……………………………………………………………………………..
Min e-post
adresse er……………………………………………………………………………..

Appendice Three: interview guide

Intervjuguide

Jeg skal begynne med noen korte ”fakta”-spørsmål om din profesjonstilknytning og din oppdragelse innenfor norsk kultur:
Hva er din profesjonsbakgrunn i forbindelse med jobben din her som terapeut? Er det lenge siden du tok den utdanningen?
Bodde du i Norge når du var barn?
Hvilke samfunnsklasse ville du selv identifisere deg med?

Jeg vet at denne klinikken noen ganger tar i mot mannelige pasienter som er fedre. Når du hører at en av dine pasienter er en far, hvordan ville du gå i gang med å finne ut mer om dette?

Hvilke type diskusjon ville du ta sikte på å få i gang med denne pasienten?

Hvor mye ville du ha vektlagt å se diskusjonen i lys av generelle samfunnsendringer?

Hva synes **du** er viktig for terapeuter som arbeider innenfor systemet for alkoholbehandling å ha i mente når de hører at deres mannelige pasienter har barn?

Hvordan la du dine pasienter få vite hva du mener selv, i forhold til utøving av deres forelderskap?

Kan du – uten å bryte ditt løfte om taushet - gi meg et eksempel av en endring i utøvelse av forelderskap som du merket skjedde i forhold til en mannelig pasient som var far, mens han gikk i terapi hos deg?

Vi vet at noen barn sier ganske klart fra til deres foreldre om hva slags forelderskap de ønsker seg; - altså at barn kan fortelle sine foreldre om hva som gjør dem trygge. Hvilke erfaringer har du gjort deg i din kliniske praksis, i forhold til dette?

Hva hjelper deg i å holde fast på ***håp*** når du utøver terapi med denne pasientgruppen?